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A transpersonal approach in a case of dissociative identity disorder

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**A
Transpersonal Approach
in a
Case of Dissociative Identity Disorder**

A Dissertation
to be
Submitted in Fulfillment
of the Requirements
for the Degree
of
Doctor of Education
1999

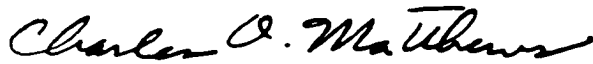
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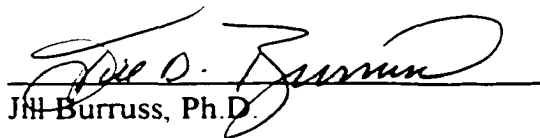
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Abstract

Psychoanalysis, behaviorism, and the humanistic movement have, in the latter years of the twentieth century, been joined by a fourth psychological force, Transpersonal psychology. This study utilized a Qualitative methodology, Social-Constructivist orientation, Case Study design, and Dual Narrative format, to explore the feasibility of utilizing a transpersonal approach in a case of Dissociative Identity Disorder. Sub-units of the investigation were (a) the treatment of Dissociative Identity Disorder by traditional, psychoanalytic/medical model psychotherapy, (b) the functions of the altered states of consciousness within the client's personality system, (c) the functions of the Internal Self Helper in the integration of the client's fractured self, and (d) the theoretical orientation of the therapist and its impact upon the treatment process.

Acknowledgment

No doctoral dissertation can be undertaken in isolation. I would like to thank my Committee Chair, Chas Matthews, Ph.D., for validating this work by offering a framework through which to view this most perplexing case. Dr. Matthews reminded me of the value of this work when I was lost in the darkness of a compelling, and seemingly endless project. I will always be grateful to him for introducing me to the world of the transpersonal.

Jill Burruss, Ph.D., ignited the fire of qualitative research through her academic expertise and engaging presentations. Victoria Foster, Ed.D., provided balance and credibility to the work through her critical writing proficiency. Jenny Wade, Ph.D., contributed an External Analysis, which has strengthened the research. Gwendolyn Pearson has gone far beyond the requirements of her position to keep me in the informational loop, a necessity for a graduate student who commutes two hundred plus miles to the college.

I am indebted to my colleagues at The Madeline Center, JoAnn Chrysanthus, Joyce Abbott, Jon Winder, Ana Ekstrom, Dan Williams, and Winnie Schenkel. These exceptional clinicians (and friends) have encouraged, at times prodded, me to follow my childhood dream. When overwhelmed (as I frequently have been), it has been these folks who have reminded me that this work needed to be written, and in so doing, legitimized my struggle.

It would be difficult, if not impossible, to undertake such a daunting task without the support of family. They have paid by far the biggest price. These guys have not, even once in more than four years, so much as hinted that I abandon the work. So to Karl, your belief in me when I had little faith in myself has sustained me throughout this process. To Jason, (J.D. to your friends at

the college), be kind to yourself. Joy is but one heartbeat away. . . it can only be found within.

To Justin, very simply, I hope I have taught you to fish . . .

And to Mom and Dad, my deepest gratitude for guiding me, in your own way, to the light. . .

Dedication

I have been told that once in every psychotherapist's lifetime, a client will present who challenges, chisels, and changes your life forever. Such was the case of Grace Ann Hughes. It is difficult to conceive that I will again be a witness to this degree of pain and suffering, nor conversely, this level of courage and commitment. Some four years later, at the most unlikely moments, I "hear" Jessica's, "Dr. Debbie, you have safe eyes," and "you can help them, Dr. Debbie, you beee's a doctor of broken hearts."

Through my work with Grace Ann, I have more fully come to know the true meaning of a "SURVIVA." And I have, through her internal self-helper, Strong Man Jesus, become acquainted with the inner wisdom and guidance that resides within, and among us all.

Grace Ann's courage has opened the doors to the potential healing of others. It is my most cherished desire that she and her inside family will "give themselves a hug" for a job well done, and will "know" their light has shown brighter than their pain.

There are many who have suggested that Grace Ann's appearance that rainy, November day was nothing more than mere coincidence, an unluckily stroke of fate's pen, an opinion I shared for several years. In retrospect, I believe her presentation to be no less than an instance of Jung's synchronicity, a "meaningful coincidence," whose purpose continues to unfold in my personal and professional life today. So to Grace Ann, I owe a debt of gratitude for what I have become, and what I yet hope to be.

And to Robbie and Annette, may your own recent transpersonal experience change your lives, as it has mine . . .

Chapter One

An Introduction

This chapter will present an overview of the case, and will focus upon (a) issues of presentation (b) boundary violations, and (c) the appearance of the first child alter. The statement of the problem will address the traditional treatment of DID, transpersonal psychology's emerging paradigm, and the feasibility of utilizing a transpersonal orientation in the successful treatment of the disorder. Four sub-areas of investigation will be posited. The research methodology will address the data collection and storage process, the dual-narrative format, and the study's inductive analysis. An external analysis will be provided by a practitioner in the field of transpersonal psychotherapy. The limitations of the research will identify the common prejudices of case study research, and will address the researcher's decision to exclude the (a) ritual abuse debate, and (b) verification of the client's memory reconstructions. The chapter will conclude with the definition of terms.

The Case

Rocking . . . rocking . . . rocking . . . she sits, precariously perched upon the precipice of the oversized sofa. Crutches positioned protectively by her side, she grasps a well-worn brown bear to her ample chest, sobbing, "I trust George, he won't hurt me, he has safe eyes . . . can you see his safe eyes?"

Reluctant, or unable, to visually engage with the therapist, her tear-filled eyes dart around the small darkened room. She checks and rechecks her temporary environment, as if to determine its presence as friend or foe. Hypervigilance gives way to detachment, as she appears entrapped in a world of darkness and fear. Her speech is slurred, punctuated by rasping sounds, exemplifying

ineffectual attempts to gasp sufficient air. At last, following a seeming eternity of uncomfortable silence punctuated only by guttural noises, she whispers, "George says I can trust you, you have safe eyes. . ."

The middle-aged Caucasian female is of New England descent, and has been referred to the fledgling therapist by a male colleague, ostensibly due to recurrent depressive symptomatology. A knee injury, aggravated by excessive weight, excessive walking, and a lifetime of double nursing shifts, has forced her out of 'her world.' She sits at home, her haven a poorly lit basement apartment. No longer successful at keeping her demons at bay (stuffing her feelings with food no longer works), she voluntarily admits herself into an inpatient treatment facility. However, after ten days she is told she must go home, for she has expressed no suicidal ideation, and her insurance company has denied additional inpatient services. It is at this point, this moment of unabashed hopelessness, that the disheartened professional turned client hesitantly enters outpatient therapy.

The ensuing months represent a cacophony of angry outbursts, sulking behaviors, self-mutilation, and flagrant boundary violations, interspersed with kindness, compassion, sensitivity, a keen intelligence, and a remarkable insight. Confusion reigns in the treatment room, with the therapist constantly on guard, never knowing who, or what, will present for the all too frequent sessions the client demands.

"I need to be here, Deborah," is the call of the day.

"George and I just need to be here."

Over time, one diagnosis is exchanged for another. The sequential unfolding appears first as depression, then anxiety, then post-traumatic stress, and eventually, as depersonalization. The

frequent flipping of the client between idealizing and denouncing the therapist, as well as the incessant boundary violations and inability to accept therapeutic limits (e.g., as many as thirty phone calls in one day), make the diagnosis of borderline personality disorder inevitable. This Axis II pathology stands until that day, that day when a child appears, complete in form and function. Sucking her right thumb while lazily twirling a lock of hair, the child, trapped in the massive female body, effortlessly glides from couch to floor (*What happened to the bad knee?*). The momentary serenity is replaced with apprehension. "Where's George," the *client-turned-child* frantically cries out. Upon zeroing in on her precious companion and heaving a hearty sigh of relief (much too forceful for a child), she surveys the astonished therapist, then matter of factly, and somewhat apologetically, declares, "Little Grace Ann don't sits on the sofa. . . only good boys and girls sits on the sofa. . . we be bad. . . we has to sits on the floor." It is at this moment that the diagnosis of Multiple Personality Disorder (later to be known as Dissociative Identity Disorder), suspected but undeniably dreaded, becomes overwhelmingly clear.

The Statement of the Problem

Traditionally, the treatment of Dissociative Identity Disorder (formerly known as Multiple Personality Disorder) has involved a long-term (three to five years), psychodynamically-oriented approach, intertwined with a mixed bag of eclectic techniques (Putnam, 1989; Barach, 1993). Few dissociative clients enter the therapist's door manifesting outward symptoms of the disorder. At these initial stages, checkered histories of childhood disappointments, chronic anxiety and depression, obsessional fears, numerous addictions/compulsions, erratic, often painful relationships, recurrent psychotic-like symptoms, self-mutilating behaviors, and suicidal ideation/intent are the presenting concerns (Bliss, 1984; Blume, 1986; Young, 1992; Cohen, Giller, Lynn, W., 1991, Loewenstein, 1993).

To date, the overarching therapeutic goal of those invested in dissociative work has been that of the arduous integration of the fractured self, with the most successful ego restorations facilitated by therapists displaying both artistic inclinations and spiritual orientations (Ross, 1989). Incomplete or partially processed trauma is known to be the primary reason for unsuccessful fusion of the altered states (Kluft, 1985; Putnam, 1989). This thwarted fusion often leads to frustration, and consequently to a premature termination, at which time the client sinks deeper into the obscure and unrelenting disorder.

The psychological community has acknowledged the need for treatment outcome data, for there is little agreement amongst treatment professionals as to which modality constitutes the best, most effective approach (Ross, 1995). While ego restructuring is undeniably essential (one must have an ego before one can transcend it!) (Walsh & Vaughan, 1993), higher states of consciousness and spiritual connectiveness have typically been rejected as effective, or even appropriate treatment modalities (Nelson, 1994; Boorstein, 1996).

Western psychological approaches (less than one hundred years old) have customarily minimized the great spiritual traditions of culture and advocated, even at times abdicated to the powerful European, positivist perspective (In Walsh & Vaughan, 1993). In the Western way of thinking, such "truths" as "the kingdom of God is within you," (Walsh & Vaughan, p. 113) may hold vast spiritual promise, but little meaning in our present day psychologies. This purposeful restriction of consciousness has been referred to by Fromm as "a mechanism of escape" (p. 110), Maslow as the "Jonah Complex" (p. 110), and Kierkegaard as the "tranquilization of the trivial" (p. 110) (Walsh & Vaughan, 1993).

While Western psychology is currently on the threshold of recognition, Eastern philosophies

have long acknowledged the higher wisdom of that which lies beyond. Within these ancient meditative disciplines, transpersonal experiences are highly valued, as they are known to produce dramatic, long-lasting changes, furnish the individual with a sense of purpose, inspire empathy and altruism, and alter one's life forever (Walsh & Vaughan, 1993).

An extension of Maslow's humanistic psychology (Figure 1.) (Maslow, 1964, 1969, 1972; Boorstein, 1996; Scotton, Chinen, & Battista, 1996; Wade, 1996), the transpersonal paradigm does not reject the choosing, creative, self-actualizing capacities of mankind espoused by psychology's third wave, but instead emphasizes the extraordinary (trans) experiences of the individual (Maslow, 1969, 1970; Walsh & Vaughan, 1993; Boorstein, 1996; Wade, 1996; Cortright, 1997). It acknowledges the observational reality of the physical world, but recognizes, respects, appreciates, and encourages the infinitive awareness of that which is beyond, that which is non-ordinary (Walsh & Vaughan, 1993; Boorstein, 1996; Scotton, Chinen, & Battista, 1996; Wade, 1996; Cortright, 1997). Through accessing the ancient practices of meditation and contemplation (Dubin, 1991, 1994; Murphy & Donovan, 1989) and shamanism (Peters, 1981), as well as the utilization of more contemporary techniques such as hypnosis (Bohm, 1980; Jue, 1996), and Grof's Holotropic Breathwork (Grof, 1988, 1994; Lee & Speier, 1996), the individual embarks on a deeper self-exploration, and an inevitable expansion of his level of consciousness.

Previously assumed to be most suitable for use with relatively healthy, growth-oriented clients, mental health providers are now on the fringes of a recognition of the transpersonal realms of consciousness, and consequently are beginning to visualize its application in severe pathology (Nelson, 1994; Boorstein, 1996). Boorstein, a transpersonal psychiatrist, asserted that the spiritual part of one's nature provides a source of inner nourishment. Therefore, transpersonal

Maslow's Hierarchy of Needs

Figure 1



Transpersonal Psychology is an extension of Maslow's Humanistic, or Third Force Psychology.

Figure 1. Maslow's Hierarchy of Needs. From Hergenhahn, B. (1994). Introduction to Theories of Personality. New Jersey: Prentice-Hall, Inc., p. 531. Reprinted with permission.

theory/orientation is equally appropriate in the treatment of the severely disturbed (Boorstein, 1996).

Following Boorstein's lead, this study will explore the feasibility of utilizing Transpersonal theory/orientation in the treatment of arguably the most severe and therapy-resistant of the psychopathologies. **A Transpersonal Approach in a Case of Dissociative Identity Disorder** will explore one client's journey, and will compare the treatment approach used with current practice in transpersonal psychotherapy.

The four sub-areas of this investigation are:

The treatment of Dissociative Identity Disorder by traditional, psychoanalytic/medical model psychotherapy.

The functions of the "altered states of consciousness" within the client's personality system.

The functions of the Internal Self-Helper (ISH) in the integration of the client's fractured self.

The theoretical orientation of the therapist and its impact upon the treatment process.

The Research Methodology

The Single Case Study (n of one) Narrative will portray one individual's therapeutic journey.

The narrative will be prepared utilizing archival, artifactual data (letters, progress notes, audio tapes, video tapes, newspaper reports, employment records, medical records, diaries, journals, artwork, etc.), collected in a therapeutic setting (private practice office) from November 1992 to June 1995. The data, secured in a locked file since termination of the case, will be appropriately modified to protect the confidentiality of the client. Since the narrative will be prepared at the former client's request, two, unsolicited, hand-written consent letters are included in the appendices (Appendix A.1.2.)

Chapter II is a review of the relevant literature. Chapter III explicates the methodology.

Chapter IV presents the Case Study Dual Narrative, and is divided into four phases: (a) Phase One: Exploratory (The First Seven Months) (b) Phase Two: Standard Treatment of Dissociative Identity Disorder (Eight Months to Two Years) (c) Phase Three: A Transpersonal Approach (The Third Year), and (d) Phase Four: Termination and Referral (The Final Six Months). The dual narrative format is employed to present the evolving dialogue of both the client and the therapist. Chapter V, The Analysis, explores each of the four phases of the treatment process outlined in Chapter IV, and in retrospect, its effectiveness. Chapter VI, Part I provides an external analysis of the research, provided by a practitioner in the field of transpersonal psychotherapy, as well as the researcher's reply. Chapter VI, Part II outlines (a) recommendations for utilizing a transpersonal approach in the treatment of Dissociative Identity Disorder, (b) recommendations for clinician training, and (c) implications for further research.

The Limitations of the Research

Historically, Qualitative Case Study Design has been criticized for its lack of rigor, high level of subjectivity, purposive rather than random sampling, and absence of statistical generalizability (Yin, 1994). In addition, the research process is known to be time consuming, and may result in massive, unreadable documents (Yin, 1994).

In an effort to minimize these traditional prejudices, this research seeks to present an exemplary case study that displays significant evidence, considers alternative perspectives, and is composed in an appealing manner. In an attempt to increase trustworthiness, the study presents the data as it has been collected, including documented narrative accounts that are representative of the case. It recognizes and appreciates the value of language as the primary means of communication between the audience and the researcher. The study acknowledges that the

ultimate value of case study methodology lies in its uniqueness, and as such, is generalizable only to theoretical propositions rather than to populations.

The therapist/researcher, as participant-observer, seeks to guard against the inherent pitfalls of this potentially dual relationship. The researcher's role, ranging from pure observation to full participation, provides a unique opportunity to observe individual behavior patterns, experience first-hand the unexpected, enrich the interpretation, and become a trusted constituent of the therapeutic/research process.

Conversely, the dual role may decrease the probability of external observation, as the very nature of the 'helping relationship' thrusts the therapist/researcher into the position of client advocate. From this vantage point, the therapist/researcher is likely to (unwittingly) emerge as a supporter/confidant of the case. Consequently, this 'participant role' may minimize the potential for independent observation. Not to be discounted will be the therapist/researcher's level of anxiety, for in cases of Dissociative Identity Disorder, it is exceedingly difficult to retain one's status of unbiased observation.

Finally, this research does not explore/investigate the Ritual Abuse phenomenon, and does not seek to verify the historical accuracy of the client's allegations, preferring instead to adopt the social-constructivist stance of acknowledging her "truths" as her reality.

Statement of Bias

This study portrays an inner odyssey, a voyage of dualities punctuated by confidence and questioning, hope and disillusionment, serenity and struggle, alienation and union, utter despair and absolute peace.

The researcher, as seasoned educator, had evolved into a skilled counselor, utilizing her expertise with children, adolescents, and their families within a public school setting. Once again the opportunity had arrived for her to set her occupational sails, this time to venture forth into the world of professional counseling. Although considerably educated and meticulously trained, nothing, no well-worn text, motivating lecture, experiential exercise, nor supervised experience had prepared her for the client she was about to encounter--the need was so great, the chasm so deep, the psychopathology so severe.

Overwhelmed with inadequacies, the fledgling therapist anxiously groped for, "What to do?" As a student of counseling ethics, (Cory, G., Cory, M., Callahan, P., 1993) she had been taught to refer those individuals whose psychological demands surpassed her level of competency. "But, a referral to where? Who would be willing to accept such an unusual client? Who possessed the expertise for the daunting task? Who, quite simply, had the time?" Upon investigation, it became rapidly apparent that she was not alone in her reluctance. Referral would not be an option. If meaningful change was to be effected, or even attempted for that matter, the neophyte therapist would be obliged, willing or not, to serve as the facilitator.

Over the ensuing months, therapeutic plan after plan would be alternately adopted and discarded. Frustration would mount. Discouragement would creep in. No longer the director, the bewildered therapist was on numerous occasions a resentful participant, sharing little of the client's unwavering faith, and even less of her zeal. Reluctantly, the 'considerably educated and

meticulously trained' therapist accepted the obvious-- 'there was no way out but through.'

Upon reflection, it was at that point that the process emerged with a life of its own, not because of the therapist's scholarship, but in spite of it. It was in this manner that the redemptive transformation began--alienation to union, utter despair to absolute peace--a transformation impacting not only the client, but unexpectedly, the therapist as well.

The Definition of Terms

- ABREACTION:** The physical and/or emotional discharge of energy that results when a repressed, previously intolerable trauma is recalled as if it were occurring in the present (American Psychiatric Association, 1980).
- ACTING-OUT:** An expression of unconscious feeling in actions rather than words. Acting out can take many forms, such as self-inflicted violence or suicidal gestures (Sidran Press, 1995).
- ALTER PERSONALITY:** A psychological entity which possesses a clear and pervasive sense of self and a consistent pattern of behavior and feelings in response to a given stimuli. The alter must have a range of functions and emotional responses, as well as its own significant life history (Kluft, 1984). This entity is a dissociated part of the mind that the individual experiences as detached (ISSD Practice Guidelines Glossary, 1994), and is frequently amnesic towards the other alters within the personality system (Friesen, 1997).
- AMNESIA:** A pathologic loss of memory, or “a time which is disremembered” (Friesen, p. 17). This inability to recall may be organic, emotional, dissociative, or a combination of the above, and may be either permanent or short-lived (American Psychiatric Association, 1994). The phenomenon may also be known as Dissociative Amnesia.
- AMNESIA BARRIERS:** The highly adaptive compartmentalization of traumatic memories that allows the individual to survive. If the abuse is long-term, the

memories are dissociated, and the illusion that the altered states/personalities are separate people becomes the victim's reality (Ross, 1989).

AXIS II PATHOLOGY: One component of the diagnostic system as outlined in the DSM-IV. An Axis II diagnosis denotes the presence of a personality disorder, such as borderline, histrionic, avoidant, or borderline personality disorder. (A personality disorder is characterized by inflexible, maladaptive personality traits.) Often comorbid (occurring in conjunction) with the Axis I diagnosis of Dissociative Identity Disorder, its presence often complicates treatment, contributing additional chaos, impairment, and distress (DSM-IV, 1994).

BASK: The Behavior, Affect, Sensation, and Knowledge Model for the treatment of Dissociative Disorders developed by Braun. The long-range goal of treatment is the integration of the four BASK components (Braun, 1985).

**BORDERLINE
PERSONALITY
DISORDER:**

A chronic pattern of instability of mood, interpersonal relationships, and self-image, beginning in early childhood and present in a variety of contents, as indicated by at least five of the following:

- 1) a pattern of unstable and intense interpersonal relationships, characterized by alternating between extremes of over-idealization and devaluation.

- 2) impulsiveness in at least two areas that are potentially self-damaging, e.g., spending, sex, substance abuse, shoplifting, reckless driving, binge eating.
- 3) affective instability: marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days.
- 4) inappropriate, intense anger or lack of control of anger, e.g., frequent displays of temper, constant anger, recurrent physical fights.
- 5) recurrent suicidal threats, gestures, or self-mutilating behavior.
- 6) marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, preferred values.
- 7) chronic feelings of emptiness or boredom.
- 8) frantic efforts to avoid real or imagined abandonment (DSM IV, pp. 650-654).

BIPOLARITY:

The Bipolar conception of Washburn's Dynamic-Dialectical Paradigm which divides the psyche into the egoic (ego functions of reality testing, self-control, and personal experience) and nonegoic (numinous power or spirit) poles (Washburn, 1995, p.11).

BODY MEMORY:

"... body sensations that symbolically or literally capture some

aspect of the trauma. . . A person who is raped may later experience pelvic pain similar to that experienced at the time of the event. This type of bodily sensation may occur in any sensory mode: tactile, taste, smell, kinesthetic, or sight" (Sidran Foundation, 1995). Body memory is referred to as somatoform disorder or somatic memory in the DSM-IV (Sidran Foundation, 1995).

BOUNDARIES: Appropriate touch, number, and length of therapy sessions, number and length of phone calls, etc., are examples of the therapeutic boundaries often established for the protection of both client and therapist. Since the DID client has little or no knowledge of healthy boundaries, having had her personal space repeatedly violated throughout the abuse, it is imperative that well-defined boundaries, or expectations, be established (Kluft, 1985; Putnam, 1989).

CONFABULATION: "This term originally referred to a neurological deficit in which a person who is unable to recall previous situations or events fabricates stories in response to questions about those situations or events. It is now used more broadly to refer to 'false memories' that are supposedly created in response to questions asked by a therapist or interviewer." (Sidran Foundation, 1995).

COPRESENCE: Copresence or co-consciousness occurs when an alter personality in the background simultaneously takes control of the body

without the primary personality's knowledge, frequently influencing the host's affect or perception (Ross, 1989).

COUNTERTRANSFERENCE: "A therapist's conscious or unconscious emotional reactions to a client. It is a therapist's job to monitor his or her reactions to a client and to minimize their impact on the therapeutic relationship and treatment" (Sidran Foundation, 1995).

DEPERSONALIZATION DISORDER:

"... an alteration of the individual's sense of self so that the person feels unreal, as if in a dream. The individual may report memories of a dream-like quality, which at times can not be distinguished as fantasy. Individuals often report the experience of being outside of one's body, watching oneself or looking down from above" (Putnam, p. 15).

DEREALIZATION:

Often occurring in conjunction with depersonalization, derealization, a surrealistic awareness, can be described as estrangement, detachment, or a sense that one's external world is strange or unreal (DSM-IV, 1994).

DISCRETE STATE OF CONSCIOUSNESS:

A unique pattern of psychological structures which, in spite of subsystem or environmental variation, is stabilized by a number of processes so that it retains its identity and function. "... an automobile remains an automobile whether on a road or in a garage (environmental change), whether you change the brand of spark

plugs or the color of the seat covers (internal variation). Examples of d-SoC are the ordinary waking state, non-dreaming sleep, dreaming sleep, hypnosis, alcohol intoxication, marijuana intoxication, and meditative states" (Tart, In Walsh & Vaughan, p. 35).

DISCRETE ALTERED STATE OF CONSCIOUSNESS:

A d-ASC is a d-SoC that differs from the baseline state of consciousness (b-SoC). The d-ASC represents a new system, a restructuring of consciousness (Tart, In Walsh & Vaughan, 1993).

DISSOCIATION:

"A complex process of changes in a person's consciousness which causes an alteration in the normally integrative functions of identity, memory, thoughts, feelings, and experiences" (Cohen, Giller, & Lynn W., 1991, p. 226). As a verb, dissociation depicts an alters surrender of system control. As a noun, the term represents the ultimate defense mechanism, i.e., the body's ability to "forget" traumatic events (Friesen, 1997).

DISSOCIATIVE IDENTITY DISORDER:

The existence within the person of two or more distinct alters or alter fragments (each with its own relatively enduring patterns of perceiving and relating to the environment and self), with at least two of these alters or altered states recurrently taking complete control of the individual's behavior (DSM IV, 1994).

**DIAGNOSTIC &
STATISTICAL
MANUAL OF
MENTAL DISORDERS:**

The American Psychiatric Association's 1994 publication which contains standard definitions of the recognized psychological disorders. The text is also known as the DSM-IV (DSM IV, 1994).

**DISSOCIATIVE
DISORDER
INTERVIEW SCALE:**

A structured interview developed by Ross, Heber, Norton, and Anderson for the purpose of standardization of the DID diagnosis. Utilized in both clinical and research settings, the DDIS has good clinical validity, and "has shown that DID is a valid diagnosis with a consistent set of features and that both dissociative experiences and dissociative disorders are common" (Ross, 1989, p. 135).

**DISSOCIATIVE
EXPERIENCES SCALE:**

The DES is a 28 item self-report instrument developed by Bernstein & Putnam (1986). The respondent is asked to indicate the frequency with which certain dissociative or depersonalization experiences occur (Putnam, 1989).

**FALSE MEMORY
SYNDROME:**

The term coined in the early 1990's by the False Memory Syndrome Foundation (FMSF), an organization established by parents of adult children whose delayed memories of childhood abuse are believed by the founders to have been implanted by therapists. The False Memory Syndrome has been popularized in the media. In reality, it is based upon neither empirical validation nor theoretical

formulation, and is not included as a diagnosis or a symptom in the DMS-IV (Sidran Foundation, 1995).

FLASHBACK: "A type of spontaneous abreaction common to victims of acute trauma. Also known as 'intrusive recall,' flashbacks can take the form of (a) dreams or nightmares, (b) dreams from which the dreamer awakens but has difficulty establishing contact with reality, (c) conscious flashbacks, in which the individual may not lose contact with reality but may experience auditory, visual, olfactory, and/or tactile hallucinations and, (d) unconscious flashbacks, in which the individual 'relives' a traumatic event while remaining amnesic of the event" (Cohen, Giller, & Lynn W., 1991, p. 226).

FRAGMENT: A dissociated, split-off part of the personality or altered state which, while consistent in its emotional and behavioral response, has a restricted function and is not as clearly defined as an alter personality (Putnam, 1989).

FUSION: The initial stage of integration, when two or more altered states of consciousness begin the process of merging (Friesen, 1997).

IATROGENESIS: The belief (frequently held by skeptics of DID) that a therapist treating a dissociative client may, with or without hypnosis, unwittingly reinforce the client's behavior and contribute to the dissociative process (Putnam, 1989; Ross, 1989). Kluft (1985) has suggested that the risks of iatrogenic contamination have been

greatly exaggerated; that a therapist's work with altered states neither reinforces their existence nor worsens their pathology.

INTEGRATION:

The disintegration of amnestic boundaries which mark an end to the frequently prolonged process of internal fusion (Duncan, 1993).

Integration has been described by one DID survivor as "connected, absorption, and cementing" (Collins, In Lynn W., Mending Ourselves, 1993, p. 164).

INTERNAL SELF HELPER:

An altered state, generally a helper or protector who has a working knowledge of the personality system. "Experienced therapists disagree about the nature or the ISH personalities and whether they occur in all MPD [DID] patients. Typically they are physically passive and relatively emotionless personalities, who provide information and insight into the inner working of the system" (Putnam, p. 110).

LOSING TIME:

Unaccounted for periods of time (minutes, hours, days, weeks, years), of which the individual has no space-time orientation/recollection. This loss of memory often causes fear and confusion for the dissociated individual. It has been speculated that these 'lost' periods may allow for re-victimization (Sidran Foundation, 1995).

MAPPING:

A drawing, outline, or chronological time line prepared by a helper personality which diagrams the altered states and explains the inner

world of the system. This 'map' must be updated periodically as additional altered/personality states are identified (Putnam, 1989).

MEDICAL MODEL: The belief that abnormal behavior results from a physical/biological cause and must be treated medically. The rise of the non-medical disciplines have at times created a conflict between the medical and social/behavioral models (Sidran Foundation, 1995).

MENTAL STATUS EXAM: A formal evaluation of a presenting client's current psychological, emotional, and behavioral functioning. The MSE includes orientation to time, place, and person, thought content, cognition, mood, affect, insight, and suicidal/homicidal ideation or intent. The MSE is often administered during the initial therapy session (Putnam, 1989).

PANIC ATTACK: An attack of uncontrollable anxiety, usually lasting several minutes though possibly continuing for hours (Bootzin & Acocella, 1988).

POSTTRAUMATIC STRESS DISORDER: An intense form of anxiety disorder that results from exposure to acutely traumatic events (natural disasters, assault, rape, wartime combat). The victims often re-experience the traumatic event in recollections and/or nightmares, may appear unaware of their present surroundings, and may suffer physical symptoms and/or intense irritability. The symptoms frequently last for six months, but may remain for years (Bootzin & Acocella, 1988), DSM-IV, 1994).

POLYFRAGMENTATION: Another term for the layering of alter/personality fragments within the dissociative client's system (Putnam, 1989).

PSYCHOGENIC AMNESIA: The sudden inability to recall important personal information that is too pervasive to be explained by ordinary forgetfulness and can not be attributed to an organic mental disorder (DSM-IV, 1994).

PSYCHOGENIC FUGUE: The dissociative individual's sudden, unexpected travel away from home or work place coupled with memory loss and the likely assumption of a new identity (DSM-IV, 1995).

REGRESSION: The return to an earlier psychological state. In DID, child alters are an example of trauma-based regression (Sidran Foundation, 1995).

REVIVIFICATION: "The vivid remembering of past experiences. When remembering traumatic events the client may see, hear, taste, smell, and feel as though the event is happening in the present. This is common during an abreaction or flashback of previous trauma" (Sidran Foundation, 1995).

SCREENING: A technique utilized by therapists of dissociative clients in which the client is helped into a trance state and asked to visualize a movie or television screen. The client is then asked to project his experiences onto the screen so they can be viewed from afar. This 'screening' serves to minimize painful revivification during an abreaction (Putnam, 1989).

- SCRIPT MEMORY:** A manufactured identity or memory alleged to have been purposefully implanted during ritual or cult abuse (Mungadze, 1992).
- SELF-MUTILATION:** A form of self-harm that occurs in at least one third of all DID clients (Putnam, Guroff, Silberman, Barban, & Post, 1986). Self-mutilation typically involves cutting with glass or razor blades, burning with cigarettes or matches, and has been known to include such bizarre patterns as insertion of broken glass or other foreign objects into the vagina (Riggall, 1931; Bliss & Bliss, 1985; Putnam, Guroff, Silberman, Barban, & Post, 1986).
- SCHNEIDERIAN FIRST RANK (ORDER) SYMPTOMS:** The medical model criteria utilized in the diagnosis of Schizophrenia. Dissociative patients frequently experience such Schneiderian symptoms as voices talking or arguing within their heads, or the belief that their bodies are controlled by outside forces (Kluft, 1984; 1987).
- SWITCHING:** A change in executive control of the body (Friesen, 1997). Switching may be the result of internal dynamics or may be triggered by external events (Putnam, 1989).
- TALKING-THROUGH:** A therapeutic technique in which the personality system is addressed as a whole. The technique encourages cooperation and

assists in the disintegration of the amnestic boundaries (Sidran Press, 1995).

TRIGGER: Any color, smell, object, individual, event, etc., which vividly reminds the dissociative individual of the prior trauma. A trigger often causes an intense emotional response (Sidran Press, 1995).

TRIPHASIC: The division of human development into three general phases--the pregoic, egoic, and transegoic (Washburn, 1995).

The Conclusions

This chapter has provided an overview of the case, focusing upon (a) issues of presentation (b) boundary violations, and (c) the appearance of the first child alter. The statement of the problem has addressed the traditional treatment of DID, and the feasibility of utilizing a transpersonal orientation in the successful treatment of the disorder. Four sub-areas of investigation have been posited. The research methodology has addressed data collection and storage. The dual narrative format, inductive analysis, external analysis, and the limitations of the research, have been reviewed. The chapter has concluded with the definition of terms.

Chapter Two

A Review of the Literature

An Introduction

This chapter is comprised of two parts. Part I, entitled **Dissociative Identity Disorder**, introduces **The Dissociative Phenomena**, and provides an overview of dissociative research. Altered states of consciousness are presented, and a question of purposeful dissociation reviewed. Sociocultural implications, traditional treatment dimensions, and the controversy surrounding ritual/multi perpetrator abuse are addressed. An Adlerian orientation and Object Relations framework are reviewed.

Part II, entitled **Transpersonal Psychology**, begins with an emerging paradigm, and introduces transpersonal definitions, precursors to the field, and historical perspectives. Transpersonal assumptions are addressed. An overview of transpersonal development is provided. The leading transpersonal theorists are introduced, followed by a critique of their contrasting orientations. The current state of transpersonal psychotherapy and the transpersonal psychotherapist is advanced. Dissociative Identity Disorder and transpersonal psychology are presented, and clinical/ethical issues reviewed.

Dissociative Identity Disorder

The Dissociative Phenomena

Dissociation can be found along a continuum from the everyday experience of an adolescent's daydream, highly adaptive in nature, to the maladaptive, often disabling diagnosis of Dissociative Identity Disorder (Braun, 1988; Putnam, 1989) (Figure 2.). It is proposed by Laney (1996) to be utilized as a "creative and resilient defense in the preservation of the self. . ." (p. 36)

CONTINUUM OF DISSOCIATION

Figure 2

Normal	Dissociative Episode	Dissociative Disorder	Post-traumatic Stress Disorder	Atypical Multiple Personality Disorder	Multiple personality Disorder
Amnesia	Fear	Psychogenic Amnesia (Including sleep walking)		Automatism	Polyfragmented MPD
Hypnosis	Repression			ADD with features of MPD	
Ego States	Highway Hypnosis	Fugue		Polyfragmented ADD	
Automatism	Mystical Experiences	Depersonalization			

Dissociation can be found along a continuum, from the everyday experiences of an adolescent's daydream, highly adaptive in nature, to the maladaptive, often disabling diagnosis of Dissociative Identity Disorder.

Figure 2. The Continuum of Dissociation, from Braun, B. (1988) *Bask Model*. Dissociation.

1.1. 11-12. Reprinted with permission.

whose existence, in the face of overwhelming trauma, allows for the continuity of normal psychological functioning. Often misdiagnosed as hypersensitivity, hypochondria, paranoid schizophrenia, or borderline personality disorder (Kluft, 1985; Putnam, 1989; Ross, 1989; 1995) DID is most often a tool for survival, for this ability to dissociate allows the individual to escape an incomprehensible environment/situation by detaching mentally and emotionally. The traumatic amnesia that results as the mind dissociates allows the victim to function outside the continually abusive situation (Cohen, Giller, & Lynn W., 1991; Putnam, 1989; Ross, 1989; 1995; Laney, 1996).

A growing body of anecdotal literature (Allison, 1974; Boor, 1982; Saltman & Soloman, 1982; Bliss, 1984; Kluft, 1984; Browne & Finkelhor, 1986; Coons, 1986, Hall, 1989; Putnam, 1989; Ross, 1989; 1995; Beere, 1994; Gould, 1995; Friesen, 1997) has proposed a direct link between sustained, severe child emotional/physical/sexual abuse and the creation of Dissociative Identity Disorder. Stolorow (1984-85) has couched the trauma within an interrelational framework as well, asserting that the instability of the child-care giver relationship disrupts the child's affective self-regulation, resulting in ego disintegration, disorientation, and ultimately, dissociation.

The developmental period in which the trauma has occurred determines the long-term effects of the disorder (Murphy & Moriarty, 1976; Garmezy, 1983; Rutter, 1983; Anthony, 1987; Farber & Egeland, 1987; Middleton-Moz, 1989), with the 'window of vulnerability' essential to the formation of DID between eighteen months and five years of age (Marmer, 1991). In addition to the trauma, the DID individual may exhibit predisposing factors, which are likely to include an inborn capacity to dissociate (In Kluft, 1985; Friesen, 1997), "a genetic-based above average

excitability of the nervous system and above-average intelligence” (Laney, p. 36), and an ability to become autohypnotic, i.e., to enter a voluntary hypnotic state (Kluft, 1984; Bliss, 1986). Friesen (1997), a psychotherapist specializing in the treatment of dissociative disorders, has observed an increased ability to fanaticize accompanied by high levels of creativity within his clinical population.

DSM IV Definitions

The Diagnostic & Statistical Manual, Fourth Edition (1994), has recognized four disorders within the dissociative spectrum. Dissociative Amnesia (300.12), known as Psychogenic Amnesia in the DSM-III, involves the sudden inability to recall personal information not attributed to either everyday forgetfulness or an organic mental disorder. Dissociative Fugue (300.13), formerly identified as Psychogenic Fugue, involves an abrupt, unexpected travel from one's home or work coupled with an inability to recall the circumstances involved. Confused about the past, the individual may assume a temporary new identity. Depersonalization Disorder (300.60) results in a sense of unreality, detached or dreamlike state, or the experience of being outside one's body while watching from outside or above. This 'outside observer' views the body and/or mental processes, while simultaneously and remarkably, reality testing remains intact. Depersonalization Disorder has an abrupt onset and gradual recovery. Dissociative Identity Disorder (300.14), known for some years as Multiple Personality Disorder, represents the ultimate dissociative state, a chronic disorder which, if left untreated, will likely manifest itself over the course of a lifetime. Dissociative Identity Disorder contains all the elements of the other, less pathological dissociative disorders (Diagnostic & Statistical Manual IV, 1994). (Figure 3.)

According to Ross (1989, the DID individual (a) is frequently female (females in treatment

Dissociative Ability, Severity of Abuse, and Presenting Symptomatology

Figure 3

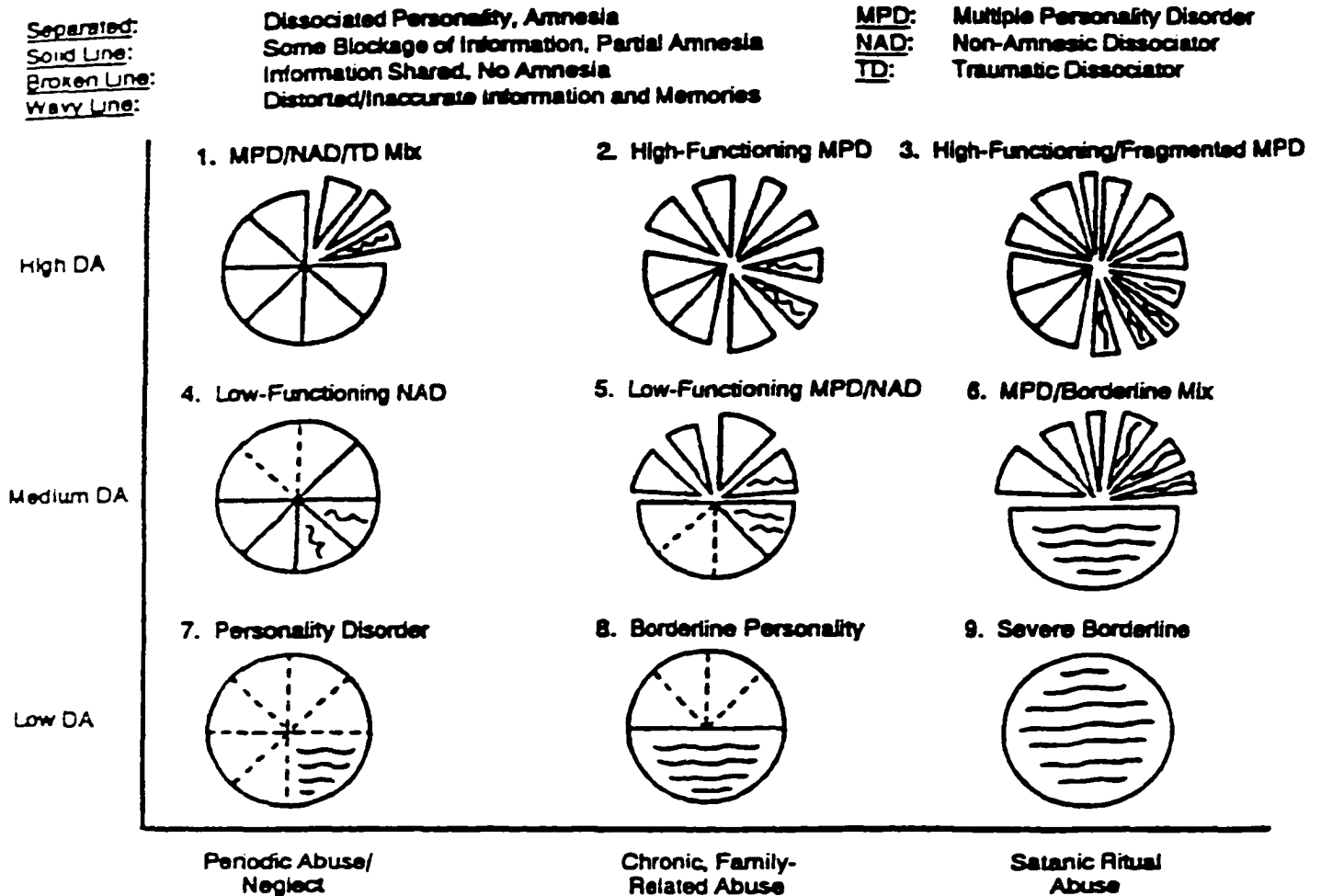


Figure 3. Dissociative Ability, Severity of Abuse, and Presenting Symptomatology. From Friesen, J. (1991). Uncovering the Mystery of MPD. Eugene, Oregon: Wipf & Stock, Publishers, p. 127. Reprinted with permission.

outnumbering males by 9:1), (b) often presented with a history of sexual and/or physical abuse, (c) experienced unexplained 'blank spells', voices inside the head, or other Schneiderian symptoms, (d) exhibited self-destructive behaviors, (e) met the DSM-IV criteria for Borderline Personality Disorder, (f) endured recurrent severe headaches, and (g) had undergone years of unsuccessful treatment for a myriad of contradictory symptoms (p. 101).

An Overview of Dissociative Research

Dissociative states were studied at the turn of the century by such theorists/clinicians as Janet, Charcot, Bernheim, and Freud. James (1890/1983) presented individual case studies referencing the "plurality of selves," while Jung (1902/1907) investigated dissociative phenomena in a treatise entitled On the Psychology and Pathology of So-Called Occult Phenomena. Binet's On Double Consciousness (1890), and Alterations of Personality (1896) addressed the clinical observations of Dissociative Identity Disorder, while Breur & Freud's Studies of Hysteria (1894) gave impetus to continued dissociative research (Ross, 1989). Freud was reported to have been the first to present dissociation as trauma-based. However, he later recanted his original clinical findings, instead positing an oedipal theory in which dissociative patients were viewed as "hysterics suffering from unresolved incestuous fantasies" (Masson [1984], as referenced in Laney, p. 36).

Dementia Praecox

The increased popularity of Dementia Praecox as a diagnostic label contributed to the demise of twentieth century dissociative research. Dementia Praecox, a precursor to our modern-day Schizophrenia, was first recognized as a degenerative mental disorder with strong, genetic/familial components. Characteristics of the disease resembled those of the earlier dissociative states, i.e., varying disturbances of content/form of thought, perception, affect, interpersonal relations,

psychomotor retardation, as well as a pathological collapse of ego boundaries (Ross, 1989).

Observed most frequently in members of the lower socioeconomic strata, it was hypothesized that disturbed family interaction patterns, downward drift, and elevated levels of stress contributed to the onset and chronicity of the disorder. It has been speculated that numerous trauma survivors, individuals whose dissociative experiences may have represented their valiant attempts to remain sane in their insane worlds, were misdiagnosed through these intervening years with Schizophrenia (Ross, 1989; Nelson, 1994).

Anecdotal Research

While the medical community was immersed in the identification and treatment of Schizophrenia, dissociative presentations continued. One by one anecdotal accounts were published, until the field was permeated with bizarre, unsubstantiated, but strikingly similar life stories. A Case of Profound Dissociation of the Personality (Copeland & Kitching, 1937), A Case of Double Personality (Maddison, 1953), and Two Names, Two Wardrobes, Two Personalities (Money, 1974), were indicative of the single case studies reported in the twentieth century psychiatric literature.

The 1970's ushered in a renewed interest in both MPD (Putnam, 1989; Ross, 1989) and the psychoanalytic paradigm of psychic trauma (Cohen, 1980; Ulman & Brothers, 1988).

Consequently, the 1980's witnessed an "exponential increase" in the diagnosis of Dissociative Identity Disorder (Ross, p. 6), which the author has attributed to a greater awareness of trauma and its aftermath following the Vietnam War, as well as to a increased consciousness and appreciation of the rights of women and children. As increasing numbers of dissociative individuals presented in the psychiatric clinics across North America, the necessity for empirically validated research has risen accordingly.

Hall (1989) has stated, “the reality is that MPD [DID] is not rare. . . only rarely identified” (p. 114). Referencing Ross (1989), Laney (1996) reported that about one out of fifty (individuals presenting for treatment) satisfy the diagnostic criteria for DID when screened using Bernstein & Putnam’s (1986) Dissociative Experiences Scale, adding further speculation as to the prevalence of the disorder.

The Need for Empirical Validation

While questions have abounded, scant empirically validated data exists (Putnam, 1989). The most comprehensive Dissociative Identity Disorder study in North America represented the first attempt to (a) devise norms for the disorder and, (b) assemble structured interview data from several locations. Using the previously cited Dissociative Experiences Scale (Bernstein & Putnam, 1986) (test-retest reliability = 0.81), and The Dissociative Disorders Interview Schedule (interrater reliability- 0.68), the researchers interviewed ninety-two women and ten men clinically diagnosed with MPD [DID] in four dissociative disorders clinics (Ross, Miller, Reagor, Bjornson, Fraser, & Anderson, 1990).

The data was examined to determine the similarities and differences among the individual presentations, and was analyzed using the chi-square for dichotomous data, the Krushal-Wallis test to determine significance for continuous data, and a step-wise regression analysis. Ninety-seven (95.1%) of the clients reported a history of childhood physical and/or sexual abuse; ninety-four (92 %) reported suicidal ideation and/or attempts, and ninety-seven (95.1%) reported an extensive involvement in the mental health system, with the average length prior to the diagnosis of the disorder to be 6.8 years. Ninety-two individuals (90.2%) reported the presence of three or more Schneiderian First Rank symptoms; ninety-three (91.2%) presented with two or more borderline criteria; ninety-four (92.2%) complained of five or more somatic discomforts; and

ninety-one (89.2%) have experienced two or more extrasensory episodes. The researchers concluded that, at least in North America, MPD [DID] was a disorder with a stable, consistent set of features (Ross, et al., 1990).

In Multiple Personality in The Netherlands: A Clinical Investigation of 71 Patients, Boon & Draijer (1993) interviewed MPD [DID] patients using the Dutch version of the Structured Clinical Interview for DSM-III Dissociative Disorders, followed by The Dissociative Experiences Scale. Boon reported the resulting percentage and frequency data were “strikingly” similar to that reported in Ross, et al. (1990) North American study, leading the author to surmise that MPD [DID] existed as a disorder with a stable set of core symptoms throughout Europe and North America (Boon & Draijer, 1993).

In an effort to obtain reliable data regarding the prevalence of MPD in Switzerland, Modestin (1972) distributed (a) a questionnaire, (b) three case studies, and (c) the DSM III criteria for the disorder to 836 Swiss psychiatrists. Of the 770 qualified responses, 3% reported currently treating MPD patients, while 10% acknowledged having treated the disorder at least once. From this survey data, Modestin concluded MPD to be a valid disorder that rarely occurred in Switzerland (Modestin, p. 88).

Adityanjee & Khandewal (1989) relied on anecdotal data in The Current Status of Multiple Personality Disorder in India, reporting on three consecutive cases presenting over a three year period at a major psychiatric clinic in India. While the researchers acknowledged the disorder appeared to be rare (0.1/1000 patients), they suggested that statistical data were likely to be invalid, due to the existence of the Eastern diagnostic category known as Possession State Syndrome. The authors speculated that the syndrome, commonly observed within the less

educated, lower socioeconomic strata of India, Nepal, Pakistan, and Sri Lanka, had its origins in the Eastern religious beliefs of polytheism and reincarnation.

Adityanjee & Khandewal have suggested that Possession State Syndrome would likely present as Dissociative Identity Disorder in Western psychotherapy clinics (1989). While anecdotal research has permeated the dissociative literature, the field would be greatly served with continued efforts to obtain empirically validated findings as to the etiology and prevalence of the disorder.

Altered States of Consciousness

Those diagnosed with DID exhibit apparently separate and autonomous altered states of consciousness, with at least two of these identities or alters recurrently taking control of the person's behavior (Diagnostic & Statistical Manual IV, 1994). Once again, little empirical data exist to support the existence of these autonomous altered states. However, numerous clinical presentations, eerily similar in nature (primarily case study in nature), have led researchers and clinicians (Allison, 1974; Kluft, 1984; Putnam, 1989), to formulate specific categories of altered states, each responsible for distinctive functions within the fractured personality system.

The host was described by Kluft (1984) as the alter having executive control of the body the majority of the time, the entity frequently initiating and presenting for treatment. Occasionally, the host was not a single alter, but several personalities attempting to present as one (Kluft, 1984). Child personalities were present, often in layers or groups of alters underneath other alters (polyfragmentation), and always suspended in time (Putnam, 1989). If the abuse occurred in infancy, the 'children' were likely to be non-verbal and frequently acted-out the abuse, more often than not viewing the therapist as the perpetrator.

Putnam (1989), theorizing from his years as a psychotherapist treating DID, also categorized alters/personalities according to their function within the system. He identified memory trace personalities as those who held the victim's complete history. Cross-gender personalities were believed to be responsible for the host's unisex look, the short hair and loose clothing that allegedly allowed the alters to emerge. According to Putnam (1989), administrator or obsessive-compulsive personalities customarily emerged in the workplace, while substance abuse personalities were often the most abused, generally requiring sedatives, hypnotics, and analgesics to function. Handicapped personalities presented when no one else wished to be in control, frequently rocking and self-stimulating throughout the therapy session (Putnam, 1989). Persecutor personalities were hypothesized to exist in one-half or more of DID patients, were often negative, openly hostile, self-mutilating, and usually attempted to sabotage treatment (Putnam, 1989). Suicidal personalities were unaware of either the host or other personalities, and frequently professed a determination to kill themselves.

Promiscuous personalities (frequently 'born' as a consequence of adolescent abuse) (Putnam, 1989) were reported to handle the sexuality for the system. They re-enacted the abuse, both in and out of therapy, and, according to Putnam's (1989) clinical observations, customarily prostituted themselves. Demon or spirit personalities were especially common in DID clients from alleged ritual/satanic abuse backgrounds (Putnam, 1989; Ross, 1989, 1995). Conversely, protector personalities (Allison, 1974; Comstock, 1987; Putnam, 1989; Ross, 1989, 1995; Mulbern, 1991; Mungadze, 1995) sheltered the body from perceived danger, and tended to flourish and become more clearly defined as therapy continued. The protector personality, introduced into dissociative literature by Allison (1974) as the Internal Self Helper (ISH) had

allegedly not been victimized, and functioned as communicator/coordinator of the system.

According to Putnam (1989), this Internal Self Helper frequently emerged as the spiritual center of the individual.

Neswald (1992), theorizing from extensive clinical observations, has suggested the original personality to rarely be the host. He hypothesized that the original (the personality developed shortly after birth) has been benevolently 'put to sleep' as a result of its inability to cope with severe stress and repeated trauma, and traditionally did not emerge until late in treatment. It was from this entity that Neswald speculated the first alter/personality was formed (Neswald, 1992). Neswald's conceptualizations, while intriguing, continue to lack empirical validation.

A Question of Purposeful Dissociation

Theoretical conceptualizations in the field of purposeful dissociation remain in the infancy stages (Beere, 1989, 1994; Neswald, 1992, 1995; Fideo, 1995; Graham-Costain, 1995; Constantine, 1995; Friesen, 1997). While clinicians and researchers have alleged the presence of individuals who maliciously create dissociative experiences within infants and children, the data to support their findings has been sparse and highly controversial. Proposed models have been based upon clinical presentations, i.e., anecdotal findings rather than empirical research.

In an address entitled "Working with Primal Dissociative Experiences in Adult MPD Survivors of Satanic Ritualistic Abuse," presented at the Fifth Annual Western Clinical Conference on Multiple Personality and Dissociation, Neswald (1992) described Primal Dissociative Experiences as those altered states artificially and deliberately induced during the first twelve months of a child's life.

According to Neswald, MPD [DID] has been intentionally created by cults/multi perpetrator groups for the purpose of comprehensive mind control. Neswald has alleged that pre-verbal

'programming' permitted alters to participate in cult/multi perpetrator group activities, while remaining both amnesic of their involvement and fully functioning in the 'outside' world.

In a lecture presented at the 1995 Ritual Abuse Conference, Gould expounded upon Neswald's exploration of Primal Dissociative Experiences. She suggested that researchers (Beere, 1989; 1994; Fidao, 1995; Graham-Costain, 1995; Constantine, 1995) have for some time theorized why cults/multi perpetrator groups (particularly transgenerational societies) have trained their children to dissociate. She emphasized, however, that extensive clinical research is needed in this area, for at the present time little empirical data exists to support the claims of early programming (Gould, 1995).

Even so, Gould endorsed Neswald's allegation (1995) that 'mind control programming' was simply stimulus responses based upon the principles of classical and operant conditioning, and contended that under periods of extreme stress, "human beings can become the equivalent of Skinner's rats" (Gould, 1995, audiotape). The clinician/author suggested that infant reflexes are "shocked and surprised" through a systematic series of overload experiences, and asserted that cutting, burning, scalding, atmospheric pressure waves, ice baths, beatings, suffocation, tossing in air, etc., have served to create a state of psychological numbing.

Gould contended that the terrified infant was forbidden to cry (crying often paired with suffocation) and, theorized that, as a result, will turn inward in an attempt to suppress healthy emotions. As the child repeatedly finds safety within (now able to exit the unbearable situation internally), the need for human bonding has been reduced.

Gould hypothesized that at this point, sleep deprivation, sedative/hypnotic drugs, and psycho neurological stimulation (brain probe placements and subcortical electrical stimulation)

may be employed, with the numerous altered states induced in infancy failing to function as fully formed personalities, but rather producing a dissociative system responsive to terror or trauma. She maintained the specific 'personality programming' does not take place until the child becomes verbal, usually between the ages of two and two and a half (Gould, 1995).

Neswald (1992) introduced three factors that he, as a clinician specializing in multi perpetrator abuse, has observed must be present before effective programming can take place: (a) the systematic torture of the child, (b) the forced injection (or ingestion) of chemicals to increase susceptibility to the programming, and (c) hypnosis to create a reliable dissociative response. Neswald suggested these highly manipulatable altered states will be motivated by a need to avoid the reoccurrence of the trauma. He hypothesized that later in life, the victim will either experience panic or dissociation, both of which can be easily controlled (Neswald, 1992).

It is important to note that while disturbingly similar reports have surfaced in therapy offices across North America, these allegations of purposeful dissociation have remained largely unsubstantiated. They persist as phenomena based upon scant evidence other than anecdotal/clinical presentations. While undeniably significant, these allegations are in need of both expanded clinical investigation and empirical validation.

Sociocultural Implications

Putnam (1989) suggested sufficient data is available to conclude that MPD [DID] "occurs across all major racial groups and socioeconomic settings" (p. 57). In addition, he maintained "a remarkable agreement" (p. 56) can be found in regards to the mean age at the time of diagnosis (28.5 years), with the "most floridly multiple clinical presentation typically [occurring] during the third and fourth decades" (Kluft, as quoted in Putnam, p. 57).

Ross (1995) proposed DID to be a complex disorder which must be viewed anthropologically, i.e., within an historical and cultural (social/familial) context. Braun (1989), Kluft (1984, 1985), Putnam (1989, 1991), and Ross (1989, 1995), conceded that Dissociative Identity Disorder, as diagnosed in North America, represents the body's attempts to cope with severe, repetitive, childhood trauma. The authors' observed the violations most frequently reported to be those of incest, extreme sadism, forced prostitution, and confinement, generally administered at the hands of a parent or caretaker. Ross (1989) suggested the diagnosis in other cultures and historical time periods may be attributed to war, religious persecution, and natural disasters.

Ross (1995) submitted that the alter presentation itself is likely to be culture bound, citing the frequent appearance of demon alters within MPD individuals of the Christian faith. While the author observed "more demons in the Bible Belt" (p. 118), he inferred there to be an increased incidence of demonic alters within fundamentalist sects, regardless of their geographical location (p. 119). He stated:

It is important to understand that the cultural and historical aspects of MPD do not make less serious, less worthy of treatment, or less a legitimate subject of scientific study. MPD is not a disease in the sense that bacterial pneumonia is a disease, but is a major health problem in North America, and is treatable. Untreated, MPD imparts great suffering on the patient, and a great drain on societal resources (p. 6).

Traditional Treatment Dimensions

Traditionally, the treatment of Dissociative Identity Disorder has involved a long-term (three to five years) psychodynamically oriented approach, intertwined with a mixed bag of eclectic techniques (Ross, 1995). Few dissociative clients entered therapy manifesting outward symptoms of the disorder. At these initial stages, recurrent psychotic-like symptoms (pseudo-schizophrenic),

checkered histories of childhood disappointments, and erratic relationships, are typically the presenting concerns. (Figure 4.)

To date, the overarching therapeutic goal of those invested in dissociative work has been that of the arduous integration of the fractured self, with the most successful ego restorations facilitated by therapists exhibiting an artistic disposition and a spiritual orientation (Ross, 1995). Incomplete or partially processed trauma is believed to result in unsuccessful fusion of the altered states (Kluft, 1984, 1985; Bliss, 1984; Ross, 1989; Putnam, 1989; Duncan, 1994; Mungadze 1995).

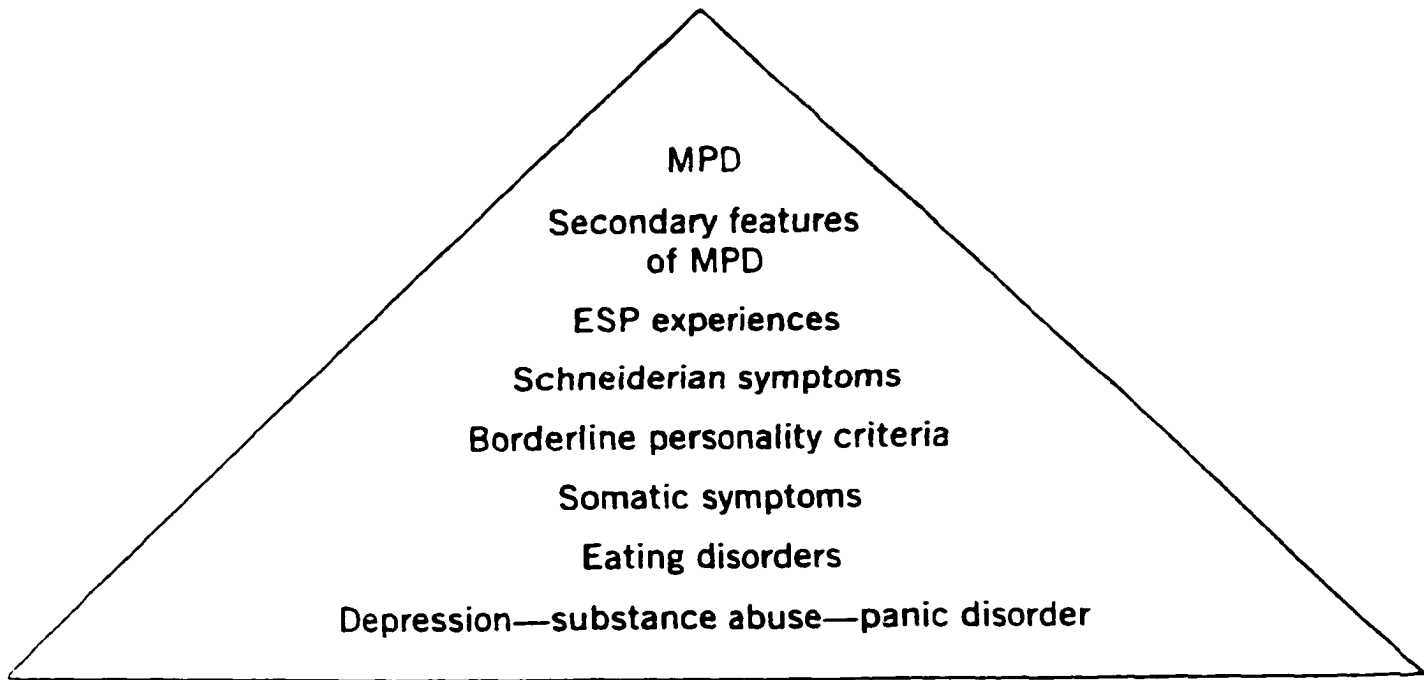
Safety and Trust

Treating professionals emphasized that no meaningful work can be undertaken without the establishment of safety and trust (Putnam, 1989; Herman, 1986; 1990). Sakheim & Devine (1992) further addressed the issue of therapeutic safety, asserting an environment of ironclad safety will likely facilitate memory retrieval. In addition, Sakheim & Devine (1992) suggested the effective DID therapist will address issues of safety outside the treatment room, as substance abuse, financial problems, relationship difficulties, occupational instability, inadequate self-care, the absence of a meaningful support system, extraordinary coping skills deficits, and altercations with law enforcement may result in a distortion and diffusion of the therapeutic process (Hall, 1989; Sakheim & Devine, 1992).

Diagnostic Considerations

Diagnostic procedures are likely to be employed during the early stages of treatment.

**Chronic Trauma Disorder with MPD Hierarchy
Figure 4**



The numerous and varied presentations of Dissociative Identity Disorder.

Figure 4. Chronic Trauma Disorder with MPD Hierarchy. From Ross, C. (1989). Multiple Personality Disorder. New York: John Wiley & Sons, p. 143. Reprinted with permission.

A mental status examination may be administered (Figure 5.), with formal assessments, screening instruments, and informal office interviews often utilized (Putnam, 1989). Comprehensive treatment planning may be undertaken.

Herman (1990) outlined the recovery process as consisting of the creation of a safe environment, resolution of the trauma, and reconnection with the world. The clinician viewed the therapist as "consultant, ally, and witness for the patient" (In Sakheim & Devine, 1992, p. 280). Barach (1993), Chairperson of the Standards of Practice Committee of the International Society for the Study of Dissociation, proposed treatment planning to be comprised of symptom stabilization, control of dysfunctional behavior, improvement of functioning, and improvement of relationships.

Recognizing that every memory is multi-faceted, Braun (1985) introduced the BASK (Behavior/Affect/Sensation/Knowledge) Model of Dissociation. According to Braun, the utilization of this theoretical model may assist the treating professional in identifying the behaviors, isolating the associated affect, focusing on the physical sensations experienced in the trauma, and incorporating knowledge and relevance of the events that have taken place (In Duncan, 1994).

Van der Kolk (1988) focused on the neurochemistry of Dissociative Identity Disorder, emphasizing the brain's bi-phasic response, i.e., the alternating revivification and psychic numbing which creates an continuous affective turmoil (In Duncan, 1994). He theorized, therefore, that stabilization of the limbic system is an essential component of effective treatment (In Duncan, 1994). Similarly, Rogers (1982) hypothesized temporal lobe epilepsy to be a likely pathologic mechanism in the formation of Dissociative Identity Disorder.

Mental Status Examination in Multiple Personality Disorder

Figure 5

Area	Characteristics
Appearance	Style of dress, grooming, general appearance, and mannerisms may change dramatically from session to session. Marked changes in facial appearance, expression, posture, and mannerisms may occur within a single session. Handedness and habits such as smoking may change within a short space of time.
Speech	Changes in rate, pitch, accent, loudness, vocabulary, and the use of idiosyncratic expressions or profanity may occur within a brief period of time.
Motor processes	Rapid blinking, eyelid fluttering, marked eye rolls, tics, twitches, startle reactions, or shudders and facial grimaces often accompany the switching of alter personalities.
Thought processes	Thought processes may appear to be nonsequential and illogical at times. Associations may appear to be loose, and patients may appear to block or lose their train of thought. This is most prominent with rapid switching or "revolving-door" crises. Thought disorder does not persist beyond a crisis, however.
Hallucinations	Auditory and/or visual hallucinations may be present, including pejorative voices, voices commenting or arguing about the patient, or command hallucinations. Voices are most frequently experienced as <i>within</i> the patient's head. Positive or secondary-process voices may be present.
Intellectual functioning	Short-term memory, orientation, calculations, and fund of knowledge are generally intact. Long-term memory may show spotty deficits.
Judgment	Patient may display rapid fluctuations in appropriateness of behavior and judgment. These shifts often occur along an age dimension (i.e., shifts from adult to childlike behavior).
Insight	The personality presenting for treatment frequently (i.e., about 80% of the time) is not aware of the existence of alternate personalities. Patients show a marked inability to learn from past experiences.

Figure 5. Mental Status Examination in Multiple Personality Disorder. From Putnam, F. (1989). *Diagnosis and Treatment of Multiple Personality Disorder*. New York: Guilford Press, p. 85. Reprinted with permission.

A Mixed Bag of Techniques

Numerous and seemingly paradoxical techniques are employed, with little consensus (either anecdotally or empirically) in the therapeutic community as to what constitutes the most effective treatment modalities. There are therapists who have espoused traditional psychodynamic techniques, while an opposing contingent vehemently argued the most severely abused fail to associate a couch with safety (Sakheim & Devine, 1992). Some treating professionals have considered physical contact taboo, while others have hypothesized that a human connection (i.e., holding a hand during an abreaction) is not only beneficial, but essential for grounding the memory retrieval process (Sakheim & Devine, 1992).

Caul (1983) introduced the DID therapist to cross-inventories, a technique in which each alter outlines the strengths and weaknesses of the others. Ross (1989) emphasized the development of a strong treatment bond. McHugh, on the other hand, directed the therapist to ignore the dissociated fragments, stating, "One simply never talks to an alter" (as quoted in Ross, 1995, p. 208).

Braun (1985) and Kluft (1985) instructed the psychotherapist to "talk through," a method of addressing the entire system simultaneously. Putnam (1989) sought to foster cooperation and consciousness in order to assemble continuous recall from memory fragments. It was hypothesized that dream work may acquaint the therapist with the dynamics of the internal landscape, and suggested that journals and diaries may prove helpful in the maintenance of psychological continuity.

Contracts, encompassing such treatment dimensions as the ever-present boundary violations and the rules for intra-psychic communication, are believed to be essential to protect both the

client and the treating professional. Screening, a method of viewing past trauma as a projected reality, has been suggested for abreactive management. Hypnosis may be employed, although the majority of DID patients are autohypnotic as the result of the repeated abuse (Kluft, 1985; Putnam, 1989).

A behavioral plan for crisis management may be set forth, and psychopharmacological needs are likely to be assessed (Putnam, 1989). History (often color-coded) may be obtained and personalities mapped, much as a systems therapist would access a family on a basis of its configural interactions (1995 Ritual Abuse Conference).

Value in Non-Verbals

In his "Draft of Recommendations for Treating Dissociative Identity Disorder," Barach (1993) addressed the use of non-verbal techniques in the therapy room. He contended that art, occupational, and movement therapy are frequently utilized and have proved helpful. Gould, Graham-Costain, Fidao, Mungadze, Neswald, and Reeves (1995), suggested that play therapy, developmental stories, and soothing lullabies may be incorporated into treatment with children alters, while prepubescent adolescents often engage the therapist in an ongoing dialogue spurred on by a budding sexual curiosity.

The Enigmatic Self-Helper

Perhaps most intriguing has been the appearance of the Internal Self Helper, or Helper Group. First described by Allison in 1974, its value (*and presentation*) has frequently been debated among therapists.

At some level the patient has an observing ego function that can comment accurately on the ongoing processes and provide advice and suggestions as to how to aid the rest of the patient in achieving some insight and control over his or her pathology. One can often find this type of function in non-MPD

(DID) patients as well as within one's own self. It is important to listen to these inner voices of wisdom, but it is a mistake to view them as all knowledgeable or all-powerful (Putnam, 1989, p. 204).

Kluft defined the Internal Self Helper as "serene, rational, and objective commentator and advisor" (Kluft, as quoted in Putnam, 1989, p. 202), but, according to Putnam, Kluft never acknowledged its presence when outlining his treatment approach (Putnam, 1989).

Braun described "switch boarding," a technique in which the Internal Self Helper is substituted for the therapist in order to foster an inner dialogue among the alters (In Putnam, 1989). Alluding to the seemingly protective nature of the phenomenon, Caul (1984) asserted the Internal Self Helper will rarely reveal more than a modest amount of information at any given time, and suggested that the 'knowledge' disclosed may be incomplete or contain understated assumptions that the therapist does not understand (In Putnam, 1989). Putnam stated, "Internal Self Helpers are enigmatic, leaving the therapist with the problem of deciphering their Delphic statements" (Putnam, 1989, p. 204), and offered,

"When one is struggling with a difficult patient, one often wishes for some miraculous intervention, and I think that this wish is what leads some therapists to ascribe omniscience to ISHs" (p. 204). Likewise, Hall (1989) questioned the presence of the Internal Self Helper in all dissociative clients, and suggested if the alter is present, it may not always be helpful to the therapy. He cautioned that "all comments about the ISH phenomenon must be regarded as speculative" (Hall, p. 113).

Conversely, Allison (1974) has attributed the greatest significance to the Internal Self Helper. He contended, "It is so unique a relationship, it has to be experienced to be believed" (as quoted

in Putnam, 1989, p. 203), while Ross (1989) initially referred to the helper group as, "watcher angels in our culture," then cautioned:

The important principle is to be aware of the central paradox of MPD (DID), not to get drawn too far into the inner hypnotic reality of the disorder, and not to pull out too far into skepticism...the memories are not the primary target of the therapy - therapy has its healing effect in the present. . . . the informational content of memories is a minor consideration compared with the internal conflicts, cognitive errors, unresolved traumatic feelings, lack of fluid and adaptive coping skills, and wide range of disabling symptoms. . . . Satanic ritual abuse survivors, properly understood, have a great deal to teach us about the nature of memory. They embody, in crystallized, observable behavior, our deepest fears and sickness. Therapists should listen carefully, while not believing too much" (Ross, 1995, p. 201).

Controversy Surrounding Multi-perpetrator Abuse

The above quotation from Ross points towards the controversy surrounding Satanic/ritual/multi-perpetrator abuse. Deikman (In Chinen, Scotton, & Battista, 1996), stated, "It is important that the therapist . . . be able to see that cult behaviors are endemic in our society" (p. 325). In an essay entitled "Alternative Hypotheses Regarding Claims of Satanic Cult Activity: A Critical Analysis," Greaves outlined the various parties to the controversy, from the disbelieving Nihilists to the uncommitted Heuristics (In Sakheim & Devine, 1992). According to Greaves, highly credible researchers are themselves deeply entrenched.

Nihilists (Gannaway, 1989, 1990; Lyons, 1988; Hicks, 1990; Noll, 1990; Lanning, 1991) have been vehement in their protestations. Ritual/multi-perpetrator abuse cannot be true and *must* be proven wrong (In Sakheim & Devine, 1992). These clinicians/authors attribute allegations of

ritual abuse to (a) incorporation, (b) screen memory, (c) the urban legend, (d) ESP, and (e) the collective unconsciousness (Sakheim & Devine, 1992).

A prominent nihilist group (Greaves, In Sakheim & Devine, 1992) has been The False Memory Syndrome Foundation, an organization which has received extensive local, national, and international coverage. The Foundation has asserted that human memory is often replete with inaccuracies/inconsistencies, that many recent cases of memory retrieval in therapy have been "mere confabulations," and that false memories have often been the result of "incompetent or unscrupulous psychotherapists" (Loftus, as referenced in Ross, 1995).

To the far right of the spectrum are the apologists (Greaves, In Sakheim & Devine, 1992), researchers/clinicians who feel it is logically inconceivable that a cult/multi perpetrator network is not in place. These individuals have pointed to the similarities in the survivors' stories, i.e., the strong criterion validity of independent observation. Terry (1987); Simandl (In Kahaner, 1988); Gallant (In Kahaner, 1988); Griffis (In Kahaner, 1988); Kahaner (1988); and Braun (1989) have been respected adherents of this conceptualization.

Soft apologists (Gould, 1989; Hill, 1989; Summit, 1989; Hill & Goodwin, 1989; Greaves, 1989; Goodwin, 1990) have maintained many survivor testimonies could be true, as there has been nothing in history to deny these allegations (Greaves, In Sakheim & Devine, 1992). The heuristics (Greaves, In Sakheim & Devine, 1992), those clinicians who have remained uncommitted towards the existence or non-existence of cult/multi perpetrator networks, comprise the fourth, and largest, orientation. These therapists search for process checks of internal and external validity. However, regardless of the accuracy of the victim's memories, those of the heuristic camp have reported that treating their patients in a confirming manner greatly improves the therapeutic prognosis (In Sakheim & Devine, 1992).

Greaves (1992) concluded that our attempts to simplify these complex “psychological, interpersonal, and social processes” (p. 69) will further distort rather than clarify an already controversial therapeutic debate. Therefore, the need remains for clinically-based external scholarship in the field of multi perpetrator abuse and its relationship to the etiology of Dissociative Identity Disorder.

Fundamental Theoretical Frameworks

The three fundamental theoretical frameworks through which view the clinical process (from the client’s presentation with Major Depression, Single Episode, Severe, to the diagnosis of Dissociative Identity Disorder) were (a) Adlerian, (b) Object Relations, and (c) Transpersonal. The following is an overview of these psychological perspectives.

An Adlerian Orientation

As a former Adlerian therapist within the public schools, I have long emphasized prevention of mental health issues rather than their remediation. Consideration has been placed upon re-education, re-orientation, and the development of worthwhile behaviors. I have long regarded Adler’s conviction, “if he walks and falls, he learns it is not fatal” (Corsini, 1984, p 81), to be a powerful motivator for positive change.

Adler’s Individual Psychology, holistic, phenomenological, and socially-oriented (Corsini, 1984), viewed man as a capable being replete with potentialities. Creative and responsible, possessing an ever-present capacity for forward movement, man was free to actively choose his path (Adler, 1963). Life in itself had no intrinsic meaning. Instead, man attributed his existence to be useful or useless, meaningful or meaningless, with this individualized assessment serving as the determinant of his behavior.

Adler's 'freedom to choose' introduced values to psychology (previously regarded as highly inappropriate), with the greatest value the attainment of social interest, i.e., the transcending of interpersonal transactions to be part of a larger social whole (Corsini, 1984). Adlerians observed that, even in cases of extreme pathology, an individual did not relinquish social interest in its entirety; that no individual existed alone, nor could be effectively studied in isolation. All behavior was said to be the by-product of one's degree of investment in reciprocal relations.

Since Adler's interpersonal psychology acknowledged the development of social interest as the key to optimal mental health, the theory understandably embraced the family as the primary socializing environment of the young child. It was this constellation that the child observed in an attempt to learn society's expectations of herself. It was in this environment that she arrived at conclusions regarding her value, as well as her potential to attain the significance she so desperately sought.

In her search for significance, a child, limited in her level of cognitive reasoning, commonly based her self-expectations on subjective observations of his world. Adler's Basic Mistakes in the Private Logic, erroneous beliefs based upon half-truths and outright fabrications (misperceptions), were internalized as fact. Among these basic mistakes, these immature representations of the child's world, were cognitive distortions, minimalizations, overgeneralizations, devaluations of self-worth, perfectionistic views of life and its demands, and the introjection of faulty values. Conflict, a "one step forward and one step backward movement," served to maintain the individual at a point of "dead center," immobilized, unable to resolve her own dilemmas (Mosak & Lefevre, 1976). Adler (1956) described this conflict as "standing still," and once stated,

It is as if a witches' circle had been drawn around the patient, which prevents him from moving closer to the reality of life, from facing the

truth, from taking a stand, from permitting a test or decision regarding his value (p. 274).

Though the individual experienced herself as stuck, she was, in effect, unwittingly creating her own antagonistic feelings, ideas, and values. Within the Adlerian framework, she was not the victim of her emotions, but rather the creator of them (Mosak & Lefevre, 1976).

As the result of the Adlerian basic mistakes, an individual was likely to adopt an inadequate lifestyle, lacking the courage needed to meet life's tasks of love, work, friendship, spirituality, and an understanding of her place in the universe (Dreikers & Mosak, 1967). If a child viewed her goals as attainable, she would aspire to these through useful, acceptable, and socially-appropriate means. If, however, the child determined her goals were unrealistic, unattainable, or overly idealistic, the resulting discouragement would direct her to seek significance through manipulative, demanding behaviors. The maladjusted child was not sick, but discouraged, and would inevitably resort to attention-getting, power seeking, revenge taking, or a sullen declaration (by default) of deficiency or defeat (West, 1986).

Within the Adlerian framework, a child created a cognitive map, or lifestyle, the spectacles through which she viewed her world. Lifestyle convictions encompassed the self-concept, a child's evaluation of "who I am," the self-ideal, her view of what she should be, ethical expectations, her personal code of right and wrong, and the weltbild, her assessment of the world and her place of significance within it.

Inferiority was defined as the discrepancy between one's self-concept and self-ideal. The conflict between self-concept and ethical expectations was known as guilt, with the disparity between self-concept and the individual's environmental assessment known as inadequacy (Corsini, 1984). While inferiority feelings were acknowledged as universal, an inferiority

complex, the medical model's equivalent of pathology, was not. Difficulties did not arise until a child 'acted as if' she was inferior, and/or became symptomatic in her behavior (Hergenhahn, 1994).

In an effort to move from a felt-minus to felt-plus position, the individual, through well-meaning but misguided attempts, tended to overcompensate, often withdrawing, attempting only safe tasks, and developing overly demanding, often socially-obnoxious behaviors. On occasion, she would resort to the excuses of the neurotic symptom, i.e., "I can't because I won't," "if only," or "I can't because my feelings might get hurt" (Hergenhahn, 1994). The origin of Adlerian neurosis was discouragement (West, lecture notes, 1986). Awareness equaled "insight translated into action" (West, lecture notes, 1986). Without this essential insight, the individual would revert to repetitive, non-productive behaviors.

Occasionally, Adler's Individual Psychology assumed a religious tone (Adler, 1958; Jahn & Adler, 1964), positioning social interest, humankind's reciprocal responsibility to herself and others, as the highest good. Adler once suggested, "Individual Psychology makes good religion if you are unfortunate enough not to have another" (Rasey, 1954, p. 254).

The Adlerian therapist was both a performer in and witness to the client's drama, seeking to actively encourage the discouraged client while silently, but never passively, providing support for insight, awareness, and meaningful change. Mosak has stated, "the concept of the anonymous therapist is foreign to Adlerian psychology. Such a role would increase social distance between therapist and patient, interfering with the establishment of an egalitarian human relationship that Adlerian's would regard as indispensable" (In Corsini, p. 91).

The Adlerian therapist would typically be eclectic in her choice of techniques. She might

undertake a life-style analysis, isolating the period from the ages of six to eight (known as the period of early recollections) in order to evaluate the child's basic mistakes. (Through this assessment, she would aid the individual in the acquisition of new knowledge, the incorporation of realistic values, and the development of a more adequate lifestyle.)

Regarding dreams as "a weathervane for treatment" (Corsini, p. 80), she might find dream analysis useful in assisting the client in a forward orientation. The therapist would be likely to invest in the active therapeutic techniques of role play, the empty chair, and experiential awareness, the extent of a technique's use a function of her own training and expertise.

The therapist might instruct the client to act as if all is well, reframe in an effort to minimize destructive cognitive distortions, or catch herself in productive behaviors. She might include journaling, bibliotherapy, play therapy, relaxation training, guided imagery, and task-setting into the therapeutic regimen. In effect, she was likely to use whatever works.

Object Relations

Object Relations Theory, based on works of Klein (1952; 1975; 1981), Fairbairn (1954), Mahler (1952; 1975), and Kernberg (1975; 1976; 1982; 1984), assisted the often overwhelmed therapist in harnessing the electric countertransference and unrelenting projections of the post-traumatic stress, borderline personality, dissociative identity disordered client. Well-suited for work with severe personality disorders, as well as in the assessment of faulty early childhood development, Object Relations rejected the premise of motivations as the consequence of Freud's biologically derived tension states. Instead, these American and British theorists asserted that we, as entities, were propelled not by the desire, but by a deep-seated need to establish and maintain meaningful relationships.

The inner world of the child was seen as a world of human relationships, with the mother-child bond forming the prototype for all subsequent relationships. Splitting was known as the “dynamic interplay” of good and bad objects, with the basic conflict one of loving and destructive feelings. Emphasis was placed on the “relationship in the room,” with this therapeutic relationship utilized as a vehicle for healthier object relations (simultaneously promoting positive change in the client’s sense of self). While no one unifying Object Relations Theory existed, each practitioner recognized the object in the object relations as a human being (Cashdan, 1988).

The work of Klein (1952; 1975; 1981), a contemporary of Freud and known as the mother of Object Relations, sought to investigate the impact of one’s childhood experiences upon later adult development. A pioneer of childrens’ play therapy, Klein found these young individuals to be a great deal more interested in interpersonal relationships than Freud’s libidinal drives. In proposing the core of selfhood to be a function of one’s relationship with one’s mother, Klein framed an individual’s basic conflict as one of loving and destructive feelings.

Fairbain (1954) defined Object Relations in a relational context, and was the first to emphasize the ego’s inability to develop outside the framework of interpersonal relationships. He focused upon the role of dependency as manifested in one’s innate desire to establish and maintain meaningful relationships. Fairbain’s construct of Early Infantile Dependency addressed a child’s merger with his caretaker. This “primary identification” represented the infant’s existence as an enmeshed mother and child, an undifferentiated or poorly differentiated self. Fairbain’s Transitional Stage (encompassing a lifetime) began with the child’s inadequate sense of self and terminated in her third stage of Mature Dependence. This healthy interdependence remained the

goal of object relations, with those individuals who failed to integrate often falling victim to varying degrees of pathology (Cashdan, 1988).

From Fairbain's perspective, splitting represented a child's attempts at dealing with an inconsistent and ungratifying world, i.e., an inconsistent and ungratifying mother. The child who was successful in dividing his primary objects into good and bad components could maintain her dependency without feeling threatened. The resulting good internal or ideal object represented the comforting/rewarding, maternal aspects of the mother. Ungratifying, hostile, rejecting, or withdrawing aspects were identified as ungratifying or bad objects.

While Klein posited a child's perception of an object's "badness" to be the result of her own inner destructiveness projected onto the external object (the mother), Fairbain (consistent with current trauma theories) supported badness as a child's internalized aspect of a parent who is, "in reality, depriving, frustrating and rejecting" (Cashdan, p.12). According to Object Relations Theory, an individual's disruptive behaviors were often the result of unresolved extremes in splitting. Pathology occurred when one is reluctant (or unable) to relinquish her infantile bonds of early childhood (Cashdan, 1988).

Mahler (1952; 1975) observed (through her experiential work with autistic children) a child's early bonding, then fluctuating attempts to establish a separate identity, as the first step in the process of ego-development she termed separation-individuation (Almaas, 1994). Mahler's separation-individuation process consisted of four overlapping sub-stages. In the Differentiation Stage (fifth to tenth month), the child could distinguish self from object, and for the first time, could experience herself as separate from her mother (Almaas, 1994). Practicing represented the true beginning of a child's psychological birth. While the mother continued to serve as the home

base, the search for autonomy began during this second subphase and continued throughout the fourth of Libidinal Object Constancy. Hatching, or looking hatched referred to a “new look of alertness, persistence, and goal-directedness”(Mahler, 1952, p. 266).

Rapprochement (approximately sixteen to thirty months) ushered in the language development stage, and commenced as the emerging child became cognizant of her separation from her mother. For the first time, she was painfully aware of her increasing vulnerability and infantile dependence. If overwhelmed by insecurity, she may have chosen to defend her fears by presenting a facade of omnipotence and grandiosity, thereby disguising his sense of emptiness. Conversely, the child may have opted to isolate or withdraw, refusing to confront, consequently remaining disabled by her fears. The resulting rapprochement crisis represented the need for Mom on one hand, and the innate human drive for separation-individuation of the other.

The primary task of the Libidinal Object Constancy Stage was the development of a stable inner representation of the mother. The achievement of this libidinal object constancy assumed both the positive and negative introjects of the mother have been integrated, paving the way for positive future relationships. Pathology resulted from faulty object relations, integration unsuccessful due to the ongoing split. This incomplete integration resulted in the child viewing others as either punitive or rejecting or unrealistically gratifying, this viewpoint frequently lasting a lifetime (Cashdan, 1994).

Kernberg (1975; 1976; 1982; 1984) hypothesized that pathology was the consequence of defensive splitting. This psychological mechanism had as its origin the deficient/distorted object relations that became representational of the child's (patient's) inner world. Kernberg's bipolar intrapsychic representations, the inner relational component of the child's self-other experience,

were comprised of (a) the image of self, (b) image of other and, (c) an affective coloring. Each tripartite configuration became a component of Kernberg's internalization systems, with these internalizations constantly in flux due to the passage of time (Cashdan, 1994).

Kernberg's stages of development (internalization systems) were comprised of (a) introjection, (b) identification, and (c) ego identity. Introjection represented the "swallowing whole" of experiences with the primary care giver, with these introjected events viewed as neither positive nor negative. Splitting first occurred during this stage, with the child initially incorporating only those experiences which he found rewarding. As he matured, he introjected both good and bad, while he defensively sought to separate the two.

Identification ushered in a more mature cognition, as the child was no longer the victim of his own emotional self. His bipolar images of self and others ceased to be responsive to the whims of the introjection's affective coloring. Instead, the child viewed himself as possessing an individual role. While this stage of identification represented significant maturational advances, the integrated ego continued to be non-existent.

Kernberg's final stage of ego identity occurred as the tripartite bipolar representations were integrated into a consistent sense of self. These varied identifications (stage two) were now consolidated into one distinct personality organization. In Kernberg's view, psychopathology was the result of defensive splitting, which prevented the integration of self and other object images. He stated, "the persistence of nonmetabolized early introjection is the outcome of a pathological fixation of severely disturbed early object relation, a fixation which is intimately related to the pathological development of splitting" (Kernberg, 1976, p. 34). In referencing Kernberg's work, Cashdan (1988) has offered,

“... relationships with others tend to be guided by highly unstable bipolar representations, and consequently are predictable, if not chaotic” (Cashdan, p. 19).

A Transpersonal Perspective

The third theoretical perspective employed in this case (and the focus of this research) was that of Transpersonal Psychology. The following literature review on Transpersonal psychology and its substrate, Transpersonal psychotherapy, will make the case that this emerging field has a new perspective to offer in the treatment of Dissociative Identity Disorder, which may change the parameters of this controversy, since its scope of research is much broader than that of traditional psychology

Transpersonal Psychology

Transpersonal Psychology: An Emerging Paradigm

Transpersonal psychology has been characterized as an integration of the “three eyes of knowledge,” the sensory (body), the introspective-rational, represented by the mind/heart connection, and the contemplative, or spirit (Walsh & Vaughan, 1993; Boorstein, 1996; Cortright, 1997). Its unitive approach has neither minimized nor negated the Cartesian-Newtonian assumptions set-forth first, in ancient Greece, and later within the scientific communities of the nineteenth century (Ross, 1989; Cortright, 1997). Instead, it has expanded the traditional materialistic, scientific paradigm to encompass a more holistic, spiritually-oriented perspective (Cortright 1997), or as Cortright has stated, “[it has] provide[d] a multi-perspective framework [that] will not need to repudiate what went before to bolster itself” (p. 48).

While the “transpersonal paradigm has not yet gathered enough momentum to significantly offset the current mechanistic paradigm” (Cortright, p. 179), it does appear to have been making a

substantial headway, as evidenced by the Diagnostic and Statistical Manual IV's recognition of the new diagnostic category, entitled "Religious and Spiritual Experiences" (D.S.M. IV, 1994; Boorstein, 1996). As intriguing as transpersonal postulates may be, relatively little has been written regarding the commingling of spirituality and clinical practice (Cortright, 1997). In referencing the initial (1978) publication of Transpersonal Psychotherapy Boorstein (1996) commented:

Compared to the detailed and clinically relevant writings of so many traditional therapists, the transpersonal field looked rather primitive at the end of the 1970's. We simply did not have the language, theory, concepts, etc., to do justice to what we were seeing and experiencing with our patients (p. xi).

To date, the field has continued to be hampered by "a marked paucity" (Cortright, p. 2) of critical examination of ideas and theories. This paucity seems likely to continue, as the question has remained, "How do we study the realms of spiritual experience in ways that do justice to the integrity of the experience and do not reduce it to outwardly measurable behavioral objectives?" (Cortright, p. 225).

Precursors

As has been previously stated, the transpersonal paradigm's psycho-spiritual framework (Cortright, 1997) has neither minimized nor negated the vast contributions of the psychology's preeminent theorists/clinicians. The works of the following distinguished individuals have served as stepping stones along the path to a transpersonal awakening.

Freud's Psychoanalysis (1894; 1900; 1914), a reductionist theory of dualities, pioneered the therapeutic technique of free association, and addressed the potential impact of transference and countertransference within the treatment room.

Adler's Individual Psychology (1917; 1928; 1929) framed man within a social context, to be viewed interpersonally rather than intrapsychically. The Adlerian Ideal Man possessed the courage to resolve the life tasks of society, work, relationships, and an understanding of God and the universe. Disenchanted with Psychoanalysis, Assagioli's Psychosynthesis (1965; 1973; 1976) minimized the role of the subconscious, choosing instead to focus upon "height psychology," the superconscious or the transpersonal (Cortright, p. 95).

The theorists of the Object Relations Camp (Klein, 1932; Kohut, 1971; Mahler, 1975; Kernberg, 1980) introduced the self-concept into psychoanalysis. Object Relationists viewed healthy individuation as predicated upon optimal early human relationships, with psychopathology the consequence of faulty relations with one's primary care giver. The Behaviorists (Skinner, 1953; Eyesnck, 1967; Bandura, 1977, 1982; Beck, 1972; 1978) viewed psychopathology as acquired, the result of problems of living.

The Existentialist movement was "born out of the urge to help people with the profound dilemmas of modern life" (Corsini, p. 354). Couched in the works of Kierkegaard (1954) and Sarte (1956), the Existentialists of post-war Europe sought to understand the meaning of human experience, inquiring as to the nature of "anxiety, despair, grief, loneliness [and] isolation" (Corsini, p. 354). Modern theorists (May, 1953, 1969, 1977; Frankl, 1963, 1969; Yalom, 1981), have focused upon man's ability, if he so chooses, to transcend the reality of life's circumstances.

Roger's Person Centered Therapy (1942; 1957; 1961; 1980) offered empathy, congruence, and unconditional positive regard as necessary and sufficient conditions for meaningful change, leading to the possibility of self-actualization within the client. According to Cortright (1997),

“Rogers [was] a forerunner of a transpersonal view of working from the heart, with love”
(Cortright, p. 240).

The Systems theorists, Ackerman (1958), Bowen (1960; 1978), Haley (1976), Jackson (1965), and Minuchin (1974), pioneered the study of interlocking relationships, i.e., the interaction, dialogue, and dynamic interchange between/among individuals within family systems.

While Cortright (1997) has acknowledged the unquestioned significance of the emerging field's predecessors, he has stated:

No mother-child interactions and early childhood development;
no explanation that only considers outward appearances will ever
provide satisfactory answers to life's fundamental questions.
We must look to the spiritual dimension which transcends
heredity and environment (p. 6).

A single psychotherapist introduced, assimilated, and paid a substantial price for his insistence upon the value of what Cortright has termed, “the spiritual dimension which transcends heredity and environment.”

Jung's Analytical Psychology

No discourse on the transpersonal paradigm's emergence would be complete without the consideration of Jung's (1924, 1928, 1929) immense contributions to the field. Jung has been acknowledged as not only the Father of Analytic Psychology, but as the first clinical transpersonal psychotherapist as well, the first to integrate spirituality with psychology (Washburn, 1994, 1995; Scotton, 1996; Cortright, 1997).

Jung's treatise, the Psychology of the Unconscious (1912) emphasized the essential nature of the spiritual experience (in effect removing sexuality from the forefront), and served to alienate him from the prevailing Freudian camp. Through such transpersonally-oriented pieces as The Transcendent Function (1958) and The Seven Sermons of the Dead (1958), Jung introduced the

concept of the transcendent within. From a Jungian perspective, psychological development not only continued throughout one's lifetime, it encompassed higher levels of awareness as well. Growth and healing were accepted as the end-products of states of consciousness, non-ordinary states that were likely to defy rational explanation (Scotton, 1996).

Jung was the first Western psychiatrist to explore, and then incorporate, the wisdom traditions of other cultures, writing the forward or commentary to Wilhelm's translations of the I Ching and The Secret of the Golden Flower, Evans-Wentz', The Tibetan Book of the Great Liberation and The Tibetan Book of the Dead, and Suzuki's, Introduction to Zen Buddhism (Scotton, 1996).

Jung believed pain and anguish to be the result of the self's separation from the unconscious, which encompassed "mythic, archetypal, and spiritual energies as well as Freud's seething caldron of desire. . . [the seat of] intelligence, creativity, and spiritual transcendence" (Cortright, p. 82). Among Jung's theoretical constructs was the notion of the collective unconscious, "the source of psychic energy, instinctual life, feelings, and archetypes and creative images" (Washburn, 1995, p. 13). Jung's archetypes (the divine child, great mother, wounded healer, warrior, etc.), represented universal aspects/forms of human experience which shaped the psyche (Scotton, 1996; Cortright, 1997).

Psychological health, from the Jungian perspective, resulted when archetypes flowed freely, organizing the individual's psychological experiences (Cortright, 1997). Pain resulted when the individual chose to identify with limited archetypes, thereby creating a limited affect and a constrained identity (Cortright, 1997).

Jung referred to the central archetype of the psyche as the Self, which he defined as "the archetype of wholeness found within each human being" (Scotton, p. 45). According to

Cortright, “Jung pioneered the view that spiritual, archetypal depths can be accessed from the first and may even guide the entire therapy” (Cortright, p. 9), a discovery Cortright has suggested to be of extraordinary significance.

Transpersonal Definitions

Transpersonal psychology, as one view of the transpersonal experience, can be difficult to conceptualize and equally difficult to define. In Walsh & Vaughan’s (1993) collection of essays, entitled Paths Beyond Ego: The Transpersonal Vision, the authors defined the paradigm as:

The psychological study of trans experiences and their correlates. These correlates include the nature, varieties, causes, and effects of transpersonal experiences and development, as well as the psychologies, philosophies, disciplines, arts, cultures, lifestyles, reactions, and religions that are inspired by them, or that seek to induce, express, apply, or understand them (pp.3-4).

Transpersonal experiences are those “in which the sense of identity or self extends beyond (trans) the individual or personal to encompass wider aspects of humankind, life, psyche, and cosmos” (Walsh & Vaughan, p. 3). In Psychology and Spirit, (1997), Cortright described the transpersonal perspective as “the melding of the wisdom of the world’s spiritual traditions with the learning of modern psychology” (p. 8). Wilber (In Scotton, Chinen & Battista, p. xviii) has defined it as simply “the personal-plus.” In The Ego and the Dynamic Ground, Washburn (1995) characterized the transpersonal as:

The study of human nature and development that proceeds on the assumption that human beings possess potentialities that surpass the limits of the maturely developed ego. . . an inquiry that presupposes that the ego, as ordinarily constituted, can be transcended and that a higher transegoic plan or stage of life is possible (p. ix).

Washburn (1995) emphasized that Transpersonal psychology concerns itself with not only the ego, unconscious, and integration, but with the spiritual, i.e., ‘falleness and transcendence’ as well. Spirituality, from a transpersonal viewpoint, is understood experientially rather than ‘doctrinally or historically’ (Washburn, 1995).

In The Inward Arc (1995), Vaughan portrayed psychology’s Fourth Force as embracing those “experiences and aspirations that lead people to seek transcendence as well as the healing potentials of transcendence,” (p.39), while Fadiman and Speeth (in press) defined Transpersonal psychology as:

The full range of behavioral, emotional, and intellectual disorders as in traditional psychotherapies, as well as uncovering and supporting strivings for full self-actualization. The end state of psychotherapies is not seen as successful adjustment to the prevailing culture, but rather the daily experiences of that state called liberation, enlightenment, individualism, certainty or gnosis, according to various traditions (as quoted in Boorstein, 1996, p. 3).

Perhaps the most comprehensive definition has been provided by Sutich. As founding editor of the Journal of Transpersonal Psychology, Sutich advanced the following description of the field:

Meta needs, transpersonal process, values and states, unitive consciousness, peak experiences, ecstasy, mystical experience, being, essence, bliss, awe, wonder, transcendence of self, spirit, sacralization of every day life, oneness, cosmic awareness, cosmic play, individual and species wide synergy, the theories and practices of meditation, spiritual paths, compassion, transpersonal cooperation, transpersonal realization, and actualization and related concepts, experiences, and activities (Sutich, 1969).

Contemporary transpersonal psychotherapists have expanded Sutich’s 1969 definition to include the presence of the sacred in ordinary life as well as in the depths of despair.

Historical Perspectives

The first known use of the term 'transpersonal' has been traced to a 1920's astrological reference by Rudhyar (1983). According to Boorstein (1996), it was later employed by Neumann (1954) and Progoff (1955), the latter on the occasion of Jung's eightieth birthday. Assagioli, author of Psychosynthesis (1965) and founder of the movement of the same name, chose 'transpersonal' rather than 'spiritual,' believing it would minimize misunderstandings of his theory (Boorstein, 1996). Maslow, in a 1976 letter to Grof, suggested the use of 'transpersonal' rather than 'transhumanistic' or 'transhuman' (Sutich, as referenced in Boorstein, 1996), with Grof eventually credited with the movement's name (Boorstein, 1996). Chinen (1996) has credited James (the American philosopher/psychologist who explored parapsychology and dissociative states and was the first to use the term 'transpersonal' in an English context) (1961) as the Father of Transpersonal Psychiatry and Psychology. Conversely, Boorstein (1995) has referenced Maslow, not James, as founder of both the humanistic and transpersonal movements.

Maslow (1969) considered humanistic, third force psychology to be a passage to a still 'higher' fourth psychology (Hoffman, 1988). Sutich (1969) referenced the transpersonal as merely an offshoot of humanism. However, a 1976 publication of Newsweek identified not three, but four forces in psychology -- behavioral, psychoanalytic, humanistic, and...transpersonal (Boorstein, 1996).

The emerging paradigm was not without its distracters. On two occasions, transpersonal psychologists and psychiatrists formally asked the American Psychological Association (APA) to consider a transpersonally-oriented division. Both petitions were denied, the first due to concerns regarding the perceived unscientific perspective of transpersonal psychology, and the second due

to criticism from leading humanistic psychologists (May [1986], as referenced in Chinen, 1996). In addition, the field has been criticized for its focus upon transcendence while minimizing life's darker sides, the alleged use of meditation without consideration for risks and contraindications, the unseemly behaviors of selected spiritual leaders, the relationship between transcendence and psychosis (Chinen, 1996), and an irrational belief in the 'Divine' (Ellis & Yeager [1989], as referenced in Chinen, 1996). Even so, with the 1994 inclusion of the "Religious and Spiritual Experiences" category in the DSM-IV, the field has emerged with a life of its own.

Transpersonal Assumptions

Positive in orientation. Transpersonal psychology addresses all levels of Wilber's Spectrum of Identity - the egoic, existential, and the transpersonal (Walsh & Vaughan, 1993; Washburn, 1995; Boorstein, 1996; Wade, 1996; Cortright, 1997). Transpersonal psychology has suggested the individual possesses an ability to choose his own path, with he alone determining to remain within the personal realm or to transcend the boundaried ego (Boorstein, 1996; Wade, 1996). The paradigm has proposed that each individual has within continuous "impulses toward an ultimate state" (Sutich, as quoted in Boorstein, p. 10), even though this awareness of these higher levels of consciousness is dependent upon time and path (Walsh & Vaughan, 1993; Boorstein, 1996; Wade, 1996; Cortright, 1997). The paradigm has recognized a sequential unfolding, from a lesser to a greater identity (Walsh & Vaughan, 1993), with this process of awakening enhanced by an inner awareness and intuition (Vaughan, 1995). It has placed a greater emphasis upon health and well-being than has traditional Western psychologies (Boorstein, 1996). The emerging conceptualization has been unitive, offering a means of understanding the psyche that has been respectful of cultures and spiritual traditions, and has been applicable to all historical periods (Boorstein, 1996, Wade, 1996).

In this fourth force, non-ordinary states of consciousness (NOSC), pathologized by traditional Western psychology, have been valued as highly regarded dimensions of the psyche (Boorstein, 1996; Wade, 1996; Cortright, 1997). The paradigm embraced the inherent assumption that human life can only be truly understood when viewed from a spiritual standpoint (Washburn, 1994).

Boorstein (1996) contended that each individual, while an insignificant biological entity, has within a potential access to the whole of the cosmos. The paradigm offered mankind's essential nature as spiritual, consciousness as multi-dimensional, and life as meaning-filled rather than punctuated by random, pointless events. In addition, Cortright (1997) suggested the only ultimate healing to be that of spiritual healing.

Transpersonal Development

Transpersonal development has been mapped far beyond that which was previously thought humanly possible, and has found accordance in both psychological and spiritual development across cultures and ages (Walsh & Vaughan, 1993). Transcendents can be found among businessmen, industrialists, managers, educators, and politicians, as well as among the 'professionally religious' (Maslow, 1969), i.e., the poets, intellectuals, musicians.

There have been many paths (Dharma, Truth, Great Spirit) and many seekers. Prather, known as the American Kahil Gibran, contended that the routes by which an individual finds her awareness of God are irrelevant (1990). Jung offered, "I don't think, I know he exists" (Scotton, 1996), while Mother Teresa (1990) spoke of "compassion in action." Steindl-Rast (1990, p. 67) described the profound sense of peace in those mystical moments when one finds herself at home in the universe. . . He wrote:

... each member belongs to all others--bugs to beavers,
black-eyed Susans to black holes, quarks to quails,
lightening to fireflies, humans to hyenas. To say yes
to this limitless mutual belonging is to love.

In "The Long Journey Home," Eisler suggested transpersonal proponents view everything as sacred, with the sacred present in everything they do (1990), while Levine, a current leader in the human potential movement stated, "there is no such thing as going home to God, [for] we are already in the living room" (1990, p. 63).

Gawain, author of Creative Visualization and Living in the Light, suggested the role of an effective path, teacher, therapist, or healer is to assist the seeker in developing a belief in herself, to support her in commencing a personal walk with her Higher Power (1990), while Brooke Medicine Eagle, teacher, healer, and ceremonial leader of the Lakota, taught the "spirit lives within you, it lives within your body. . . you can touch the Great Spirit by touching your own aliveness" (1990, p. 73).

In The Pearl Beyond Price (1990), Almaas suggested an individual must find God "independently from the opinions of others" (p. 57), and contended that if we sincerely seek the truth, we will not be denied. Ram Doss stated, "[the] ego is important for achieving success in the world but. . . it can be a great obstacle in obtaining real peace" (1990, p. 41).

It is believed that transpersonal experiences span three dimensions. Transcendence of spatial barriers, referenced by Watts as the transcendence of "the skin-encapsulated ego" (as quoted by Grof, In Boorstein, p. 49), assumed the potentialities of a dual unity. All that we have experienced in our ordinary state of consciousness (OSC) has as a counterpart, a NOSC, a subjective non-ordinary state of consciousness (Boorstein, 1996).

Temporal boundaries may be transformed through the transcendence of linear time (past life

experiences, historical regressions, etc.), while cosmic consciousness (Universal Mind, Brahman, Buddha, Allah, Great Spirit, Cosmic Christ) represents the ultimate of all transcendent experiences, "an identification with the supra cosmic or metacosmic void, the mysterious and primordial emptiness and nothingness that is consciousness itself and is the ultimate cradle of all existence" (Grof, as quoted in Boorstein, pp. 50-51).

Transpersonal development has been suggested to be a multistep, multilevel process by which the individual sees, dimly at first, through the bounded limits of her conventions, and then quietly, subtly, embarks upon the unfolding of her previously dormant, but ever self-actualizing human potential (Walsh & Vaughan, 1993). The quest may involve "experiencing for oneself the flashes of illumination that transform future potential into present realities, extending the flashes of illumination into abiding light, and bringing that light into the world for the benefit of all" (Walsh & Vaughan, p. 114).

Transpersonal Theorists

Transpersonal theory provides an "overarching framework that defines transpersonal psychotherapy" (Cortright, p. 15). Wilber (1979; 1986) and Washburn (1994; 1995) offered competing theories of transpersonal development. The authors conceded (a) the individual must develop a solid ego before it (the ego) can be transcended, (b) a failure to develop the ego may result in pathology, and (c) an individual, if fully invested, is capable of progressing from the egoic to transegoic states, with the ultimate destination a reawakening to the Absolute (Boorstein, 1996; Wade, 1996). In addition, both authors developed triphasic paradigms (preegoic, egoic, transegoic), but, according to Washburn (1995), it is there that the similarity ends.

The Spectrum of Consciousness

The work of Wilber, (1977; 1979; 1980; 1986; 1995) with its roots in Piaget's cognitive development theory, viewed human development as hierarchical, a vertical ascent through pre-egoic, egoic, and transegoic stages. Wilber referred to these multilevel experiences as the "Spectrum of Consciousness" (Wilber, Engler, & Brown, 1986), with each ascending level representing a broadening of the Spectrum of Identity (Wilber, Engler, & Brown, 1986).

Wilber added to Piaget's traditional stages of development by positing four stages beyond formal operational thought. The first of these stages, which is the last stage of purely personal development, was based in part on the theoretical work of Broughton (1975) and Cowlan (1978) in developmental psychology. The final three stages, based upon the literature of contemplative spiritual traditions, document the transcendence of ego in the quest for unity consciousness (Washburn, 1995). (Figure 6.)

These stages are divided into the existential, ego, and persona/shadow levels. Wilber identified any organism existing as a function of time and space as the existential level. In this existential area, the area of the will, one's cultural experiences create one's reality. At the ego level, the self-image reigned. The body, with its intellectual processes and bounded reality, takes precedence over all. The narrow most point of the Spectrum of Consciousness was identified as the persona/shadow level, with its identification of the parts, rather than with the whole of the ego. Those impoverished, alienated, undesirable, psychic tendencies which have been denied a place in one's persona, exist in the personal unconscious, the shadow (Walsh & Vaughan, 1993; Cortright, 1997).

Wilber's Spectrum of Consciousness encompassed Eastern approaches as well as Western

Wilber's Hierarchical Psyche* Figure 6

	Psychic Level	Basic Structures
Transcendental Levels	ULTIMATE UNITY	Complete psychic integration and coincidence of individual with reality. Unity beyond all division and duality.
	CAUSAL (35 years and up)**	Unitive consciousness; contemplation of unity of human and divine; radiant absorption in the godhead.
	SUBTLE (28 years and up)**	Paranormal psychic abilities; archetypal, visionary intuition; spontaneous devotional and altruistic feelings.
Egotic Levels	VISION LOGIC (21 years and up)**	Holistic-synthetic thinking; mind-body, thought-feeling integration; existential wholeness and authenticity.
	REFLEXIVE-FORMAL MIND (11 to 15 years)**	Formal operational (Piaget) or secondary-process (Freud) cognition: abstract, analytical, inferential, hypothetical thinking. Self-consciousness combined with ability to assume perspective of others.
	RULE-ROLE MIND (6 to 8 years)**	Concrete operational thinking (Piaget); initial command of basic laws of the logic of classes and propositions. Ability to assume role but not perspective of others.
	REPRESENTATIONAL MIND (15 months to 2 years)**	Preoperational thinking (Piaget); rudimentary conceptual thought. Narcissistic; inability to assume role of others.
Pre-egotic Levels	PHANTASMIC (6 months to 12 months)**	Primitive imaginal or "picture" thinking.
	EMOTIONAL-SEXUAL (1 month to 6 months)**	Basic organismic dynamism (bioenergy, libido, <i>prana</i>) and its basic instinctual modes of expression.
	SENSORIPERCEPTUAL (Prenatal to 3 months)**	Simple sensorimotor skills (Piaget).
	PHYSICAL (Prenatal)**	Basic physical substratum of organism.

* Reconstructed from table by Wilber (1990, p. 285).
 ** Wilber's estimate of ages at which levels are developmentally achieved.

Wilber's Spectrum of Consciousness

Figure 6. Wilber's Hierarchical Psyche. From Washburn, M. (1995). The Ego and the Dynamic Ground. New York: State University of New York Press, p. 30. Reconstructed from a table by Wilber, 1990, p. 285. Reprinted with permission.

ideologies. While those of the East traditionally focused on the optimal attainment of the level of cosmic consciousness, theorists of the West exhibited little or no understanding of this uppermost region of the Spectrum. On the other hand, Western approaches invested considerable energy into understanding the psychological conditions of the ascending rungs of the ladder, while those sub-optimal levels of psychological attainment received sparse attention in the East (Wilber, Engler, & Brown, 1986; Walsh & Vaughan, 1993; Washburn; 1995; Wade, 1996).

In Wilber's paradigm, each structural level encompassed the one below, with the lower levels supporting the higher (Walsh & Vaughan, 1993). The ascension to each band is the consequence of the successful integration of the one below, with the level by level progression possible until Unity or Cosmic Consciousness has been obtained. In Wilber's conceptualization, the self exists only as an identification with the particular psychic level attained. Consequently, as the individual progresses through the hierarchy, the identification with the previous level fades away and a new self is born (Wilber, Engler & Brown, 1986).

Dynamic-Dialectical Paradigm

Washburn's Dynamic-Dialectical Theory of Transpersonal Development is of a psychodynamic and phenomenological orientation, with its roots in Jungian psychology, mystical theology, yoga, alchemy, and the existentialist philosophy of Kierkegaard, Nietzsche, and Sarte (Washburn, 1994; 1995). In Washburn's view, human development proceeds on a spiral, rather than hierarchical course (Washburn, 1994; 1995). The ego emerges from its non-egoic potential during the first half of life (ego dominance), and returns to it during the second half to become integrated at the transegoic level (Washburn, 1994; 1995). Washburn's spiral loop is theorized to be:

The existence of an original dynamic, creative, spontaneous source
out of which the ego emerges, from which the ego becomes estranged,

to which, during the stages of ego transcendence, the ego returns, and with which ultimately, the ego is integrated (Washburn, p. 10).

Washburn viewed the psyche as Bipolar, comprised of the egoic (the ego) and nonegoic (numinous power or spirit), both originating from a single source, the Dynamic Ground. As did Wilber, Washburn, considered human development to be triphasic, comprised of pre-latency (Wilber's preegoic), latency to midlife (the egoic), and midlife (Wilber's transegoic stage). Washburn's theory began with the Original Embodiment, a "blissful condition" during which the ego is minimally separated from the Dynamic Ground. Here, the nonegoic pole, the primordial self, reigned (Washburn, 1994; 1995).

The Original Embodiment gives way to the Preegoic, or Body Egoic stage, during the first weeks of a child's life. While the struggling ego has attempted to establish itself, it remains weak and underdeveloped, and under the influence of the nonegoic potentials of the psyche. (Washburn, 1995). (Figures 7. 8.)

Washburn agreed with Freud that repression makes the creation of the ego possible. While primal repression frees the fledgling ego from the overarching power of the source (Dynamic Ground, Great Mother), it simultaneously closes the door to its nonegoic potentials, effectively ending all spontaneous expression of its nonegoic self (Washburn, 1995). Primal alienation, therefore, essentially ends the child's symbiotic ties to its primary care giver (Washburn, 1995). Latency, the period of adolescence through early adulthood, is made possible by primal repression and primal alienation. It ushers in the stage of dualism (self-others, egoic-nonegoic), and is characterized by a nonpathological regression, 'progressive regression', a regression in the service of transcendence (Washburn, 1994; 1995).

The Dynamic-Dialectical Paradigm

Figure 7

INTEGRATION	The two poles of the psyche are harmoniously united and their potentials and functions are effectively integrated. The two poles begin functioning as a true Bipolar system, a coincidence of opposites. The power of the Ground, as spirit, is the sovereign power of the psyche.
REGENERATION IN SPIRIT	The ego, having yielded to the Dynamic Ground, now begins to be empowered rather than overpowered by nonegoic potentials. The ego begins to be regenerated by the power of the Ground as spirit.
REGRESSION IN THE SERVICE OF TRANSCENDENCE	Primal repression gives way and the ego is regressively reclaimed by the Dynamic Ground. The ego is unseated as the central power of consciousness and challenged by awakening nonegoic potentials. The ego undergoes a regression to origins.
EGOIC OR MENTAL- EGOIC STAGE	The ego develops its own functions in relative independence from the nonegoic pole, which underlies the ego as the deep unconscious. The nonegoic pole is not-self or id; the egoic pole is a mental ego or Cartesian self.
PRIMAL REPRESSION	The ego finally wins its independence from nonegoic potentials, but only by regressively disconnecting itself from the nonegoic pole, which is submerged and becomes the deep unconscious.
PREEGOIC OR BODY- EGOIC STAGE	The preegoic stage is a period during which the ego is progressively differentiated from the Great Mother but is still under the sway of nonegoic potentials. The nonegoic pole is the primordial self; the egoic pole is a bodily self or body ego.
ORIGINAL EMBEDMENT	The ego at birth is only minimally differentiated from the dynamic Ground and exists as an ego germ immersed in the Ground, which here is the original source of life prior to selfhood. Original embedment is a blissful condition to which the ego frequently returns throughout the preoedipal period.

In Washburn's Dynamic-Dialectical Theory of Transpersonal Development, human growth proceeds on a spiral, rather than a hierarchical course.

Figure 7. The Dynamic-Dialectical Paradigm. From Washburn, M. (1995). The Ego and the Dynamic Ground. New York: State University of New York Press, p. 27. Reprinted with permission.

The Bipolar Structure of the Psyche
Figure 8

Nonegoic or Physicodynamic Pole	Egoic or Mental-Egoic Pole
Dynamic Ground: dynamism, libido, energy, spirit Somatic, sensual experience Instinctuality Affect, Emotion Imaginal, autosymbolic cognition Collective memories, complexes, archetypes	Ego as organizing and controlling center of consciousness Reflective self-awareness Impulse control Self-control, deliberative will Operational cognition Personal, biographical experience

In Washburn's theory, the ego emerges from its non-egoic potential during the first half of life (ego dominance), and returns to it during the second half to become integrated at the transegoic level.

Figure 8. The Bipolar Structure of the Psyche. From Washburn, M. (1995). The Ego and the Dynamic Ground. New York: State University of New York Press, p. 12. Reprinted with permission.

As a result, the adolescent enters early adulthood with an intact ego. The ego begins to actualize its potentialities, with the process typically completed by mid-life. This independence from the nonegoic pole, however, foreshadows the disillusionments one suffers towards the end of mid-life, signaling the possible end of Bipolarity. Mid-life transvaluation occurs when the ego begins to sense its emptiness and incompleteness and longs to return home to the Dynamic Ground. It finds itself conflicted, at once drawn to transcendence while fearful of relinquishing control to the unknown. During this stage between ego maturity and transegoic birth, dis-ease may grow into an existential despondency (Washburn, 1994; 1995), with the ego beginning the process of dying to the world (Washburn, 1994; 1995).

It is at this point that psychological/spiritual growth ceases for the vast majority of humankind. For those willing to endure the purgative process, Saint John of the Cross' The Dark Night of the Senses (withdrawal), and The Dark Night of the Spirit (spiritual awakening), Regression in the Service of Transcendence is likely to occur. Redemptive in nature, the egoic pole will reopen to the nonegoic pole, with the ego returning to the original source, the Ground, (Washburn, 1994, 1995; Kavanaugh, 1991).

Regeneration in Spirit represents both a second birth and a redemptive transformation, with its goal an integrated psyche (Washburn, 1994; 1995). Darkness gives way to light, descent becomes ascent, and the ego is no longer overpowered, but empowered, by its nonegoic potentials (Washburn, 1994; 1995). Washburn proposed:

Integration, as a higher unity of opposites, is not a unity of equals. For again, in the integrated psyche the nonegoic pole has primacy: the egoic pole accedes to the nonegoic pole as the superior power/authority. The egoic pole is an instrument of the nonegoic pole--the ego is a servant to the power of the Ground as Spirit (p. 244).

Washburn's integrated psyche represented transcendence of all duality, an empowerment of the ego by the Ground, a spiritual presence, higher intuitive/contemplative possibilities, increased openness and spontaneity, and a resurgence of altruistic endeavors (Washburn, 1995). In undertaking the daunting task of establishing a competing Transpersonal theory, Washburn wrote:

I am aware of the ambitious nature of any attempt to formulate an encompassing transpersonal theory, so acutely aware, in fact, that I have been plagued with self-doubts throughout the writing of this book. There were countless times when, for lack of understanding, or learning, I felt inadequate to the task and unable to proceed (Washburn, p. x).

Wilber vs. Washburn: A Critique

To date, Cortright, (1997) has provided the most comprehensive critique available on Wilber (1977; 1979; 1980; 1995), and Washburn's (1994; 1995) contrasting theories of transpersonal development. On a positive note, Cortright (1997) has suggested Wilber's hierarchial model, comprised of the prepersonal, personal, and transpersonal stages, reflects both symmetry and logic. Cortright (1997) viewed Wilber's pre-trans fallacy as a significant theoretical construct with far-reaching clinical implications. He credited Wilber's non-dualistic stance with opening the West to a more complete understanding of Eastern spirituality. He applauded Wilber's integrative viewpoint, a viewpoint which, according to Cortright acknowledges traditional psychologies, positioning them at varying points along the Spectrum of Consciousness.

Cortright criticized Wilber's nondualistic bias, suggesting the Spectrum of Consciousness merely represents Wilber's Eastern interpretation of the Perennial Philosophy. In addition, he suggested that Wilber's three transpersonal stages have failed to accurately represent a spiritual unfolding.

Cortright posited that psychological and spiritual growth exist as separate and distinct processes, and fail to form, as Wilber suggested, one continuous line of development. He believed Wilber's model "attempt[ed] to commingle two different dimensions of development" (Cortright, p. 80). Finally, Cortright suggested Wilber has written as a theoretician, not as a clinician. Therefore, his work, while setting the standard for comprehensive transpersonal theory, lacked experiential grounding (Cortright, 1997).

Conversely, Washburn (1994, 1995), a philosopher by training, has offered a theistic-relational interpretation of the Perennial Philosophy based on the theological orientation of the West (Cortright, p. 85). Cortright credited Washburn with providing a direct challenge to the Eastern spiritual traditions which have traditionally dominated the field of transpersonal psychotherapy. He suggested the Dynamic-Dialectical model posited by Washburn provided an expanded view of the collective unconscious (dynamic ground), which became a "[significant] psychological notion that now permeate[s] the entire psychotherapeutic field" (p. 89). Cortright suggested an increased clinical applicability in Washburn's view of the mid-life crisis and its role in psychological growth and transcendence, as defined by his concept of regression in the service in transcendence.

Cortright believed Washburn's model fell short in its attempts to delineate the relationship of psyche and spirit. He insisted Washburn's work presented a Western bias of the Perennial Philosophy, which, while based upon clinical experience, may have lacked the depth of Wilber's theory. In addition, he believed Washburn's Dynamic-Dialectical theory ignored the first half of human life. According to Cortright, Washburn's assumptions focused on mid-life transvaluation, while negating the potential for spiritual work in early adulthood (Cortright, 1997).

Cortright emphasized the dissimilarities between the authors approaches to the theoretical concept of transcendence. In Wilber's conceptualization, the goal of transcendence was that of unity consciousness, i.e., the disillusion of the self into "Brahman or Buddha Nature" (p. 85). From Washburn's perspective, regression in the service of transcendence did not eliminate the self, but transformed it into a higher unity. Once integrated, the self, no longer in competition with its higher power, willingly assumes its role as the lesser aspect of the integrated duality (Cortright, 1997).

According to Cortright (1997), Washburn and Wilber also disagreed on Wilber's Pre/Trans Fallacy. Wilber attacked Washburn's Jungian orientation, denouncing Jung for committing "the classic pre-trans mistake" (pp. 85-86), i.e., confusing infantile narcissism (pre) with altruism (trans), or primary processes (pre) with vision logic (trans). In addition, Wilber remained uncertain as to the nature of the Jungian archetypes, questioning if in fact transpersonal archetypes did, or do, exist.

Transpersonal Psychotherapy

In the collection of essays entitled Transpersonal Psychotherapy, (1996), Boorstein suggested that transpersonal psychotherapy, rather than characterized as an emerging paradigm, may in fact be the oldest of all therapeutic approaches. Walsh & Vaughan (1993) proposed that unlike traditional approaches, transpersonal psychology acknowledged the value of the therapist's spiritual quest in molding the therapeutic outcome, with this shared relationship invaluable in facilitating a higher spiritual awakening in both the therapist and client (Walsh & Vaughan, 1993).

Boorstein (1996) questioned a therapist's ability to psychologically transport a client further than he himself has personally progressed, fearing that insufficient transpersonal awareness may lead the experientially inexperienced therapist to mistakenly interpret transpersonal experiences as pathological. He suggested transpersonal psychology differs not so much in technique as in orientation, with the primary distinction the attitude of the therapist, this attitude essentially shaping the course of the therapy. He contended the transpersonal psychotherapist confronts and explores the issues of human value and meaning, recognizing their working through will be helpful in resolving the patient's [client's] intrapsychic conflicts (Boorstein, 1996).

Hindas (1981) cautioned the psychotherapist to approach transpersonal 'surrender,' the initially negative disillusion of the client's reality, with "sensitivity and subtlety" (p. 31). Cortright (1997) stated, "Transpersonal therapy lies not in what the therapist says or does, but in the silent frame that operates behind the therapist's actions, informing and giving meaning to the specific interventions" (p. 16). He cautioned that transpersonal theory is not a substitute for poorly trained psychotherapist, stating:

The Being of the therapist is important, but as a support to thorough clinical training and experience, not as a replacement. For it is only by the integration of the therapist's being and solid therapeutic skill into a larger or more theoretically justifiable transpersonal framework that the Transpersonal approach will represent a true advance in psychotherapy (Cortright, p. 226).

The Transpersonal Psychotherapist

According to Boorstein (1996), transpersonal psychotherapists may view the therapeutic relationship as Karma yoga, growth through service to the client. As a result of practicing the "Learning to Cope Model," the Transpersonal psychotherapist may emphasize humanity's shared experiences, thereby acknowledging that we all, therapist and client alike, are in this journey

together (Boorstein, 1996). In "Meditation: Royal road to the Transpersonal," Walsh & Vaughan (1993), highlighted six common elements that the authors believe constitute "the heart of the art of transcendence"(p.48).

Ethical training fosters kindness, compassion, and calm, while attentional training, the cultivation of concentration, is needed to quiet our fickle minds. The growth of the positive emotions of joy, love, and compassion may lead to emotional transformation, with the "cultivation of equanimity" (p. 50), the sense of emotional imperturbability (even under stress) a goal of transcendence. According to Walsh & Vaughan (1993), the therapist who becomes immersed in a program of ethical training and increased concentration will model decreased compulsivity, intensity, and self-centeredness, along with corresponding increase in altruism and transcendence.

The refinement of awareness and perception may provide a more sensitive, more accurate, and appreciative intuitive understanding, "introspective sensitization" (p. 51), of each moment. Consequently, this heightened level of awareness will effect a motivational shift - a "purification" or "giving up attachment to the world" (p. 50). This dis-identification will lead to the refinement of perception, and ultimately, to a self-transformation often regarded as the attainment of wisdom (Walsh & Vaughan, 1993).

The transpersonal psychotherapist is not only likely to be involved in a personal program of meditation and/or contemplation, but encourages the client to do so as well (Walsh & Vaughan, 1993). The therapist may model a strengthening/purification of the physical and emotional body through exercise, a lacto-vegetarian diet, and a decreased consumption of sugar, nicotine, and stimulants (Walsh & Vaughan, 1993; Cortright, 1997). He may seek to bring increased consciousness into the body through movement, utilizing such activities as nature walks as

opportunities for balance/centering (Cortright, 1997). The therapist may model/encourage the incorporation of spiritual practices within the client's life and work (Walsh & Vaughan, 1993; Boorstein, 1996; Scotton, Chinen, & Battista, 1996), and if appropriate, may encourage/participate in inspirational readings addressing *The Dark Night of the Soul* (Kavanaugh, 1991; Walsh & Vaughan, 1993; Washburn, 1995; 1996).

In "Healing and Wholeness," Vaughan (1993) characterized the effective therapist as one who models authenticity, affirms the value of spiritual practices, and encourages the client to live in harmony with the present (Vaughan, 1993). Cortright (1997) underscored the potential significance of bodywork, which he asserted, "focus[ed] consciousness on the physical" (Cortright, p. 176). Appropriately chosen musical selections can be emotionally cathartic. Dreamwork may be undertaken. Cognitive reattribution may assist the client in reframing her non-productive thoughts, while the hypnotic induction of altered states can produce powerful therapeutic benefits.

Affirmations allow the client to differentiate "consciousness from its content", with the doctrine of dis-identification, (essential for transpersonal work), assisting the client in transcending the ego and personal history (Walsh & Vaughan, 1993). The transpersonal therapist is likely to encourage the client's creativity (crafts, architecture, the Arts, etc.), recognizing the healing potential of creative awareness is frequently fostered through the expressive arts (Walsh & Vaughan, 1993; Cortright, 1997). The "primal holon of art" (Wilber, 1996) represented:

... an interior perception, feeling, impulse, concept, idea, or vision.
From exactly where, nobody knows, the creative impulse bubbles up. . .
this primal holon may in fact represent something in the external
world, an interior state, feeling, idea. . . Around that primal holon,

like the layers of a pearl growing around an original grain of sand, will develop contexts within contexts of subsequent holons, as the primal holon inexorably enters the historical stream that will govern so much of its subsequent fate (p. 75).

Likewise, Grof's holotropic therapy, which activates the psyche and induces non-ordinary states of consciousness (Grof, 1988), also facilitates the transfer from the egoic to the transpersonal (Grof, 1988).

The transpersonal psychotherapist is likely to emphasize the development of integrity and genuineness, while focusing upon integration (Vaughan, 1995). Borrowing from Jungian terminology, the therapist understands projection can only be minimized when both the persona and shadow are accepted and appreciated (Vaughan, 1995). She recognizes the value of confession, acknowledging that "healing occurs when the rejected, disowned aspects of the self are accepted and integrated into a larger vision of wholeness" (Walsh & Vaughan, p. 3).

The therapist may assist the client in a language change, substituting his 'should's' for 'coulds' (Vaughan, 1995). The transpersonal psychotherapist is likely to set aside lengthy blocks of time for extended sessions, recognizing that transpersonal work often does not fit neatly into the 50 minute therapy hour (Cortright, 1997). She may encourage the client to seek a medication evaluation, recognizing this adjunctive therapy may be helpful for symptom relief, while appreciating "what psychopharmacological intervention can and can not do" (Victor, 1996, p. 333). Psycho education may serve to depathologize the client's issues, adding normality to the treatment and instilling hope by reframing the disorder within a psycho spiritual framework (Cortright, 1997).

The Transpersonal psychotherapist is likely to understand the value of a "safe container" (Cortright, p. 173), a sanctuary or retreat. This non-sterile environment may be equipped with

soft lighting and a connection with nature, and may provide haven for emotional catharsis and physical release (Cortright, 1997).

The numerous and varied clinical experiences of transpersonal psychotherapists are contributing to an ongoing definition of transpersonal psychotherapy. These theoretical and anecdotal reports, although lacking empirical evidence, are providing the broad brush strokes of this new field.

Engler (1993) explored the integration of Buddhism and psychoanalysis. In "Becoming Somebody and Nobody: Psychoanalysis and Buddhism," the author suggested severe pathology to be a consequence of one's attempts to "annihilate the ego" (p. 120). Levin addressed mankind's current sense of alienation. In "The Body's Recollection of Being," Levin emphasized that our willful separation from our deepest selves creates "ego-centered subjects estranged from our bodies, from each other, and from the world" (as quoted in Washburn, 1995, p. 3).

Foote (1996) addressed the issues surrounding guided imagery therapy and the transpersonal psychotherapist. Deikman (1996) pioneered scientific investigations into the psychological ramifications of meditative practice. Don (1996) explored the psychophysiology of altered states of consciousness, while Fehmi (1996) contributed data in the areas of biofeedback and attentional training.

Vaughan, author of The Awakening of Intuition (1979) and The Healing Arc (1994), examined spirituality and the transpersonal, addressing techniques, methods, and the healing potential of the transpersonal perspective. Grof (1988; 1994) opened the doors to non-ordinary states of consciousness (NOSC) through the use of holotropic (oriented toward wholeness) breath work (Grof, 1993, 1996; Yensen & Dryer, 1996), while both Grof (1972; 1988; 1994) and

Yensen (1973), designed and conducted clinical studies utilizing psychedelic drugs as an adjunct to psychotherapy.

Boorstein, author of Transpersonal Psychotherapy (1996), and Clinical Studies in Transpersonal Psychotherapy, (1997) has written extensively on transpersonal psychotherapy, emphasizing the need to revise our basic ideas regarding consciousness, while underscoring the value of the perinatal experience. Scotton, Chinen, & Battista (1996) emphasized the need for a multidisciplinary /cross-cultural approach in transpersonal psychiatry/psychology. The biopsychosociospiritual developmental continuum (p. 411), which acknowledges that differing states assume dissimilar forms at various stages of human development, must be considered.

Wittine (1993, p.166) formulated postulates inherent to the transpersonal vision, framing transpersonal psychology as an attempt "to weave a Western psychology and the perennial wisdom." He stated, "What differentiates transpersonal therapy from other orientations is neither technique nor the presenting problems of clients but the spiritual perspective of the therapist" (p. 166).

Wittine (1993) believed the search for the higher consciousness has not negated the value of the lower, and emphasized the transpersonal therapist recognizes the necessity of the personal quest in shaping the process of psychotherapy. The author believed the transpersonal therapist to be in the process of awakening to individual identity, traveling from the pre-egoic to transcendent state. Wittine's transpersonal therapist sought to relinquish perceptions and judgements, and in so doing, to honor the emergence of intuition and inner awareness.

Dissociative Identity Disorder and Transpersonal Psychology

To date, little has been written on the severe pathology of Dissociative Identity Disorder from

the transpersonal perspective, leaving the looming field fertile ground for empirical exploration. Tart (1991; 1993) addressed ASC's (altered states of consciousness), i.e., waking states, sleep hypnosis, intoxication, etc., as often confused and turbulent, and suggested discrete altered states of consciousness can be induced by disruptive forces, with these psychological and/or physiological events serving to interpret the stabilization process (Tart, 1993). He stated:

If induction is proceeding successfully, the disruptive forces push various structures/sub-systems to their limits of stable functioning and beyond, destroying the integrity of the system. . . Then we apply patterning forces during this transitional, disorganized period-- psychological and/or physiological actions that pattern structures/ sub-systems into a new system, the desired ASC. . . at the opposite extreme, certain kinds of psychopathology, such as multiple personality, can be treated as d-ASC (pp. 36-37).

In Healing the Split, Nelson (1994) proposed an awareness of transpersonal theory may contribute to a greater understanding of MPD [DID]. He theorized that the individual, repeatedly abused during second chakra consciousness (prior to the self turning away from the Ground), fails to integrate due to the repeated trauma. As a result of this unsuccessful fusion, the imaginary playmates that are common among all children are not incorporated, thereby allowing the child's self to remain open to the Ground. Nelson suggested, ". . . what was once an invisible friend crystallizes into an alter" (pp. 228-229).

Therefore, therapists treating MPD [DID] "reactivate the natural process of integrating imaginary playmates" (Nelson, p. 229), with this new extension of the self's boundaries now encompassing the previously fragmented, altered states. Nelson theorized that as a consequence of these expanded self boundaries, the alters forfeit their individual identities, merging as one with the host (Nelson, 1994).

Mungodze (1995), a psychotherapist specializing in the treatment of ritual abuse, ascribed a

sense of omniscience to the role of the Internal Self Helper. In a lecture entitled, "Christian Perspectives on Healing from Ritual Abuse and Mind Control," Mungodze suggested the DID client's spirituality has been purposefully blocked. He alleged multi-perpetrator groups are exceedingly aware of the power of spirituality in recovery, and maintained the treating professional's first order of business is an evaluation of the client's ability to assess his own spiritual core, regardless of his faith. Mungodze stated, "If this client is a human being, I know that [this] part [does] exist" (A Lecture Presented at the 1995 Ritual Abuse Conference.)

In "Theoretical and Empirical Foundations of Transpersonal Psychology," Grof (1996), a pioneer in non-ordinary states of consciousness exploration, proposed transpersonal psychology to be a intriguing arena for MPD [DID] research. Theorizing from extensive clinical practice, Grof maintained consciousness extends beyond the function of the brain, and suggested that the potential exists for several separate units of consciousness to simultaneously compete for control of the body. He stated:

Therefore, even an ordinary personality can be comprised of numerous units of consciousness. In addition, patients with multiple personalities often have a history of ritual cult abuse. The traditional understanding of this strange phenomenon, whose incidence has grown enormously in recent years, is very superficial and unconvincing, because it misses entirely the critical role of the perinatal and transpersonal dimensions involved. Transpersonal psychology is thus finding exciting supportive evidence in another area where traditional thinking has failed to provide adequate answers (p. 61).

Clinical/Ethical Issues

As has been previously stated, the Transpersonal paradigm's assumptions, although innovative and intriguing, have evidenced little empirical validity and undergone scant critical review or empirical validation. While it has been recognized that the emerging field has brought

much needed attention to experiences previously pathologized in the mainstream clinical community, the transpersonal approach has been criticized for its positive orientation, viewed by some as an overly optimistic focusing on “the high end of human life” (Cortright, p. 13).

In addition, questions have remained as to the therapist’s role within the therapeutic process. What is an appropriate level of self disclosure? What is the therapist’s role within the relationship? Is she viewed as a teacher, a spiritual guide? What are the effects if any of transference and countertransference? Should the therapist “prescribe” meditation, bibliotherapy, or focused body work outside the therapy session? How does the therapist, who may be surpassed in spiritual awareness and growth, avoid grandiosity? These and other unexplored areas are likely to be addressed as this emerging field gains momentum.

In conclusion, Cortright (1997) has cautioned the transpersonally oriented therapist to avoid assuming that spiritual awareness is only achieved through an individual’s investment in the psychotherapeutic process. He has advised:

While the tendency to see the transpersonal as therapeutic may be especially strong for psychologically-minded therapists, it is possible to work transpersonally and yet be open to non-psychological approaches to spiritual development and experience. Spiritual development does not necessarily follow from nor is it identical with psychological work (p. 90).

The Conclusions

This chapter has been comprised of two parts. Part I, entitled Dissociative Identity Disorder, has introduced the dissociative phenomena and provided a brief overview of dissociative research. Altered states of consciousness have been presented, and a question of purposeful dissociation has been reviewed. Sociocultural implications, traditional treatment dimensions, and the controversy

surrounding ritual/multi perpetrator abuse have been addressed. An Adlerian orientation and Object Relations have been reviewed.

Part II, entitled Transpersonal Psychology, began with an emerging paradigm, and featured transpersonal definitions, precursors to the field, and historical perspectives. Transpersonal assumptions have been addressed. An overview of transpersonal development has been provided. The leading transpersonal theorists have been introduced, followed by a critique of the contrasting orientations. The current state of transpersonal psychotherapy and the transpersonal psychotherapist has been advanced. Dissociative Identity Disorder and transpersonal psychology has been presented, and clinical/ethical issues have been reviewed.

Chapter Three

Methodology

An Introduction

This chapter provides a brief review of quantitative and qualitative research design. The study's qualitative methodology, social-constructivist/constructionist orientation, case study design, and dual-narrative format are posited. The use of archival data is discussed. An introduction to the case is provided. The study's procedures are reviewed, and its audit trail and ethical considerations discussed. The study's analyses, both inductive and external, are addressed.

An Overview of Education Research Traditions

Educational research methodology ranges in scope from positivistic empiricism to relativist constructivism/constructionism. Positivism assumes a dualistic, objective, external reality, asks the question, 'what is reality,' and is referred to by the authors of The Handbook of Qualitative Research as "naive realism" (Denzin & Lincoln, p. 109). Postpositivism seeks to discover 'how things are' through experimental/manipulative methodology, and focuses upon the verification of hypotheses to explain or predict. Somewhat more subjective is postpositivism, which seeks to adopt a "critical realism" (Denzin & Lincoln, p. 110) stance, but concedes that reality is "only imperfectly apprehendable" (p. 110). Postpositivism acknowledges that as long as humans develop instruments, it is possible to approximate, but never fully comprehend reality (Borg & Gall, 1994). Post-modernism is involved with critical theory and historical realism. Constructivism, also known as constructionism, assumes a relativist ontology. Highly subjective, it seeks to investigate the "multiple, apprehendable, and sometimes conflicting social realities that are products of human intellects, but that may change as their constructions become more

informal and sophisticated" (Denzin & Lincoln, 1994 p. 111). Constructivist/constructionist methodology assumes reality to be a by-product of the interaction between the investigator and the respondents. It employs the hermeneutic/dialectical method, which strives to reconstruct the previously held constructions of the researched.

... instead of focusing on matters of individual minds and cognitive process, they [social-constructivists] turn their attention outwards to the world of inter-subjectively shared social constructions of meaning and knowledge. . . with accounts of the world not viewed as external expressions of the speakers internal processes (cognition/intention), but as expressions of relationships among persons (Denzin & Lincoln, p. 127).

Quantitative research methodology encompasses both positivistic and post-positivistic methods of inquiry, while qualitative methodology embraces post-positivistic, post-modernist (critical theory), and constructivist/constructionist research designs. Although the term "research design" (p. 321) in its broadest sense, refers to the procedures selected to study a set of hypotheses, it is more typically references a researcher's choice of either quantitative, qualitative, or mixed methodology (Borg & Gall, 1994).

Quantitative Research Design

Quantitative research design is the process of developing an empirical test to support or reject a knowledge claim (Borg & Gall, 1994). Evidence to support this "knowledge claim" (p. 97) (is it true in this particular situation?; is it generalizable) is collected through direct observation, with these observations translating into research data (Borg & Gall, 1994).

According to Borg & Gall (1994), quantitative methodology adopts "Krothwohl's Model of the Chain of Reasoning" (pp. 325-328). A review of the relevant literature is undertaken, the examination of which enable the researcher to draw conclusions from the existing body of

knowledge. Following this investigation, an explanation or knowledge claim is posited, with this knowledge claim more credible if grounded in a feasible rationale (Borg & Gall, 1994).

Questions or hypotheses are stated in a manner conducive to empirical testing. The study's design is set forth (descriptive, causal comparative, correlational, experimental), with the design or methodology including sampling techniques and size, the experimental procedures, and measurement. At this stage, the design must be specific and sound, or the study's results will necessarily be rejected.

The next step in the Chain of Reasoning Model outlines the procedures used to gather the data, and points to those problems in the collection process which have the potential to compromise the study's integrity. The data, assembled numerically, is then summarized. A statistical test (t-test for differences between means, analysis of variance, non-parametric tests such as chi square, etc.) is performed to determine statistical power, directionality, effect size, and generalizability. The section entitled "Conclusions" reviews the data analysis to determine if the knowledge claims have been supported by the results, and seeks to analyze and eliminate alternative explanations. The remaining link represents the study's publication. The research findings, once reported, complete the cycle as they, too, become a part of the existing body of literature (Borg & Gall, 1994).

Qualitative Research Design

A second major paradigm in educational research has been referred to as phenomenological, naturalistic, subjective, post-positivist, and qualitative (Denzin & Lincoln, 1994). Qualitative methodology relies on the human power of observation rather upon empirical testing and random sampling. Assuming both an etic, i.e., outsiders, or emic, i.e., insiders, point of view, the

researcher herself serves as the primary data collection instrument. Initially at home in anthropological and sociological research, qualitative design values perception, intuition, and subjectivity. Unlike quantitative's empirical emphasis, qualitative methodology accepts feelings as "legitimate knowledge" (Borg & Gall, p. 387).

Qualitative research employs holistic field study inquiry within the natural setting. Asking the questions of who, what, where, when, how, and why, the design emphasizes social processes, and the focuses upon the meanings the research subjects attribute to their social and cultural settings. Unlike quantitative's deductive statistical analyses, qualitative design allows, even encourages, the research subject to play a role in the interpretation. Qualitative methodology employs inductive data analysis to explore multiple realities and to examine frequently overlooked variables.

Case Study Research

Case Study Research, an all encompassing design, involves an incremental focusing (In Denzin & Lincoln, 1994). Increasingly utilized as a research tool, Yin (1994) defined a case study as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (Yin, p.13). In his forward to Yin's text, Campbell, a pioneer in the field of quantitative research, described case studies as ". . . extended networks of implications that (while never complete), are nonetheless crucial its scientific evaluation" (Campbell, as quoted in Yin, 1994 p. ix).

Stake characterized case study inquiry as both the process and product of learning about the case (In Denzin & Lincoln, 1994). He portrayed the intrinsic case study as one in which the goal is better understanding of a particular case, rather than the examination of abstract phenomena or the development of theory; the instrumental case study as one in which the focus is on the

underlying theory rather than on the case itself; and the collective case study as the study of a number of cases examined jointly, whose intent is that of inquiry into a phenomenon or population (In Denzin & Lincoln, 1994).

Asking how and why questions, a case study can be quantitative, qualitative, or mixed in design, depending upon the nature of the data to be collected. The case study can be either holistic or embedded (Yin, 1994). If examined holistically, the researcher seeks to focus upon global data. Conversely, an embedded analysis examines sub-units as factors, with careful attention given to the ultimate return to the larger unit of study, the case itself (Yin, 1994). The case study methodology to be utilized is determined by the research question asked, the degree of control the researcher has over the behavioral events under investigation, and "the degree of focus on contemporary as opposed to historical events" (Yin, p. 6).

In Case Study Research Design Methods (1994), Yin portrayed case study research as a comprehensive method of inquiry, utilizing any combination of qualitative and/or quantitative data, to define, depict, portray, or explore a contemporary phenomenon within a real-life setting (Yin, 1994). Yin asserted that case study design is not easy and contended the intellectual and emotional demands of this research design are far greater than other research strategies (Yin, 1994).

However, an effective case study, while challenging to develop, will seek to examine and appreciate the complexity of organizational phenomena, incorporate a wide variety of evidence (documents, artifacts, interviews, observations, etc.), utilize analytic generalizations, present the evidence fairly, consider and rule-out hypotheses, and offer the research data in an informative and engaging manner. While trustworthiness, credibility, confirmability, and data dependability

are vital components in quantitative, qualitative, as well as mixed research designs, these traits are particularly essential in case study research.

Qualitative Case Study Design

The qualitative case study design is utilized in this research for a variety of reasons. Case study design acknowledges the value of single subject (n of 1) research. It permits an investigation into contemporary phenomenon within a real-life context, and does not require a control over behavioral events. Its non-judgmental, longitudinal approach allows the researcher to 'progressively focus,' thereby paving the way for a detailed exploration, examination, and/or description of a particular phenomenon, an extreme or unique case (a case worth documenting and analyzing for its strengths and weaknesses), or a revelatory case (a phenomenon rarely accessible to the research community).

Since case study design accepts the likelihood that interpersonal relationships will be developed, it acknowledges blurred boundaries between the researcher and the researched. Case study design has the unique ability to deal with multiple sources of evidence (interviews, observations, documents, artifacts, etc.), thereby increasing its potential for discovering overlooked variables, opening new areas of investigation, and investigating new or poorly defined phenomenon. Qualitative case study design allows for a more in-depth understanding of an individual, and, in clinical cases, may be helpful in the development of possible treatments.

The Research Design

Qualitative Methodology

This study utilizes a qualitative methodology, social-constructivist/constructionist orientation, case study design, and dual-narrative format. The qualitative paradigm was selected due to the

holistic nature of the inquiry, an "n of one" (small, non-representative sampling), and the availability of "soft" research data, i.e., letters, progress notes, audio tapes, video tapes, newspaper reports, employment records, diaries, journals, artwork, etc. The very nature of the therapeutic process demands that the therapist interact with the subject, thereby assuming an etic point of view.

The therapist, as researcher, fills the role of participant-observer. This role, ranging from pure observation to full participation, provides a unique opportunity to observe the client's behavioral patterns (non-verbal expressions), experience first-hand the unexpected, and become a trusted confidant in the therapeutic/research process. Informal and evolving, qualitative methodology's inductive, context-bound process honors the client's voice as she presents her story and undertakes the arduous task of integration and transcendence. Highly subjective and interpretive, the evolving, emergent design supports the therapist/researcher as the primary data collection instrument, accepts the inevitability of the biased, value-laden observations, and embraces the intuitive nature of the process.

Social-Constructivist Orientation

Constructivism/constructionism encompasses a broad eclectic framework (Guba & Lincoln, 1989; Denzin & Lincoln, 1994). The social constructivist/constructionist paradigm seeks to comprehend the individual's lived experiences through an incorporation of her world view into the subject at hand. The paradigm explores the specific meanings constructed by the actors, accepting reality as a social configuration, shaped by relationships and exchanges among people (Guba & Lincoln, 1989; Denzin & Lincoln, 1994).

The researcher has chosen the social-constructivist/constructionist orientation in an effort to

establish the subjectivity of truth, for the paradigm acknowledges that we, through our shared experiences, our shared social constructions, create our own reality. Both the therapeutic and educational research traditions demand that the therapist/researcher exercise a caring respect in her work with the client/subject. She, the client/subject, must be trusted, her life and its experiences valued, and her convictions honored. Her story must be embraced as her truth.

The social-constructivist/constructionist paradigm not only accepts but appreciates the role of ethics in research. As "ethics is intrinsic to constructivism" (Denzin & Lincoln, p. 115), this conceptual framework was selected to ensure the highest possible regard for the client/subject and her emotionally charged reconstructions.

Archival Data

The case study narrative was prepared using archival data, i.e., information that has been previously collected. Archival data can be obtained from both public and private sources. Public documents include artifacts, the print and electronic media, police statements, brochures, resumes, calendars, telephone listings, and employment service records. Journals, diaries, personal correspondence, photographs, audio/video tapes, medical/psychotherapeutic treatment notes, and psychological testing sources are among the private sources.

Archival research asks new questions of old data (Elder, Pavalko, & Clipp, 1993). Suitable for longitudinal study, archival inquiry "is not just a window on the past" (Hill, 1993, p. 79), but a "forward-looking alternative vision[s] for the social sciences" (Hill, p.78). Archival inquiry allows the researcher to explore those "collegial networks" (Hill, p. 80) whose work is not readily available through customary literature searches (Hill, 1993). Rich in context, the approach

challenges our current perceptions and portrayals, while expanding our existing knowledge base (Glesne & Peshkin, 1992).

Archival inquiry not only allows the investigator to reformulate the original research question(s) to better fit the data, it provides the opportunity to recast (reshape) the data, thereby maximizing the data to fit the question at hand (Elder, Pavalko, & Clipp, 1993). Due to historical orientation, archival research poses no danger to its subjects (Smiley, 1997). Unfortunately, this form of qualitative research is a time-consuming approach, requiring a great deal of patience and resulting in vast amounts of unused data. While its contextual dimension adds to its uniqueness, it is that very uniqueness which reduces its generalizability.

The data under study is frequently incomplete, leaving the researcher to ascertain both its purpose and intended audience. In addition, the archival researcher must evaluate the accuracy of the materials collected, for it is a mistake to accept the information as “unmitigated truth” (Yin, p. 82). Interpretive in nature, Smiley (1997) reported that archival data is frequently subject to researcher bias.

Qualitative research methodology frequently utilizes archival data, with the case study one form of qualitative inquiry. Case study research commonly utilizes documents, interviews, direct and participant observation, physical artifacts, and archival records (Yin, 1994). The steps in the archival research process include, problem specification, the search for appropriate data, the preparation of the research proposal, an analysis of the archival data (first step), a decision to recast the data, and the sequence of the analysis (Elder, Pavalko, & Clipp, p. 22).

The Case

The forty-five year old white female was currently on medical leave from her nursing position due to a knee injury, an injury which can not be surgically corrected until one hundred pounds are shed. She presented for counseling describing herself as depressed and anxious, with gastrointestinal concerns and erratic sleep patterns. As an emotionally hurting individual, she reported to be most disturbed by feelings of "needing to cry, feel clean, and vomit. . ."

Having recently been released from an inpatient treatment facility specializing in childhood sexual abuse, she offered, "I wish I had not been such a bad child and wouldn't have caused my foster parents to do what they did to me." The client described herself as a victim of the foster home system, with her foster parents having used alcohol "heavily."

To date she reports having had no contact with her natural parents, and denies knowledge of their educational level, occupation, or place of residence. She stated she has been told that while her natural mother is divorced (from the client's father), her natural father is currently married to his ninth wife. She described herself as single, living alone, with one close friend from whom she receives support.

Having been emancipated from the age of fourteen and a half, she has independently educated herself, achieving LPN and RN status, and subsequently earning a double major in Social Science and Foreign Missions. In addition, she has completed course work towards a Master of Education degree.

As a Nursing Supervisor, the individual was responsible for all third shift activities, from staffing coverage to evaluations. She viewed herself as a "good nurse who listened to her staff and cared about them individually," and as a result, reported she had received many above average

evaluations from her supervisors. However, she reported she was a perfectionist and a workaholic, tending to log sixteen-hour shifts, seven days a week. While she felt well-suited for her profession, she would consider changing to another position because, "I often feel used and burned-out in nursing. . . I feel given out."

The individual described religion as holding a great importance in her life, but currently does not attend an organized church, stating, "I feel angry and distant from God." Even though her social contacts appeared to be limited, the client reported valuing loving, caring, non-judgmental people. Honesty, respect, morality, and kindness were offered as important personal attributes. The client reported her inability to trust others and her overeating (morbid obesity) in order to stuff her feelings have been her greatest weaknesses. She reported disliking "people who spiritually, sexually, and emotionally abuse children." The individual's goals appeared to be centered around an emotional healing and the development of a meaningful personal life. She stated, "I would one day like to get married and have someone love me for me, and not use me to satisfy their needs. I never want to be a victim again."

Upon presentation, the forty-five year old female was experiencing significant levels of anxiety and depression as the result of issues involving sexual abuse in childhood, and the loss of her coping mechanisms, i.e., work, food, and exercise. At the time of the intake, she was internally focused, reflective, and detached. Exhibiting a below average integration and realization of potential, she presented as withdrawn, self-defeating, and vulnerable.

Procedures

The researcher first sought permission for the study from the college's Doctoral Committee, and then requested approval from the Human Subjects Committee. Once granted, she reviewed

the research materials, the archival/extant data collected in the therapeutic setting (private practice office) from November, 1992 to June, 1995. Letters, journals, progress notes, newspaper clippings, diaries, audiotapes, videotapes, agency records, artwork, memorabilia, etc., as well as participant/observation data, were included in the review process. The case study was prepared utilizing the extant/archival data as well as the researcher's 'asides.' Four broad categories were identified (see Chapter III, Analysis). The dual-narrative format, presenting the client's ongoing dialogue along with the researcher's clinical findings and subjective therapeutic impressions, provided insight into the evolving world of both participants. All data, i.e., journals, artwork, correspondence, audio and video tapes, and therapist's progress notes, were made available for review by the doctoral committee upon request. The data continue to be stored in a secured location, obtainable, upon appropriate inquiry and consent, as documentation of this unusual case and verification of the accuracy of the reporting.

The Analyses: Inductive and External

Qualitative's inductive procedures allowed the researcher to develop a chronological clinical analysis, describe multiple realities from the perspective of both the researcher and the client, and, by avoiding preconceived hypotheses, reveal unanticipated outcomes. The procedures acknowledged the value of purposive sampling (Denzin & Lincoln, 1994), relied on the power of human observation (Denzin & Lincoln, 1994), and accepted feelings as "legitimate knowledge" (Borg & Gall, p. 387).

The case study research involved an incremental focusing (Denzin & Lincoln, 1994), and allowed the researcher to explore this "contemporary phenomenon within a real-life context" (Yin, p. 13). This qualitative case study was analyzed inductively, utilizing the previously mentioned

chronological clinical analysis method. Recurring patterns and divisions of information were identified. As these emerging patterns were isolated (in this case and reflectively, as the result of two subsequent cases), they were categorized into four broad phases; Phase One: Exploratory; Phase Two: Standard Treatment of Dissociative Identity Disorder; Phase Three: A Transpersonal Approach; and Phase Four: Termination. The voluminous clinical information was sorted into the above-mentioned classifications, with the data selected for inclusion representative of the whole of the case. Significant recurring vignettes that depicted, portrayed, and captured the essence of the case were included.

The subjective interpretation compared the findings of the case study with the previous research (provided by the review of the literature), and sought to address the question, "Can transpersonal psychotherapy be used successfully to treat Dissociative Identity Disorder?" Following the inductive, chronological clinical analysis, an external analysis was provided by Dr. Jenny Wade, a theorist and practitioner in the field of transpersonal psychology. A summary of the research, complete with recommendations for (a) clinician training and development, (b) clinical practice, and (c) further research was included.

Ethical Considerations

The qualitative researcher acknowledges that she is a bystander in the world's innermost spaces (In Denzin & Lincoln, 1994). As such, she collects data in a respectful, non-exploitive manner so as to avoid harm and prevent deception. It is her responsibility to defend her client's rights, shield her vulnerabilities, and guarantee that her dignity and privacy remain intact. The therapist/researcher insured her client's anonymity during the reporting phase of the research. She sought to safeguard her client's freedoms, guard her against potential danger, and protect her case.

The Conclusions

This chapter has presented a brief review of quantitative and qualitative research design. The study's qualitative methodology, social-constructivist/constructionist orientation, case study design, and dual-narrative format have been posited. The use of archival data has been discussed. An introduction to the case has been provided. The study's procedures have been reviewed, and its audit trail and ethical considerations have been discussed. The study's analyses, both inductive and external, have been addressed.

Chapter Four

The Case Study Dual-Narrative

An Introduction

Chapter IV presents the Case Study Dual Narrative, and is divided into four phases. Phase One: Exploratory (The First Seven Months) addresses (a) the referral (b) intake and initial presentation (c) the clinician's Adlerian orientation (d) the advent of managed care (e) Pandora's Box, i.e., the client's allegations and complex symptomatology (f) phase one treatment strategies (g) the emergence of borderline pathology, and (h) a diagnosis confirmed.

Phase Two: Standard Treatment of Dissociative Identity Disorder (Eight Months to Two Years) describes the conventional treatment techniques historically associated with DID. This phase includes (a) issues of safety and trust (b) a return to journaling (c) medical consultation (d) introduction of the altered states of consciousness, (e) bulletin board system of communication (f) internal group therapy (g) abreactive therapy/screening (h) the creative arts: poetry, play, and art therapy (j) issues of grief and loss (j) reconstructing a life (k) burgeoning ego strength (l) bibliotherapy) (m) dissolving amnesic barriers (n) the value of humor, and (o) minimizing minutia.

Phase Three: A Transpersonal Approach (The Third Year) includes (a) a turning point, i.e., the shift from conventional treatment of DID to an acceptance of Strong Man as inner guide, and (b) the healing, an account of Strong Man's facilitation of the integration process.

Phase Four: Termination and Referral (The Final Six Months) describes the last stage of our work together. It includes the initial exhilaration of (a) a tremendous breakthrough, then follow a more somber path through (b) aftermath (c) a thwarted hospitalization, and (d) termination.

Obviously, the data collected over this treatment period was voluminous. As was previously stated in Chapter III, the researcher utilized the constant-comparison method of inductive analysis, choosing to organize the narrative by broad, recurring categories of information that were representative of the data under study. These designations will be discussed in Chapter V. Materials were highlighted from the multiple sources in order to provide an accurate and thorough depiction of the case study events. The data were sorted and the classifications selected retrospectively, with greater clarity, after the successful integration of two additional Dissociative Identity Disordered individuals. The dual-narrative format was employed to present the evolving dialogue/awareness of both client and therapist.

A system of symbols has been provided to ensure accurate reporting of the data. The system's notations will occur as follows:

Case Notes	*
Video Tape	+
Audio Tape	@
Personal Journal	^
Client Journal	#
Phone Consultation	=
Clinical Consultation	%
Correspondence	~
Personal Reflection	>

Italics were utilized to present the researcher's asides. In addition, the client's written use of the lower case I (i) was referenced throughout the narrative.

The Case Study

Phase One: Exploratory

The First Seven Months

The following account of Phase One: Exploratory (The First Seven Months) addresses (a) the referral (b) intake and initial presentation (c) the clinician's Adlerian orientation (d) the advent of managed care (e) Pandora's Box, i.e., the client's allegations and complex symptomatology (f) phase one treatment strategies (g) the emergence of borderline pathology, and (h) a diagnosis confirmed. It must be emphasized that insufficient symptomatology emerged until the end of this introductory period to substantiate a Dissociative Identity Disorder diagnosis.

The Referral

November 1992

"I ran into an old acquaintance of mine at the doctor's office the other day, a gal I knew from the university. She's in pretty bad shape. . . . told me she had been just released from, I don't know, I think a some sort of a treatment program. She's out of work with a bad knee, and I think its getting to her--depression, maybe. You interested?" [*]

Am I interested? Are you kidding? My first referral! As a newly Licensed Professional Counselor, I have just signed a contract with an established psychotherapeutic practice. My new colleague and I have agreed that I will be assigned to a satellite office in January of the coming year, as soon as I have completed an Educational Specialist program, and resigned my position as elementary school counselor. I haven't even hung a shingle, and I have a referral! This is, as my younger son would say, too awesome! I proceed to run- through the commuting

logistics in my electrified mind. Let's see, I can drive the two hundred miles every other weekend between November and January, see the client, and return to complete work and graduate school obligations. If she is still in need of service when I have relocated to the area, the sessions can be increased to once weekly. In the meantime, the extra money would certainly help with both the moving and start up expenses of a private practice. Perfect! Everything is falling into place! Couldn't be better! [>]

I turn to my new colleague as we emerge from the dimly lit hall. As we huddle beneath the building's less than adequate overhang, preparing to dart into the evening's intermittent rain, I casually, perhaps even indifferently reply,

"Sure, I'll be happy to see her. . . give her my phone number. Tell her to contact me if she wants to set-up an appointment." [%]

Mistake number one!

A scant twenty minutes later I pull into the driveway of our weekend retreat. Scurrying through the now obnoxious downpour, I am greeted at the fully-flung door, not with the anticipated congratulatory hug, but with an unexpected scowl. Caught off-guard, I search for the source of my husband's apparent exasperation. I locate the culprit within our recently purchased cordless phone. Clapping his hand across its receiver, he thrusts the offending intruder towards me, stating,

"This lady has called twice. . . she sounds awful . . . I told her you would return her call, but she keeps calling . . . Here, you talk to her."

Flustered, I exchange the newly signed contract for the phone.

"Hello. this is Deborah, may I help you?"

My query was met with silence. I stare at my husband, as if to accuse him of manufacturing both the controversy and the call.

“Hello, may I help you?” I ask a second time. Again, no reply, but I detect an erratic, rasping sort of breathing.

Another hesitation, then a low-pitched, scarcely audible reply is heard, the voice an odd mixture of professionalism and passion.

“My name is Grace Ann Hughes. Jim Driskill told me you would work with me, and that I could trust you. When could we meet?” [;> =]

Some forty-five perplexing minutes later, a session is scheduled. We agree to meet the following Saturday in my colleague’s office, for the renovations on what will become the satellite facility are not to be completed for another several months. Already several hours behind schedule, I proceed to pack for the late evening drive back to the university. The phone continues to ring. Six additional calls are received from the beleaguered individual. In each instance, I am assured by the now familiar voice that I can change my mind if I choose, since I might not wish to associate with someone as “bad” as herself. Drawing, deeply drawing, upon my therapeutic training (rather than upon my now depleted emotional reserves), I recall Roger’s “necessary and sufficient conditions for change. . . empathy, congruence, and unconditional positive regard.” Confirming and reconfirming the appointed place and time, I seek to reassure the invasive caller that Saturday will be just fine, that I look forward to our meeting, and that I am not at all likely to change my mind. [;>]

My husband has married a middle and high school teacher, turned elementary and middle school guidance counselor, turned psychotherapist, and is understandably “green” regarding

the appropriate therapeutic boundaries of repeated phone calls. It is true that I do not have an office, nevertheless an office phone. While his weekend wife ponders the day's events during the long drive back to school, he continues to respond to the unrelenting calls, confronting each new assault with a mixture of agitation and concern. All he knows is that "this woman sounds desperate."

By the time I have reached my destination, some three-and-a-half weary hours away, a phone is again ringing. Tearing through the condominium to silence the midnight pandemonium, I breathlessly seize the faultless receiver, only to be greeted with,

"Deborah, this is Grace Ann Hughes. Are you sure you haven't changed your mind?" [=]

Frustrated, no furious, I phone my husband to demand an explanation as to why he has released my second number.

"She said it was an emergency," is his only reply.

Intake and Initial Presentation

"I Feel Angry and Distant from God"

Rocking . . . rocking . . . rocking . . . she sits, precariously perched on the very edge of an oversized sofa. Crutches positioned protectively by her side, she desperately clutches a well-worn brown bear to her ample chest, sobbing, "I trust George, her won't hurt me, he has safe eyes. . . Can you see his safe eyes?" Reluctant, or perhaps simply unable to visually engage with the puzzled therapist, she checks and rechecks her transient environment as if to determine its existence as friend or foe. Hyper vigilance gives way to a curious detachment, as she appears to become spontaneously submerged in a world of shadowy apprehension. Her speech takes on a slurred quality, punctuated by rasping sounds, as if she were laboring to acquire sufficient air. At

last, following a seeming eternity of guttural clamor, she reports, "George says I can trust you. You have safe eyes." [*; >]

Following this protracted initial session, Grace Ann asks if it "would be possible to meet again tomorrow," a pattern that is to continue throughout this initial period. Through oral interview and the client's subsequent completion of the Biographical Index Blank, it is determined that the middle-aged caucasian female of New England descent is currently on medical leave from her nursing position due to a knee injury, an injury which can not be surgically corrected until one hundred pounds are shed (she reposts her current weight to be 489 ½ pounds). No longer afforded the luxury of her time-tested coping mechanisms (working, walking, and eating), she sinks into a world of despair. A Folger's coffee commercial, featuring a son returning home for the holidays, is credited with the onset of the now debilitating panic attacks. [□]

The client reports voluntarily admitting herself into an inpatient treatment facility specializing in childhood sexual abuse, only to be released some ten days later, ostensibly due to an absence of suicidal ideation. It is at this point that she presents for outpatient counseling, describing herself as depressed and anxious, with gastrointestinal concerns, erratic sleep patterns, and a stress-induced asthma. She portrays herself as an emotionally hurting person, and is most disturbed by feelings of "needing to cry, feel clean, and vomit. . ." Characterizing herself as a victim of the foster care system, she offers, [□]

"I wish I had not been such a bad child and wouldn't have caused my foster parents to do what they did to me. I wish I could forgive them. I wish I could love my enemies." [□]

When asked about her natural parents, she hesitates, then blankly stares ahead. Void of emotion, she reports having no knowledge of either parents' birth date, birthplace, educational

level, occupation, or place of residence. She has been told that while her birth mother is divorced (from the client's father), her biological father is currently married to his ninth wife. She robotically volunteers she has been told by a distant aunt that her mother, currently under the care of a sister, was a patient in a "mental hospital" for twenty years. While she reports having two brothers, she alleges to know "nothing about them," not having seen or heard from either for some thirty years. In summary, she describes herself as having no family, single, living alone, with one close friend from whom she receives support. [□]

Having been emancipated from the age of fourteen and a half, the client reports independently educating herself, achieving Licensed Professional Nursing and Registered Nursing status, and subsequently earning a double major in social science and foreign missions. In addition, she has completed course work towards a Master of Education degree.

As a nursing supervisor, Grace Ann is responsible for all third shift activities, from staffing coverage to evaluations. She feels she is a "good nurse who listens to her staff and cares about them individually," and as a result, reports she has received many above average evaluations from her supervisors. However, she feels she is a perfectionist and a workaholic, and tends to log sixteen-hour shifts seven days a week. While she feels well-suited for her profession, she would consider changing to another position because, "I often feel used and burned-out in nursing. . . I feel given out." [□]

Grace Ann describes religion as holding a great importance in her life. Reared as a devout Catholic, she reports converting to Baptist fundamentalism while a student at a fledgling Christian college. She states she currently does not attend an organized church, because,

“I feel angry and distant from God. . . I think my ultimate hatred is toward God. I don’t understand why He would allow those people to do that to me.” [□]

Even though she reports her social contacts to be somewhat limited, she values loving, caring, non-judgmental people. Honesty, trust, respect, morality, and kindness are offered as important personal attributes. The client reports her inability to trust others and her overeating (morbid obesity) “in order to stuff my feelings” as her greatest weaknesses. She describes disliking “people who spiritually, sexually, and emotionally abuse children.” The individual’s goals appear to be centered around an emotional healing and the development of a meaningful personal life. She states,

“I would one day like to get married and have someone love me for me, and not use me to satisfy their own needs. I never want to be a victim again.” [□]

At the conclusion of the intake and ensuing information gathering sessions, the following therapeutic impressions are recorded:

Upon presentation, the forty-five year old female is experiencing significant levels of anxiety and depression as the result of purported issues involving sexual abuse in childhood, and the loss of her coping mechanisms, work, food, and exercise. At the time of the intake, she is internally focused, reflective, and detached. Exhibiting a below average integration and realization of potential, she presents as withdrawn, self-defeating, and vulnerable. It is important to note, however, that her methodical, systematic approach to life may prove a valuable component in the healing process. Her willingness to pursue counseling with regularity, as well as her desire to become less internally focused and more socially oriented,

poised, and self-confident may provide a reassurance that better days are ahead for this lovely, but hurting individual.[]*

An Adlerian Orientation

It is through 'Adlerian spectacles' that I initially view the case of Grace Ann Hughes (see Chapter Two). Grace Ann has developed an inadequate lifestyle. She has determined her life to be useless, and is alone and miserable as the consequence of her choices. Her family of origin (the primary socializing unit) appears to have been woefully inadequate, if not downright neglectful and abusive, leading her to feel insignificant and devalued. Her early subjective valuations (Adler's "basic mistakes in the private logic") have caused her to adopt a distorted, overly perfectionistic, unreasonably idealistic view of the world and its demands. Maladjusted, she is trapped at a point of "dead center" ("conflict"), dejected, discouraged, the author of her own despair. Grace Ann lacks the courage to meet life's basic tasks, and has resorted to an attention-getting, albeit sullen, declaration of defeat. She is entangled in a cycle of inadequacy and guilt. An "inferiority complex" has developed, and at the present time, she exhibits negligible insight awareness, and little forward orientation. She even feels "angry and distant from God."

Post Traumatic Stress Disorder

Post Traumatic Stress Disorder is employed as a preliminary working diagnosis, for Grace Ann's initial symptomology appears to be consistent with that of the trauma response. The disorder is described in the American Psychiatric Association's Diagnostic and Statistical Manual- III-R as an anxiety disorder based on an individual's degree of response to a traumatic

event. *The following criteria must be met prior to a diagnosis of the disorder commonly known as PTSD:*

The person has experienced a traumatic event that has involved actual or threatened death or serious injury to himself or others, and has responded with intense fear, helplessness, or horror.

The traumatic event is re-experienced as recurrent and intrusive recollections or dreams.

The trauma creates a "numbing" of the individual's responses.

Hyper vigilance and irritability are persistent symptoms.

The disorder creates overwhelming distress, eventually leading to an impairment of the individual's ability to function.

The symptoms must have lasted longer than a period of one month (198 , pp. 250-251). [%]

Based upon intake and subsequent clinical data, this appears to be the most appropriate diagnosis. However, I believe categorizing the client within a DSM-IV classification is a mute point, for whatever the cause, obesity, panic disorder, depression, or abuse, Grace Ann is hurting, simply hurting. At times she is exceptionally coherent, regurgitating her life story in a detached and seemingly unaffected manner. At other moments a spontaneous rocking erupts, often for no discernable reason. Eyes closed, her breathing grows ragged and strained. Sobbing, she clutches the ever-present George. Turning inward into a presumably very private world, Grace Ann proceeds to mumble,

"I be sorry, I be so sorry, I dint [didn't] mean to bee's bad." []*

Agony (pain is far too small a word) exudes from every pore. I sense a child, but do not see a child, and am confused at my own confusion.

The Advent of Managed Care

Our most immediate “external” crisis revolves around the changes within the insurance industry. According to our intake data, the client has been enrolled in an employer-sponsored health care plan since 1968. Prior to the onset of the depressive symptomology, she alleges to have rarely filed a benefit claim. As of January, all mental health treatment is to be approved through a Managed Care system, contracted with by the insurer to contain the industry’s spiraling health care costs. As a new practitioner, I must await approval into the “network.” I state my discomfort with what I perceive to be an invasion of the client’s rights to privacy, but am overruled. Therefore, eight weeks after commencing therapy, I prepare the following mandatory treatment plan, and reluctantly submit it to the appropriate governing agency for approval.

United Recovery Systems Treatment Plan

Presenting Problem: The client presents for outpatient therapy upon release from an inpatient treatment facility. Currently on medical leave due to obesity/knee injury concerns, the client is experiencing significant depression, panic attacks, hyper vigilance, and recurrent/intrusive recollections.

<u>Diagnosis:</u>	Axis I	309.89 (Post-traumatic Stress Disorder)
	Axis II	301.83 (Borderline Personality Disorder)
	Axis III	Morbid Obesity
	Axis IV	4
	Axis V	40-50
<u>Medication:</u>	Prozac	30 mg. b.i.d.

Xanax 1.0 mg. q.i.d.

Voltaren 75 mg.

Problems to be Addressed: We will address depression, self-esteem issues, adult survivor issues, an eating disorder, anxiety/hyper vigilance (including panic attacks), and recurrent dreams/night terrors/flashbacks. The client will re-experience long-term childhood abuse as a component of the reintegration process, [will] experience a lessened anxiety reaction, [will] experience fewer panic attacks less severe in nature, [will] address issues of morbid obesity.

Methodology: The client will participate in [a] lifestyle investigation, food-addiction recovery program, group work, journaling, cognitive restructuring (positive self-talk), experiential awareness exercises, bibliotherapy, affirmations, autogenic relaxation training, guided imagery, and medication management. [*; %; ~]

*The already strained relations with the managed care company continue, as they are unwilling to acknowledge the severity of the post- traumatic stress disorder diagnosis. To make matters worse, there is little room in managed care for an Adlerian therapist, as preference is given to those of the cognitive behavioral and brief systems therapies schools. I see no need to introduce Grace Ann's religious orientation, for there is certainly no place in behavioral psychology for a self-guided spiritual tour. [*; ^ ; >]*

Pandora's Box

March 1993

I am unprepared for all these external factors. I feel like I'm juggling too many balls (morbid obesity, allegations of sexual abuse, intrusive flash-backs, negative self-talk, hyper vigilance, depression, managed care) and need a case manager. Issues are popping out so fast

and furiously that I routinely plan and discard treatment strategies. While I have mapped a tentative Adlerian agenda, both in my mind and in the formal treatment plan, I find less resistance, and ultimately greater success when I am willing to follow the client's lead. I discover that I am fine-tuning my observational skills, reading between the lines of her journal(s), and modifying my therapeutic training to meet the transitory, but none the less overpowering needs at hand. I am realizing that I must rely as heavily upon the subjective skills of creativity and intuition as I do clinical training, an awareness of which is generating an intense discomfort within me. Themes are emerging, themes of persistent overeating, hindered feelings, oppressive anxiety, and emotional, physical, and ritualized sexual abuse. [; ^; >] The following allegations have been excerpted from the research sources previously noted in the chapter's legend.*

Allegations of Abuse--Grace Ann's Hurts

Grace Ann is asked to bring a list of her "Hurts" to a session. She has obviously spent ample time reflecting upon her considerable pain. To my utter horror, she presents with the following journal entry:

"i will make your body unfit and undesirable for any man." [#]

She [foster mother] tied me to my bed. She took a butcher knife and cut off my nipples. Then she sucked the blood out. She took a candle and burned my private parts. My foster father asked her why she saw the need to make me unfit for any man. i don't think he agreed with her, but he never said anything. Then he said, maybe I can make her stop crying. . . he had sex with me. . . If i could have gotten loose, i would have killed him . . .

"If you didn't fight you wouldn't have to be tied to your bed. . ."

“If you weren’t so bad, you wouldn’t have to be put in the closet. . .” [#]

If you didn’t cry, you would get beat with the strap until you cried. If you did cry, you would get beat with the strap or yard stick until you stopped crying. . . When you are BAD you get put in the closet. If you cried at all in the closet you get handcuffed to the water pipe and the back of your arm and wrist hurts BAD. . .

My foster mother would go out at ten p.m. to get a hot dog. My foster father would take me out of the closet and uncuff me if i promised not to fight him to have oral and vaginal sex with him. i hated that worse than anything. i wish i could vomit just to think of it. . . [#]

i had to make everyone’s bed before going to school in the morning. If i didn’t put the flat sheet on correctly, when i came home from school the beds would be stripped and i would have to remake them. My foster mother would say,

“You are so stupid, you can’t even put a sheet on right. . .”

My foster father would take me out of the closet early in the morning before anyone got up to have sex with me. i hated it. He would stuff a sock or wash cloth in my mouth if i cried so i wouldn’t wake everyone up. . . [#]

“Grace Ann is the fattest, ugliest thing that was ever made on this earth. . .”

My foster father would tie my hands to the top of the bed and my feet to the bottom with ropes. He would say if you would just learn not to fight, it wouldn’t hurt so much. He and my foster mother would make us watch him, my foster mother, and their daughter have sex together. He pointed out that they didn’t fight and it didn’t hurt them or make them cry. We were supposed to learn from them not to fight or cry. . .

Every time he would have sex with me, he'd ask me was i ready to join the cult. He must have asked me that a million times. i said,

“No, no, no, no, no, no. . .” [#]

I feel sick to my stomach. I'm afraid to turn another page. I find myself reverting to that quick shallow breathing pattern, that panicky feeling I still get when called upon to address large groups of people. I want to run. I am clinging to an unlikely divine intervention, the remote chance that the office floor will miraculously break open and suck me out of my discomfort. I don't think, I know I can't handle this! I cautiously glance across the room. Grace Ann is nonchalantly sipping water from an oversized green travel mug. I'm sick, and [she's placidly] sipping water! [^; ~]

The grizzly account continues:

i hated Saturday's. First to Confession with Father Stafford, who i first trusted until i didn't like him saying he would make my hot dog roll big enough with his fingers for his hot dog to fit into. He began by telling me i was special. [#]

“I'm going to show you how much I love you,” he would say.

The Saturday before making my first communion, he put his hot dog in me. It hurt so bad. i felt so dirty all the time. i saw him hurt those alter boys . . .

i hated Saturday nights. Every Saturday night i had to go to the Big Hall and be tied down with leather straps to a hard, cold table, where men would force their peckers into my bottom and my mouth. With each time, they would ask, are you ready to join? When i said no, they would, i thought, urinate in my mouth. It made me so sick and ashamed. . .[#]

My foster mother would make us eat liver once a week. i hated liver. If i didn't finish it in the

allotted time for supper, it would get put in the refrigerator and i would get put in the closet. She'd serve me the same cold awful liver for breakfast and every meal until i ate all of it. If i put the dishes facing the wrong way in the dish strainer, i would get my hands strapped across my knuckles with a ruler and then put in HOT, HOT, water--just for putting the dishes the wrong way. [#]

She would throw my peanut butter and jelly sandwich out of the back door if i put the bread together wrong.

They would come and ask again if i was ready to join the cult. i continually said no. So they would start with different things to get me to join. This would go on every Saturday night from six p.m. to midnight or twelve-thirty a.m. That's how i learned in my mind to escape to my safe place. That's where i want to go right now. . . [#]

My foster mother and father said only good, pretty girls should have dimples, not FAT, UGLY, and UNWANTED girls like me, oh, and unlovable girls shouldn't have dimples either. . .

"No one wants or loves you and no one ever will. . ."

Father Stafford said the night before my first communion,

"Tomorrow will probably be the only white dress you will ever wear."

He was right. . . [#]

"Mrs. Lang [*the social worker who arranged for the client's foster home placement*] told me three years ago if I or the boys [*the client's two brothers*] had told her what was going on at the Reynolds [*the foster parents*], she would have moved us, but since none of us told her, it was all our fault these things happened to us. So my foster mother was right. i caused everything that

happened. i feel dirty, bad, no good, just a big zero, and a failure. Doing this assignment has made me anxious and i am shaking.”

“i want to go to my safe, free place. i hate me.” [#]

The Unrelenting “Triggers”

As an apparent victim of trauma, it seems little is needed to trigger an emotional, and with increasing frequency, a physical release. Grace Ann states that she refuses to touch her friend’s hand lotion, “because it reminds me of placenta.” She reports, “lemon yogurt makes me gag.” A circular opening in the office’s stippled ceiling prompts her to shrink and cry out,

“Are they going to drop a hook through that hole?” [*; #]

A display (the black comedy and tragedy masks of Mardi Gras) at the base of the office steps creates a virtual uproar. Hearing the commotion, I rush out, attempting to protect her from an invisible prey. To my amazement, I watch as she tosses the previously indispensable crutches down the steps, turns around, and sets-off sprinting back towards the safety of the office door.

I arrive for a late winter session attired in a red wool dress and black leather jacket.

(I later discover red and black are alleged to be ritual “trigger” colors!) Upon seeing me, her affect, initially pleasant and welcoming, instantly changes. Hiding her face behind her shaking hands, she needs repeated reassurance before she will accompany me to the treatment room.

Dates, especially the seasonal equinoxes, are chaotic, and are met with projected anger, increased resistance, and petulant sulking. [^; >]

The attending orthopedic surgeon suggests that she swim daily, an exercise she reportedly enjoys immensely until she swallows a mouthful of water and is consumed with an image of a faceless man attempting to drown her in a tub of water. The Folger’s coffee commercial triggers,

“how at Christmas we would have to sit and watch our foster sister open present after present. Our foster mother would say to us, ‘See, if you were good children, you would get presents like Susan.’ All my brothers and I would get were a pair of homemade pj’s.” [*; #]

At my suggestion, the client attends a panic support group facilitated by a male therapist. Shortly after the initial meeting, she calls, sobbing into the phone,

“I just got home from talking to that man. I can not do this right now. I am not comfortable with men. I went by Krispy Creme and got one dozen donuts and ate the whole dozen.”[=; ~]

Grace Ann reports,

“i’m sitting here watching the Home Show. They are talking about child sexual abuse by a friend or relative. A thirteen year old girl has come forward with it. i wish i had the courage to come forward before now. It triggered how my foster father would [come] into my room when i had been sleeping and he’d wake me up ‘to do our special thing as he would say.’ He seemed larger than life to me. He just seemed overpowering . . . i couldn’t get him off of me no matter how much i tried to push him off. i hate him for what he used to do. i still feel so dirty and shameful inside. i hate men, i wished i could have told earlier and wouldn’t have wasted so much of my life. i hate life. . . i am a failure in everything in life.” [#]

She tells of watering her beloved azaleas, only to become overpowered with images of punishment by the insertion of enemas. She states,

“. . . it triggered our foster mother’s giving us enemas with what felt like a water hose. She said she was washing the bad out. She would make us hold it until it gave [us] pains in the stomach, and if we let any water come out before she said we could, she would put more in and make us hold it longer, then beat us with the strap for not holding it.” [*]

There is no question that Grace Ann is experiencing an acute Post Traumatic Stress Disorder. However, a fellow graduate student has heard my discouraged commentary regarding this unusually challenging client, and has suggested that I administer The Dissociative Experiences Scale and The Dissociative Disorders Interview Scale, declaring,

“I’m sure you have a Multiple.” (He is referencing Dissociative Identity Disorder, formerly known as Multiple Personality Disorder.) [%; >]

Incredulous, and anxious to prove him wrong, I systematically conduct the testing, but am deterred from completing the administration due to the client’s obvious decompensation. Several hours after our session has ended, I am contacted by the Grace Ann, who, through sobs and screams, reports having experienced “a significant setback.” [=] She returns to the office, distressed and trembling, and presents me with the following journal entry.

“The assessments triggered memories of ritual abuse. We processed the Halloween between [the ages of] nine and ten. My birthday (writing changes to an elementary script), which we never celebrated, was October 18th, and Halloween was October 31st, so I [had] just turned ten years old. Halloween is the highest Holy Day in the Satanic witchcraft cult. It’s like Christmas is to Christians. It was horrible. i escaped to my safe, free place even before i got into the car coming from the house. At the Big Hall, they tied me to that hard table, took off all my clothes. They tried to vaginally and orally hurt me with their peckers. . . They continually asked if i was willing to join. It seems like i came back from my safe free spot long enough to say no, then back to be free and safe. The next thing i knew i was home and had a huge blister on my bottom and left thigh. i didn’t even remember coming home from the Hall. i just knew I couldn’t sit down.” [#]

(Appendix A.3)

What is Satanic Witchcraft? The Big Hall? Hard tables? Who are they? I decide to allow the "story" to evolve.

First Phase Treatment Techniques

The following therapeutic issues were addressed as outlined in the United Recovery Systems Treatment Plan: (a) Adlerian Lifestyle Investigation (b) bibliotherapy (c) journaling (d) eating disorder program and group (e) cognitive restructuring (f) medication management (g) experiential exercises, and (h) affirmations and guided imagery.

Adlerian Lifestyle Analysis

Ever the educator, I have meticulously prepared the Adlerian Lifestyle Analysis, but choose to cast aside the well-manicured therapeutic plan due to the client's erratic, at times incoherent, behavior. I choose instead to rely upon the intake information provided by the Biographical Index Blank administered during the first session. []*

Bibliotherapy

As a former elementary and middle school counselor, I have, for many years, incorporated bibliotherapy into my therapeutic regimen, finding the simple, straightforward truths of a child's story to hold tremendous healing potential for folks of all ages. While extensive bibliotherapy resources were utilized throughout our work together, The Hurt (Doleski, 1983), Jessica and the Wolf: A Story for Children Who Have Bad Dreams (Lobby, 1990), and The Promise of a New Day (Casey & Vanceburg, 1983) depict instances in which this strategy was implemented during Phase One.

The Hurt

During the initial treatment phase, Grace Ann characteristically enters the treatment room

emotionally distraught, tearfully stares blankly ahead, and "checks out." In no time at all she appears oblivious to her surroundings, with no orientation to time and space. Aware that she is struggling to stay present, I discard my suddenly inconsequential cognitive strategy to instinctively return to my days as an elementary school counselor. Rummaging through a still-taped box of childrens' books, I ferret-out a well-worn friend from my very recent past. I return to find a still-agitated figure, bereftly hugging George while staring past his tattered right ear into a faraway space. It is to this hurting, childlike soul that I read The Hurt (1983) Doleski's small tome of pain and forgiveness. [o; >] (Appendix A.4)

Doleski's diminutive, but profound edition concludes with, "and he always let it [The Hurt] go before it got too big . . ." Remarkably, the story appears to have a calming effect. I observe that as I read, Grace Ann becomes still, pauses, then deftly slides her generous frame onto the floor. Sitting somewhat cross-legged (crossing her ankles rather than her calves), she cautions George to be very quiet, positioning the bear so he can view the book's pictures as well. They both sit, she transfixed, he predictable. At the end of the tale of pain and forgiveness, she assists her companion in applauding the happy, emotionally liberating ending. []*

Jessica and the Wolf: A Story for Children Who Have Bad Dreams

Over time, Grace Ann reluctantly confesses that the dark circles beneath her eyes are the result of her refusal to sleep. As debilitating as the daily, often hourly triggers are, Grace Ann describes the night terrors insufferable, tearfully stating,

"I'm scared to close my eyes." [*; #]

Crying, sobbing into a pillow, kicking the covers off the bed, and awakening behind chairs or huddled in corners are reported as the nightly norm. Bruises appear on the ankles and wrists, cuts

cover the arms, and to my dismay, she frequently raises her shirt to display a multitude of oozing blisters across her chest and abdomen. She appears oblivious to their origin. [*; #; %]

Grace Ann is experiencing nocturnal flashbacks, and reports being terrorized by an illusive, faceless man. In an attempt to help her face this now nightly adversary, I read Lobby's Jessica and the Wolf--A Story for Children Who Have Bad Dreams (1990). In the story, the child is able to halt the nightmares by abruptly turning and facing her attacker. By giving him a face, she no longer lives in fear of what might be. She is no longer terrorized by the mystery, she now knows. She then gleefully observes him as he dejectedly slinks away, no longer possessing the power to rob her of a refreshing sleep. [o]

Together, Grace Ann and I resolve to disarm her nocturnal foe, to "give the man a face." However, unlike Jessica, Grace Ann reports finding no peace. Instead, she exhibits a dramatic psychological deterioration. Nail biting, pulling skin from the cuticles, increased agitation, a violent twitching and rocking, erratic breathing, and voice fluctuations (from guttural to infant-like) are the end-products of the unsuccessful experiment.

My Spiritual Journey

Acknowledging her need to begin "my spiritual journey," I research a variety of daily devotionals, sharing with Grace Ann the Hazelden Meditation Series, including The Promise of a New Day (1983) and Each Day A New Beginning (1982), along with MacDonald, Brown & Mitch's (1991) Setting New Boundaries: Daily Devotions for Those in Recovery. [*; #; o] True to form, Grace Ann commits to a daily program of devotions and contemplative thinking. In time, she reports her single peaceful moments occur when she is engaged in spiritual pursuits at sunrise.

(Meditation was strongly discouraged by the therapist due to insufficient ego strength and a fear of further decompensation.

Journaling

Communication with this frequently unreachable client is facilitated through the use of journals. Grace Ann would "record" her daily (and nightly) thoughts and feelings in a spiral-bound notebook and place it on the therapist's chair prior to our session. While she, George, canvas bag, and the crutch, positioned themselves on the sofa, I would take advantage of this 'squandered' therapeutic time and peruse the most recent entry. In retrospect, Grace Ann's journals have provided a complete account of her years in therapy. The following are several excerpts from the voluminous journal entries, along with the impressions I have recorded in my case notes.

Life Sentence from a Priest Child Molester

"i know i can reward myself in nondestructive ways. i can go for a walk, call a friend, take a warm bath, or ask for a hug (this is very hard for me to do, but sometimes i need one BAD). [I have] mixed-up feelings, [a] volcano inside of me, constant coughing and asthma. [I feel] angry inside. i could eat a dozen doughnuts."

"Why couldn't I have been a more obedient child?"

"[I've] blocked out years. [I] can't remember teacher's names. [I] can't remember being in those grades. No one told me it would be this hard. . . " [#]

"How much should I trust her," she asks, *evidently referring to me.*

"i am really scared. Sometimes talking about things is hard because i have to feel. It hurts to feel. i just wish the Lord would come to take us home so i wouldn't have to hurt anymore inside.

i think i should have left this tucked away. i wish i had been good so all these things wouldn't have happened to me. [My] insides are racing. [My] mind is thinking one hundred miles per hour. [I] feel like a robot." [#]

As if this emotional outpouring is not enough, Grace Ann reaches into her canvas bag and removes a poem she reports to have written for a sexual abuse recovery publication. Attached to the poem is a series of newspaper clippings chronicling the arrest, trial, conviction, and sentencing of the priest she references in the poem. In one hand I am holding a recent clipping of a tiny, nondescript gentleman alleged to have sexually violated a considerable number of girls and boys. In the other, I am grasping a bitter, heart-wrenching poem, written by someone who knows, first hand, the price children pay when adults pillage their childhood. I am numb with disbelief! [; ^; >]*

Life Sentence
from
A Priest Child Molester

Tears burn my skin
With each vision of pain
I can still see the jury
Hearing my experiences of the past
But, I see his presence in my brain
Will I ever forget what he put me through
I keep reminding myself
I am one of the lucky ones
Who lived to tell all I know

I wonder about the others
 Their lives scarred, as mine
 The jury sentenced him to 6 MONTHS
 HIS VICTIMS GOT LIFE!

By Grace Ann Hughes

The unimaginable session concludes with Grace Ann holding George, rocking, and wheezing. She has to be encouraged to use her inhaler. I am angered by her allegations, overwhelmed and confused. As a mother, it is inconceivable that an individual, most particularly a tiny, nondescript man of the cloth, could violate a child in such a heinous manner. I am captured in what is to become a hauntingly familiar inner battle, i.e., the struggle to maintain a "therapist's face" when bombarded with material too grotesque to digest, or to even imagine. I "know" that in order to help her, I must convey an empathic and encouraging support, but must not be pulled too far into "her stuff." Upon regaining my composure, I ask,

"Grace Ann, what do you feel would be most helpful during this stage of your recovery?"

Without hesitation, she responds,

"I need to work on my spiritual journey." [*; =; >]

Grace Ann has mentioned this "spiritual journey" repeatedly from our very first session. However, I continue to feel that within the realm of our present difficulties, I find, "I need to work of my spiritual journey," to be an inconsequential and exceedingly shallow response . . .

"Failure, Failure, Failure"

In the days to come, Grace Ann writes:

“i just got home from talking with Deborah for one hour and forty five minutes. . . it sure did go by fast. . . Sometimes it’s hard to go home. . . i have all these mixed-up emotions like a volcano inside of me. . . i have coughed since i left her office. Sometimes i wish i could throw up, but i can’t stand throwing up. . . Sometimes i wish i could cry and feel better. i have so much anger inside me. Right now i feel like eating a dozen doughnuts. . . What am i feeling? i don’t know. i sometimes wish i [had] left all this packed away. i didn’t have to feel then. When Deborah asked me about that incident in the second grade, i thought i would be sick to my stomach. Its strange how i remember that yet [for] years i have blocked [it] out. i can not even remember my teacher’s names after the second grade. i really feel like a failure having to ask. . . for help. Why? All these years i could have everything packed in my closet. i didn’t have to feel. How much should i trust her? i am really scared. i ate three bananas. . . my insides can’t stop shaking. . . i wish i could go to sleep and never wake up. i need something to eat. i need to take a shower. i need to get clean. i need to eat. i can’t stop rocking and shaking, i need to throw-up.”
[#]

Then, several hours later.

“i blew it. . . i just ate a piece of frozen pizza. Yuck! Then a piece of pound cake. My heart won’t stop racing. i hate me. i’m a big FAILURE. i ate that pizza frozen and two large pieces of pound cake. It didn’t take care of the anxiety attack. i literally inhaled the food to stuff my feelings, [and] the feelings are still there. FAILURE, FAILURE, FAILURE.” [#]

The Paradox of Powerlessness

Grace Ann continues to communicate her new found awareness in her journal, appearing to be comforted by the anonymity of the written word. At the beginning of each session, she

ceremoniously unpacks her worn canvas bag, presenting me with her most recent soul-baring entry. I tentatively peruse each spiral-bound journal while she sits, wordlessly, holding her breath, as if in anticipation of certain rejection. The entry, entitled, "The Paradox of Powerlessness," represents the first step in her self-avowed spiritual exploration.

I tell you as seriously as I know how that anyone who refuses to come to God as a little child will never be allowed into His kingdom. Mark 10:15

"We admitted we were powerless over the effects of our separation from God, that our lives had become unmanageable. [We] came to believe that a power greater than ourselves could restore us to sanity. . . [We] made a decision to turn our will and our lives over to the care of God as we understand Him. . . [We] made a searching and fearless moral inventory of ourselves. . . [We] sought through prayer and meditation to improve our conscious contact with God as we understand Him, praying only for knowledge of His will and the power to carry it out. . . Having had a spiritual awakening because of these steps, we tried to carry this message to others, and to practice these principles in all our affairs. . ." [*]

I have always believed that spirituality and psychotherapy make poor bedfellows! While I do not discourage her rambling, I am uncomfortable with this talk of supernatural matters. My discomfort is perhaps heightened due to the strong fundamentalist contingent in our area, an exceptionally vocal group who, since my return home, has repulsed me with what I perceive to be a politically-oriented, overly-judgmental, at times down-right cruel, religious dogma. I do recognize that, as an Adlerian therapist, I have never practiced totally value-free counseling. While Driekers (a student of Adler's) did introduce spirituality into the treatment room, I just don't think this "spiritual journey" stuff is what they had in mind. Even so, Grace Ann appears

to at least have a plan, which is more than I can say for me at this point. Some part of her is in control, so I have no choice but to support her in her "wandering." [>] As if attempting to call attention to her own sense of powerless, the journal entry continues,

"i [wake] up crying, scared, shaking. i go to the freezer to get the frozen chocolate pound cake and frozen pizza. i trust Deborah with just about everything now, but i am really scared. i need her. The little girl in me really needs Deborah. i wish she were here. i would ask her if i could put my head in her lap and ask her to help me. My heart is racing and i can't stop shaking. Sunday i was going to ask her for a hug. but then i got scared. i am so mixed up and confused. i like her and trust her, yet i'm scared of her. Sometimes i want to tell her everything, yet if she really knows how BAD i am, she will hate me. i don't want to lose her. i need her help. Deborah, please don't leave me. i need you. i wish i could just go to sleep and never wake up! [I] need to be clean. [I] need serenity, courage, and wisdom. i can't do it anymore. i admit i am powerless over my life, my eating, my stuffing. i am powerless." [#]

"Lord, you told me once, when my Father and Mother forsake me, then you will take me up. You are my Heavenly Father. My Daddy Jesus. I need you to help me banish my fears. I know you love me. I have accepted you. I now need your help, and help Deborah and Dr. Gentry (the client's friend and personal physician) to help me fix the mess i've made. I want to be healed and I can not heal myself. I need to admit I am powerless, I need to humble myself and submit to the process that will eventually bring about my recovery." [#]

"I can't see why my heart doesn't break and allow death to free me."

"Daddy Jesus, the little girl Grace Ann inside of me needs to be held. I can't ask anyone else so will you hold me? Maybe one day I could let a real person hold me without hurting me.

Daddy, i'm so scared of touch by real people, yet I need it all of a sudden. Up until recently, I couldn't even shake someone's hand, and would physically push them away. Why can't I push them away anymore? Why do I need now to be held?" [#]

Food-Addiction Recovery Program

We must get control of something. The anxiety fuels the eating, the eating feeds (literally) the obesity, the obesity exacerbates the bad knees, the bad knees initiate the disability, the disability kindles the cognitive distortions, the cognitive distortions provoke the depression, and ultimately, escalates the anxiety! This exhausting cycle is repeated daily.

Recognizing the very real possibility of premature death in an individual as morbidly obese as Grace Ann. I purchase Minirth, Meier, Henfelt, and Snead's Love Hunger (1990), a twelve-step recovery program in which the cycle of food addiction is depicted as one's futile attempt to "feed the hungry heart." The client is, as always, fully compliant, and not only purchases her own copy but presents with the work book as well. We agree to cover one chapter per week, and she volunteers to compliment the assignment with a workbook assignment. []*

Grace Ann has reported shedding some eighty pounds on a medically supervised liquid diet some years ago, only to regain it and an additional one hundred pounds within the next eighteen months. Understandably, she is reluctant to begin a second weight loss program. However, we agree that, having been an intensely active person (at one point walking up to fourteen miles per week after working a double shift), her current state of isolation is worsening an already difficult life stressor. We discuss the merits of group attendance, noting that a group activity may alleviate the escalating anxiety panic while providing support for weight loss as well. A great deal of encouragement, and three less than successful attempts transpire before she attends her

first Weight Watchers Meeting. She reports arriving late and sitting on the end seat of the back row. But, she makes it! Grace Ann contracts to attend three meetings weekly until the binges are under control. []*

(Grace Ann continued to utilize the principles set-forth in Love Hunger (1990), and remained in the weight loss group throughout our work together. At the time of termination, she had reportedly shed two-hundred-thirty-five pounds.)

Cognitive Restructuring

Borrowing from the Cognitive School, Grace Ann is encouraged to restructure, or in her case, reverse her thinking, to,

“Catch yourself saying bad, change it to good. Change ugly to beautiful, worthless to worthwhile, failure to success, victim to survivor.” []*

While she listens politely, she is less than enthusiastic in her response.

“Well, I’ll try,” is her halfhearted reply. [; #]*

Experiential Exercises

The client is affectively depleted (discouraged). perhaps bankrupt is a more apt descriptor. As is often the case in abusive situations, the individual learns to cope with the reality of daily living by suppressing his own awareness. After a period of time, feelings are simply not a factor, and are either minimized, ignored, or obliterated. The road to optimal mental health is paved with an “awareness,” an acknowledgment and appreciation of the affective domain.

A child is, by his very nature, experiential, unable at times to “give voice” to her pain, but most certainly able to act it out. I have long utilized an aggression bat, an unwieldy, superpadded apparatus with a red plastic handle. Many a child or adolescent has pounded a

desk or chair in an effort to safely liberate herself from her momentary, but crippling emotions. With this in mind, I tentatively introduce Grace Ann to the concept of processing feelings physically within the therapy room, not wishing to offend her by suggesting her to be childlike in her ruminations. [^; >]

To my pleasure and surprise, she readily embraces the practice, requesting to take one of the bats home. "so I won't have to call you every time something comes up."

Needless to say, I am enthusiastic in my donation.

Affirmations/Guided Imagery

I am simultaneously introduced to Assagioli's Psychosynthesis (1965), an alliance of traditional psychoanalysis and active therapeutic techniques. Positive in orientation, Assagioli's holistic stance seeks not to minimize nor deny life's pain, for to exclude less desirable facets of the personality in favor of those more pleasing or acceptable is to undermine our potential as fully-functioning beings. Instead, it emphasizes man's creative, joy-filled experiences, and in so doing, magnifies the healing potential inherent in pure awareness.

While I am forewarned by the author to make judicious use of disidentification (the "pure awareness" inherent in psychosynthesis) when dealing with severe pathology, I am struck that psychological theories do exist which embrace, not religion, but the supra conscious. For the first time I am cognizant of spirituality and its potential role in the therapeutic process. For the first time, I comprehend a "lived" spirituality. Assagioli states:

. . . the realization of the spiritual Self is not for the purpose of withdrawal, but for the purpose of being able to perform more effective service in the world of men. . . There is no division, no separation between inner and outer, between spiritual and worldly

life. In psychosynthesis threshold be a dynamic balancing of the two. . . (p. 210).

Aided by symbolism, the personal self-conscious gradually gives way, with self-identity in the personal fading into a spiritual realization. Psychosynthesis " leads to the door, but stops there." Assagioli's acknowledgment of symbolic life catches my eye, as I have observed symbols (a myriad of religious emblems, colors, the rose, the butterfly, the safe, free prairie) to provide enigmatic meaning in Grace Ann's life. [^]

In addition, Psychosynthesis places a key emphasis upon the strengthening of the will through the repeated use of affirmations, with faith, no longer a subjective, ill-defined concept, but "an assured conviction." Grace and I decide that the use of affirmations would likely strengthen therapy by serving as a convenient reminder of a forward orientation. I am unwilling, however, to introduce Assagioli's acclaimed "I have a body; but I am not my body: . . ." for, as has been previously stated, I am concerned that the client's already fragile sense of self will be further disrupted. Instead, I ask Grace to develop her own list, assuming she will know far better than the affirmations useful in strengthening her resolve. Always the dutiful student, she presents with the following:

"I can do all things through Christ who strengthens me."

"My grace is sufficient for you, for my power is made perfect in weakness."

"Everything is possible for him who believes."

and, to my pleasure and surprise, a phrase I have frequently quoted when attempting to confront Grace Ann's dependent nature,

*"The greatest gift you can give your therapist is your own healing." [*; #]*

A Walk Through A Country Garden

In the upcoming weeks, the client's existential anxiety and increasing panic are addressed. The physiological by-products of panic disorder, i.e., shortness of breath, dizziness, profuse perspiration, and absolute terror, are proving to be as much of a hindrance to therapy as the depression and disability. [; %] With this in mind, I combine an autogenic relaxation training procedure (a progressive muscle relaxation procedure would create an undue discomfort within a physically disabled individual) with a guided imagery, which, interestingly enough, is based upon vivid recollections of my long-deceased grandmother's country garden. . . The guided imagery reads, in part.*

In your mind's eye, you may be leisurely strolling through a tranquil country garden, hand-in-hand, not with another, but with yourself. Remember, Grace Ann, healing comes in turning inward, not in our attempts to alter or manipulate others. . . You are beginning to relish the warmth of the Spring day. The bulbs, complete within themselves, are residing in the dark protection of mother earth, and when they are ready, they burst forth, exhibiting a beauty only to be found in nature. . . Remember, once again, as we embrace the sometimes stillness of our lives, that it is then we hear the still small voice within us, and it is then that we connect with our Creator. . .

The soul-warming sun is boldly peeping through, and you are becoming more attuned to your own peaceful core. A furry newborn bunny scurries through, perhaps in route to her own security. A mother robin, exhausted from the ever-constant demands of her precious offspring, is slowly, ever so slowly arousing herself from a refreshing sleep. You observe her as she slowly, ever so slowly, stretches a wing, then draws it near to her body. The second is ever so slowly extended, then withdrawn. There is no hurry, no mad rush, for as a creature of nature, she intuitively understands that to become one with the world around her, she has no choice but to obey its natural laws

An ever-so-tiny hummingbird, then another, circles contentedly around the pastel yellow and lavender blossom of an early-blooming columbine, its face tenderly turned upward in an attempt to gather instructions from The Master Planner. The columbine possesses wisdom, for she understands that in relinquishing her life-force to the creator of the garden, she in turn will be enriched as well as replenished. In the stillness of the garden, all that she needs to know will be revealed to her. She does not fret, nor does she worry. She is one with nature. She is at perfect peace. You, too, Grace Ann, can know that peace. . .” [^]

When asked if she thinks an audiotape would be helpful, Grace Ann responds with an enthusiastic, “Yes,” but insists that we wait to record until George can be included in the undertaking as well. When the taping’s appointed hour arrives, Grace Ann removes her shoes, sprawls across the therapy room’s sofa, and tenderly hugs George to her substantial chest. Appearing utterly contented, she, and presumably George, promptly drift into a well-earned sleep. [; >]*

The therapy notes report, “I am observing a small positive movement. [She] does not appear to be quite so stuck. The combination of drugs [psychotropic medications] and therapy appear to be beneficial at this time.[]*

The Emergence of Borderline Pathology

The most difficult component of Phase One has been the petulant, demanding, inconsistent behaviors of the borderline personality. The following excerpts provide insight into this therapeutically demanding and oftentimes debilitating symptomatology.

“Why Can’t You Be My Friend?”

While I am merely uncomfortable with the religious piece, I am wholly repelled by all this dependency! I am immediately struck with the repeated references to me, and discuss with

Grace Ann the disparity between needfulness (dependency) and healing. I explain the role of a therapist is as a guide, not a friend, for to blur these therapeutic boundaries is to create a dual relationship and a distortion of objectivity. [; ^; #; >; ~]*

“But, you’re the kind of person I would like to have as a friend,” she pleads.

“Why can’t you be my friend?” [*; #; ~]

I refuse to be drawn into this pathetic inquiry.

As is often the case, she chooses to journal her feelings, for she is able to pen but not speak of her inner discontent. The evening’s entry reflects her confusion and concern. Grace Ann writes.

“i’m sitting here still trying to sort out that dependency thing. I say I will never call Deborah again, only talk to her in my allotted session time. Then something starts to make me anxious and I really don’t know how to pinpoint what its is, so I call her. Is that dependency on her? Yet I know in my heart I trust her and I know she can help me see or get out whatever I am anxious over or whatever is bothering me. I am so confused about that. Yet I need her at the time I call her. How do I distinguish between becoming dependent on her and needing her help at a specific time? She said i was too dependent on her. She also said i was very manipulative. i’d like to know how i am manipulative? If she thin[k]s i am all these things, i wonder why she even bothers to help me.” [#]

“I Want to be Held!”

We are now in the throes of a determined late winter. It is as if we are somehow in need of one more icy blast, one more sprinkling of snow, to remind us that we merely harbor an illusion of control.

The phone calls have continued, currently to an office pager and thankfully, no longer, to my home phone. Now she wants to be held! It is difficult to establish ironclad boundaries with an individual in this much pain, but there is only so far I am willing to go. While I have accepted that our work together will be emersed with spiritual value, I am not going to bend my training regarding physical touch. Grace Ann may need to be held, but I will not be the one doing the holding! [: ^; >]*

I hope to deflect this confrontation as long as possible, and obtain two releases, one to consult with Dr. Gentry, Grace Ann's long-time personal physician (PCP), the other to the sexual abuse treatment facility's staff psychiatrist, Dr. Abbot. Calls are placed to both physicians. Dr. Gentry confirms the primary diagnosis of Major Depression, Single Episode, Severe, and comments that Grace Ann is a kind, compassionate, and highly capable individual whose selfless devotion to her patients and staff has earned her an exemplary reputation.

Dr. Abbot, on the other hand, provides little assistance and no reassurance. Reluctant, and seeming intentionally vague, his single significant comment is in reference to my question regarding an anticipated length of treatment. To my amazement, he responds,

"I expect you can count on at least five years."

I don't understand what he means. [=; %]

The Hospitalization Debate

"I'm Going to Stop Therapy for Awhile"

Dr. Gentry phones, ostensibly to inquire into Grace Ann's therapy. After the usual small talk, she confesses the actual reason behind the unexpected consult. She reports that my client/her patient, repeatedly phones both her office and home, lamenting,

“She has driven the receptionist crazy.” [=]

Dr. Gentry reports Grace Ann’s litany of concerns includes her belief that she is in need of an additional 1.0 mg. of Xanax, “so I can stop shaking.” Dr. Gentry reports that, due to the level of distress, she grants permission for the medication increase (*the dosage is now an incredulous 5.0 mg. of the anti-anxiety medication daily*). The physician reiterates that while she herself has addressed the hospitalization issue, Grace Ann remains adamantly opposed to a hospital readmission. She suggests a forced hospitalization would be ill-advised, as the client would likely view the ‘incarceration’ as just another instance of abuse. Although we agree that significant improvement has been noted, we both feel progress will continue to be slow and treatment is likely to be lengthy. Dr. Gentry admonishes,

“Be sure to take care of yourself.”[%; =]

The day’s notations read, “[The] client does not want to be re-hospitalized. What am I to do? Isn’t this an awfully high dosage of Xanax? [I am] concerned regarding another addiction. This all appears to be on my shoulders. I plan to push for the managed care psychiatric consult, in hopes of finally obtaining financial reimbursement for the client, as well as direction and support for myself. [On a] positive note, [the client has experienced] a thirty-two pound weight loss—at least [this] is going well. [The] client [is] also gaining [an] awareness of issues surfacing prior to eating—another positive.” []*

Psycho-social Stressors Mount

The bitter decompensation continues, spurred on by managed care, career, financial, interpersonal and, surprisingly, the skeletal remains of family of origin issues. (The psychosocial stressors, or Axis IV in the DSM-III-R, are scored at the highest level of “five.”) [*] United

Recovery Systems, the managed care company employed for cost containment, has refused to reimburse the client until seen by a network psychiatrist. She protests, stating she has a personal physician and has been evaluated by a psychiatrist. When informed that the single local provider is a man, Grace Ann is furious.

“I’m being punished by my own insurance company,” she laments. [*; #]

After repeated calls to the caseworker, an offended Grace Ann angrily retorts,

“Jean Banks (the licensed clinical social worker assigned to her case) treated me as if I were crazy” [*; #]

Grace Ann initially refuses the psychiatric consult, then, after further consideration (primarily financial in nature), reluctantly agrees. She states,

“I will go if it will help you help me.” [*]

Dr. Johnson, the client’s orthopedic surgeon and avowed long-time friend, informs her that it is unlikely she will be able to return to her nursing position. He requires her to lose an additional one hundred pounds prior to the surgery, and even then, is skeptical of a full recovery. His admonitions may prove a mute point, for rumors abound that her health care facility will be closing its doors, an apparent casualty of the trend towards government downsizing. In addition, Dr. Johnson writes a medical order for psychotherapy, informing the client,

“I can see you’re not handing this well at all.” [*; #; %; ~]

She discovers the “long-term” disability policy she purchased twenty plus years prior is effective for only one year. She reports Worker’s Compensation to be some nine weeks behind in payments. In addition, the agency has now received the surgeon’s updated report, detailing the severity of her medical condition. Concerned in regards to her future employability, Worker’s

Compensation attempts to initiate retraining, suggesting the office/clerical field might be most appropriate for the heretofore “temporarily” disabled health care professional.

Boundary Violations Escalate

The Lending Library

The client is briskly exhausting her meager savings. Phone bills, from five to fifteen hundred dollars per month, are advancing the fiscal deficit. Generous to a fault, Grace Ann continues to be a major contributor to numerous children’s charities, even though she no longer has the funds to do so. “Friends” borrow money with an alarming regularity. Anxious to garner support for herself and her, as yet unnamed condition, she purchases costly hard-bound books weekly, presenting the new additions to the primary care physician, orthopedic surgeon, therapist, and the newest member of the unlikely group, the unsuspecting psychiatrist. While I can not speak for the others, I am anxious to maintain the fragile therapeutic boundary. Determined to avoid a dual relationship, I repeatedly refuse her purchases, only to be greeted with whimpers of,

“I was only trying to help. You have helped me, why can’t I help you.” [*; #]

My insistence is met with a prolonged haughty irritability:

Eventually, an office lending library is established. Upon hearing of its inception, the calculating client dispatches her friend with assorted boxes of the previously rejected materials. Reminded, once again, that “we cannot accept gifts from our clients,” she points to the inside cover of each volume. “I didn’t give these to you. I gave them to the library, see?”

Each volume is now meticulously inscribed with the handwritten message,

“From the Library of Deborah Berkley-Carter, L.P.C., from Grace Ann Hughes.” [*]

Against Doctor's Orders

Grace Ann is admonished to keep her leg elevated throughout the day, to walk only when necessary, and then, only with the aid of her crutch. However, apparently anxious to help a friend in need, Nancy (the client's single confidant) arranges to take Grace Ann to a fundamentalist healing service. [=]

"Claim your power and rebuke Satan," she is counseled by the television evangelist. Ignited by the evening's religious fervor, Grace Ann, in a show of faith, is videotaped ambling, unimpeded, across the coliseum's massive stage. (*"Where are her crutches?" I silently ask, before I remember that I, too, had observed a similar occupance at the top of the office stairs.*) Arms swinging excitedly by her side, she wears her customary pink tee shirt and a blissful, childlike grin. Following this remarkable demonstration of conviction, she reportedly runs to the arena's uppermost seats before dropping to her untroubled knees in a prayer of gratitude. Unfortunately, the healing is short-lived, for the next morning several Darvocet are required prior to her rising from bed. At this point, she reports constant pain, and is reluctant to walk even with the assistance of her much needed wooden companions. [+; *; #]

A Need To Reconnect

Throughout our time together, Grace Ann has repeatedly referenced a need to reconnect with her past. (The Folger's commercial has unearthed a need for family.) While I can certainly appreciate her desire to research her roots, I have, repeatedly, suggested that the time is not right, that she has "enough on her plate," that she is just too fragile. She is, however, determined, and continues to place call after call to her home state. Her ill-advised attempts prove no less than devastating, for, unsure of where to start, Grace Ann contacts the Child and Family services

agency she has been told was responsible for her several “foster” placements. Unable, physically or financially, to travel the fifteen hundred miles to her childhood home, she requests that her records be mailed. She is at first told she must sign a release, and when no records are forthcoming, is informed by a second official that the records can not be delivered until all others referenced agree to sign releases as well.

Not one to be easily dissuaded, Grace Ann explains her circumstances to a hierarchy of officials (via phone), and is finally told she will be granted altered copies as soon as a records clerk can delete all mention of her brothers, foster family, etc. While awaiting the record’s arrival, she locates a distant aunt in yet another corner of the country, and is told her mother has been released into the custody of her elderly sister. Delighted, she phones the number shared by her new-found relative, only to be informed by the caretaker that the client’s mother is to receive no calls from her children. Shortly after the aborted communication, a letter arrives from an attorney, confirming that her biological mother does not wish to be inconvenienced with memories of an unfortunate past. [~; *; #; >]

The more contact [the] client has with persons agencies from her past, the more instability and personality decompensation [is] observed. In true borderline fashion, Grace Ann becomes extraordinarily labile (severe mood swings), overwhelmed, and anxious, the end result of which is an octopus-like dependence. Once rebuffed, either externally or intra psychically, she enters a “childlike depression” (Millon, p. 347). At this point Grace Ann, as do most individuals suffering from borderline pathology, sinks into a cognitive disorientation, a sense of estrangement and disembodiment (a sense of “nothingness”). Dejection gives way to irritability, histrionic behaviors, self-mutilation, then fury and rage, the latter of which is

generally projected upon the person who, a short time before, has been over-idealized as the savior. Therapeutically, this is known as the classic "borderline flip." [^; >

The "Borderline Flip"

The journal entry is listed as 3:30 a.m.

"Sometimes i feel sub-human. i feel like i have a loss of identity. i feel like i was a prisoner in the welfare system. Where did i get the strength to continually say NO to joining the Satanic Church where people weren't important. i got to where i wouldn't allow myself to feel good things or bad things. i escaped to my safe place in my mind sometimes even before we left the house (foster parent's home) because knew what pain was coming. i would go to my safe place yet, i continually said no to joining. Where did that strength come from? Yet at home i had no strength, no control. Both my foster parents controlled my body, my mind, and my spirit. Why did i give them that control? i am really confused about that??? . . . (*writing turns to a nearly illegible scrawl*) i [removed] the scar on my left thigh, from when they burned me with a candle. [It] didn't hurt as much as all that hurt, what they did to me. This big fat ugly forty four year old is a hurting little Grace Ann and needs to be loved and nurtured. i wish someone would just hold me and let my cry out all the hurts. i don't want to hate. i want to be able to forgive. But how do i do that? Little grace Ann hurts a lot. But there is a big strong man who protects grace Ann." [#]

Twenty-three call are received over the next several days. By now, the office knows the drill.

A typical question is,

"Why does Deborah hate me?"

The secretary is instructed to "avoid buying into her stuff," and is to simply ask,

"May I take a message?" and then hang up the phone.

If Grace Ann is in the "redial mode," we often place the service on voice mail until she either tires of the "game" or fills the boxes. At times she is petulant and sulking, at others, outright abusive. These tirades are generally followed with sobbing and repentance. If the behaviors can be contained to office hours, we, as a group, can usually manage. However, when they spill-over into the evening, it proves to be quite a different matter, as is evidenced by the following episode involving the local police and fire departments. [>]

Grace Ann has followed-up the twenty three calls with three to my home in the early evening. By-passing the pager and voice mail system, she leaves repetitive, threatening messages on the family's answering machine. Desperate to capture my attention, her final plea sounds drugged and groggy, and hints of possible suicide ideation.

"You won't have to worry about me again. . . I won't call you again, ever!" [=]

At this point, wary of the borderline behavior but genuinely concerned, I decide I have no choice therapeutically but to return her call. After several hours of no response, I contact an associate, request that she listen to the messages, and advise me as to the appropriate response. She, too, believes this to be nothing more than an "attention-getting stunt," but suggests that I contact the local police, "just in case." The following is a smoldering Grace Ann's journal account of the evening. [%; =]

(In an angry scrawl)

"The Police, Fire Department, and Rescue Squad have been to my house. They said, 'Someone called and left two messages on the machine and i sounded groggy.'"

"i called Deborah two times and she didn't return my call so i went to the bedroom. i had

taken a pain pill as i had been in severe pain all day. The next thing i know, i hear someone banging on the door. By the time i put on my robe and got my crutches to get to the door, five policemen were coming down the stairs from my landlady's house. They asked me if i had taken too many Xanax. i hadn't taken any. The only thing i had taken was a Darvocet N 100 for my leg. . . then the fire department and the rescue squad came and asked me if i was O.K. . . (rambling). . . i tried to call Deborah at home--no answer. i called twice more on the (office) number. . . i tried to call Deborah again at her house, i got the answering machine this time. i asked her to call me back. It is now 11:45 p.m. and she hasn't called me back. i am mad at her for doing this. i cannot believe she did this. . . Deborah still hasn't called me back. What is she trying to do to me? i am going to ask her tomorrow if she still wants to keep me. . . i am just so shocked and hurt that she did this. . . i trusted her so much. . . now i am more confused than ever " [#]

The therapy notes of this period all but vault off the page with frustration. I appear to have forgotten about the MPD diagnosis, for I write,

Borderlines should have a capital B on their foreheads when they present [for treatment]. I don't even want to work with another. This clinging, dependent behavior is obnoxious. No wonder she has no friends, she drives them all crazy. United Recovery Service will no longer be an issue. She will attend and pay or discontinue. I am not responsible to her insurance company. I will NOT continue unless she respects [my] boundaries. I need help! [I] need to reread the chapter on the Borderline in Millon's, Disorder's of Personality.[]*

The next day's "emergency" session is surprisingly calm, at least on the client's part. I inform her that she has now lost her pager privileges, that I am, in fact, having it discontinued due to her

refusal to respect my private time. I tell Grace Ann that she may contact the office between the hours of nine a.m. and three p.m., Monday through Friday, for appointment scheduling and rescheduling only. I (forcefully) remind her that she is NOT to contact me at home, after hours, etc., and give her the local hospital's mental health number should she have another "emergency."

I conclude by stating she will be entitled to three therapy hours (two ninety minute sessions) per week and no more, which, one more time, includes no outside calls. I ask her if she understands me, and promptly exit the room, leaving her soaking George's fur with her tears.

[*; #]

In true borderline form, the next day's journal entry reads:

"I truly thank god for allowing me the privilege of giving Deborah to me as a therapist . . . Jesus, thank you for my therapist, Deborah Berkley-Carter. Please bless her and reward her, as there is no way financially or materially that I could ever thank her enough for how much she has helped me. . . i'm ashamed to admit at forty four that until now I never [knew] a good touch or good hug. It feels good. Thank you, Deborah." [#; ~]

I will not respond to this journal entry, no matter how much she tries to triangulate me once again!

The moods continue to swing wildly, as the next entry, eleven hours later, attests.

"i am so frustrated, confused, ANGRY, and hurt. Today i would like to wake up from this nightmare and have everything behind me. Deborah says i'm too dependent on her. She also said i [am] manipulative. . . i wish that she would show [me] what she means that i am manipulative. . . i am so confused. . . i don't understand (*handwriting decompensates to a regressive, child-like scrawl*). [#]

The therapy notes are somewhat conciliatory. The day's entry reads,

Although the client is clearly dissociative, no alter personalities have presented. It is obvious that a child fragment is in place (Little Grace Ann, based upon voice, petulant behavior, thumb sucking, autostimulation, etc.) She (the child alter) appears copresent with the client, as the affect and behaviors vacillate moment to moment. Perhaps the borderline behaviors reflect the presence of a developmentally-fixated, tantruming child, as well as a needful, hurting adult. At least it makes it more bearable to view these difficult behaviors this way.[; ^]*

[I] review [the] latest journal. Little grace Ann. When agitated or recalling painful events, [the] handwriting is a huge, erratic scrawl filled with misspellings and disconnected letters. Otherwise (when in a cognitive state), [the] handwriting is as expected from a well-educated adult. Remarkably, the client is unaware of the changes, and appears amazed when the variability is called to her attention.

The notes of the following week are filled with my own sense of inadequacy, of a growing discouragement. I write:

I don't know how to communicate with this child. It is so painful to observe her despair. The treatment plan at this time reflects bibliotherapy, art therapy, music therapy, autogenic muscle relaxation, journaling, and experiential work (aggression bat). The client is clearly motivated. [She] has contacted courts in Nevada for information regarding [her] parents divorce. [She has] contacted Social Services regarding [the] abuse in [her] foster home. [She has] mailed [an] appropriate card to [her] Mother, whom [the] client has only seen once since [her] removal [from the home] as a child.

[The] client has shed sixty plus pounds, attends a weight loss group on a weekly basis, and is

swimming daily as prescribed by [her] physician. Of significant concern is the loss of ALL coping skills due to disability. [; ^]*

Managed Care Continues

As usual, I am reluctant to submit the required treatment plan, recognizing that this highly unusual case fails, once again, to meet accepted medical model criteria. True to form, the following terse request is received in response to my most recent submission.

“We ask that you attempt to work on current symptom relief instead of focusing on uncovering past trauma.” Thank you, Jean Banks.[~]

I am furious! How dare she tell me how to handle this client! No matter how angry I am, there is not, at least at this time, any recourse. Whatever Managed Care wants, Managed Care gets! I wish I had known about this absence of anonymity prior to licensure. I'm beginning to agree with my son. I liked me better as a teacher, too.

Just when I think I can not take one step further, I am presented with Reaching To Be Free, a framed poem ostensibly written by the client (I use the term ostensibly, as I have no proof of the authorship of any of her writings.) In time, it becomes apparent that originality is not of particular importance, for the presentations are symbolic and invariably a portent of events to come).

Reaching To Be Free

I was alone, desperate, surrounded by a wall of fear;
Then you came into my life.

You say my wall, but knew it was not impenetrable,
And you worked to break it down.

Not all at once--painfully, like a woodcutter with
his ax cutting swiftly and carelessly,
leaving sharp, piercing splinters:

Now my wall is thinner: Cracks are beginning to
appear, and light enters.

I reach out toward the light,
with my sound in the shape of fingers.

My fingers grope, and find yours,
reaching out to me.

I feel the warmth and softness of your touch
and I am less afraid.

Through your loving touch I am encouraged
to reach further:

Anxious to free my fingers--my soul--
to encounter the many things outside
my wall. . .

The rocks, the sand, and the ocean I have seen
through your love.

By Grace Ann Hughes

I record the following in my personal notes:

I am initially optimistic. The client is journaling, engaged in cognitive restructuring, affirmations, autonomic muscle relaxation, and experiential therapy. The work has been painstakingly slow and methodical. However, at the present time, a distinct decompensation is noted. While she is clearly motivated, [Grace Ann] appears to possess a limited ability to participate in her own healing. It's as if something outside of herself is holding her back-- blocking her participation-- as if her will alone is keeping her going.

Recurrent, intrusive recollections are occurring at an overwhelming pace. (I never know

“what triggers what.”) Coping strategies are at times grossly insufficient. The client alternates among inappropriately dependent, passive-aggressive, and compulsive tendencies. Boundary issues(repeated phone calls in particular) are extremely difficult to maintain. An analysis of her most recent journal entries demonstrates an unmistakable variation in handwriting, particularly when detailing the abuse. In addition, testing indicates the presence of possible Dissociative features, along with the obvious Post Traumatic Stress Syndrome. I suspect Borderline Personality Disorder as well. [The results of the incomplete DES and DDIS have indicated the likelihood of MPD, however, I am unwilling to wholly introject the findings, for I am aware that, depending upon the degree of severity, borderline personality disorder can present as MPD. In addition, Grace Ann is my very first client. I don't believe the fates could be so cruel!] For the first time, hospitalization is considered as a treatment option. [; #; %; >]*

Burdened and appearing confused by her own thoughts, she exclaims,

“I can see the Big Hall. I can describe every inch of it. Am I dreaming this, Deborah . . . Its so real to me! []*

I have no reply. I just don't know. Sensing a wariness in me, the heartfelt query abruptly turns to fury:

“I'm going to stop therapy for awhile,”she announces, arms defiantly crossed, legs twitching indifferent to direction, tears streaming down her now misshapened face.

“You won't be my friend.” [; +; #]*

Angry, sulking, and petulant, Grace Ann doggedly continues the interrogation,

“Why won't you be my friend?” [; +; #]*

Once again I attempt to discuss the role of the therapist as a helping professional, the need for

objectivity, and the inappropriateness of unrelenting phone calls between sessions. Having accomplished nothing more than further agitating the smoldering individual, I offer,

“I will support you in the decision you feel you need to make. . . I will be happy to make a referral to another therapist.”

“I don’t want another therapist,” she lashes out.

“I’m not coming back. It’s too much money.” [*; #; +; %]

I suggest that she might want to return to therapy once she is willing to embrace her deep-seated issues.

Incensed by the implication that she is not serious about recovery, she aims a no less than venomous glare across the room, while gutturally screaming,

“I don’t want to be dependent on you. I’m going to stop counseling.”

As calmly and detached as possible. I reiterate,

“I support you in your decision and wish you well.”

“I’m quitting therapy.” [*; #]

Furious, she proceeds to pound the nearby chair, all the while screaming,

“You’re just like the others, you don’t care. All you care about is my money. Don’t you worry, you’ll get paid if it’s the last thing I do. You’re never there when I need you. Do you treat all your patients this way?”[*]

The tantrum continues. I stand to leave the room as she first throws her inhaler, and then her journal. Hauling herself up by one crutch, she continues the lengthy tirade as she hobbles through the reception area and out of office door. [>]

The day’s notes read: *As a therapist, I must consider my limits. [I] can’t continue two*

double sessions per week. I am inundated with the constant call, pages, cards, "helpful" notes, [am] inundated by the client's needs. Borderline behaviors are up (three arrows are drawn pointing up). Dependency needs [are] up! Passive-aggressive tendencies [are] up! Compulsivity [is] up! []*

Several hours after the assumed termination, four calls are received by a now frazzled secretary:

"I didn't mean it, I'm sorry. Will you forgive me? I don't really want to stop. You're the only person I trust, please don't leave me," she pleads. [=]

I do not return her plaintive wails. The calls continue, detailing her fragile sense of self, her uncertainty and confusion.

"I don't want to be dependent on you."

"I decided I was going to yell at you today."

"I'm sorry I bothered you."

"I almost called you at home last night."

"I still love you." [=; #; ~; %]

Other clients are beginning to complain that the voice mail is always full. The secretary, tired of transcribing the repetitive missives, asks if she can simply delete the client's calls.

Dr. Gentry calls. Grace Ann has phoned her service, declaring an emergency. When the now bewildered physician returns the urgent summons, she encounters a wailing child, shrieking,

"I bee's bad, I bee's bad. Dr. Debbie hates the Big Lady, 'cause I bee's so bad."

"I don't know what else to do for her," she declares.

“I can’t increase her medication, and she won’t go into the hospital. If I tell her she can’t continue to act this way, will you reconsider?”

“I don’t know if I can do it,” is my honest reply. . . [%]

Another session is *[begrudgingly]* scheduled. . . Grace Ann, seemingly amnesic to her prior pleas of repentance, again lashes out.

“I guess I’m dependent on you. You won’t be my friend. Everyone I want as a friend refuses to be there for me. I am quitting therapy.”

Gritting my teeth, I respond, “The next time you call with, ‘I’m quitting,’ I am going to refuse to treat you any longer.”

“I’m paying for this. I can do anything I want.”

“No you may not. . . as a therapist I also have rights. . . You may not abuse my rights.”

[*; ^; =; >]

I feel the anger rising inside of me and sit without speaking. Furious, I refuse to acknowledge her tirade. I hear my now not so subtle inner helper insist, “Calm down! Calm down! Breathe! Breathe!” [^]

When she has ended her most recent barrage (and I have restrained myself from thoughts of homicide), I again address the therapeutic issues, using terse phrases and displaying little patience. The “voice” inside beseeches me to calm down. From somewhere, something reminds me that an abused individual often seeks to reconstruct the abuse as a warped affirmation of his existence. I am cautioned that to respond in the way that I wish, in the manner that her behavior deserves, will be to furnish nothing more than a confirmation of her ever-present feelings of worthlessness.

“Grace Ann, we will have to again set definite boundaries. I am your therapist. My job is to help you get well. If your behavior continues along these lines, I will refer you. If Dr. Gentry and I feel hospitalization is necessary, and you enter voluntarily, I will go [with you] as your therapist. If not, I will set the admission process in motion and you will be referred. Grace Ann, if I don’t believe I can help you to help yourself, I will not continue to see you.”[*; > ^; #; =]

Moments pass in silence. The client glances around the room, seemingly on a diversionary quest. The video, Beyond Hate, is resting on cherry end table, awaiting use later in the day. Grace Ann picks it up, scans its cover, and asks to see it. I, too, am searching for a distraction, so I acknowledge her request. However, instead of focusing upon the film’s message of unconditional forgiveness, she is immediately overtaken with,

“... the blood all over that little boy. . . [it] reminds me of [the] abused child on the table . . . there was so much blood.” [*; #]

The client fumbles through the never-ending contents of the canvas bag, producing what appears to be a framed photograph. Initially, I believe she is offering a present. Upon a closer examination, I determine that the “present” is actually an 8 x 10 framed photograph of pre-adolescent child attired in a white communion dress. The sepia-toned formal portrait is covered by a pink sheet of lined notebook paper, the paper secured tightly across the back of the frame by a hodge-podge of assorted tape.

Puzzled, I glance questionably at the dejected client.

“[This is] not a bad child. . . how could this be me. . . I must not see myself as others see me,” was her baffling reply. [*]

Even though we have discussed this on *far too many* occasions, the phone calls continue,

twenty-six on this particular day. With each call, Grace Ann's agitation escalates and her comprehension wains. Interestingly, this episode is different from the others. It does not appear to be at all purposeful. At my request, the embattled secretary attempts to inform the client that a phone block will be necessary if the irresponsible behavior continues. She reports she is not certain what, if anything, of the conversation Grace Ann has heard.

In an attempt to diffuse the out-of-control situation, an 'emergency session' is hurriedly arranged. The client arrives and departs sobbing. A colleague comes to work. Upon entering the building, he informs the office manager and me that Grace Ann is sitting in her car, trembling and weeping. He reports approaching her car in an attempt to offer comfort, but that upon seeing him, she screams, hurriedly locks the vehicle's doors, and proceeds to cover her head with her hands. We observe her, perplexed, uncertain as to the most appropriate therapeutic move.

Several long hours later, the stalemate is broken. Grace Ann contacts the office via the car phone. She informs the office manager that she is just too upset to drive home, and requests to return to the reception area.

"Just until I feel better."

As is often the case, she asks if she can see the therapist,

"For only a minute."

Frenzied and wheezing, she spits out the details of the most recent intrusive flashback.

"I'm experiencing nine years of Saturday nights flashing before my eyes. [I am] forced [into] acts with dogs. [I am] forced [into] acts with [my] brothers while our foster father records us on film." (The client expresses concern as to the whereabouts of the film, and voices her belief that it has been sold to a distributor of pornographic materials. She continues,

“My foster mother would put lipstick on me and hold me down while my foster father did that to me. The movie camera was running the whole time.”

“He [foster father] was on top of me. . . My foster mother would chain me to the water pipe in the closet. . . After she left me her would let me out if I would be good. It happened every week. He would make me do horrible, disgusting things. Our foster sister would ask him if they could go do their special thing. She seemed to enjoy it.”

“I haven’t cried since I was fourteen, and now I can’t stop. . . I’ve cried two thousand pounds. I feel like the weight of the world was off my shoulders--like I can breathe. . . I thought it would be completely over. . . I guess I’m impatient.” [*; #; ~; %; =; ^; >]

I again speak with Grace Ann regarding a voluntary hospitalization. Once again, she refuses. She is contracted for safety, and is asked to wait in the reception area until the shaking subsides. []*

Another call is placed to Dr. Gentry, the client’s primary care physician. I request that she see Grace Ann as soon as the client is calm enough to drive. I describe her most recent irrational behaviors, this episode clearly spurred on by something or someone out of her control, and ask that she be hospitalized, as I am fearful for her safety. The concerned physician extends her day, and in the early hours of the evening, phones the office, where I am now seeing the client that has been forced to reschedule due to Grace Ann’s extended therapy session.

A remarkable transformation appears to have taken place, for Dr. Gentry reports the client to have arrived composed and psychologically intact. When questioned as to the events of the afternoon, Grace Ann is alleged to have replied,

“I was upset, but I’m O.K. now.”

“Deborah, I have no reason to hospitalize her, she’s fine,” is the message that falls on my astonished ears. [%; =]

I don’t know who I’m more upset with, Grace Ann or Dr. Gentry! I’m beginning to think we’ve all gone crazy! What is going on here? Its time to circle the wagons. After an extended time out, I realize this totally isolated individual is in dire need of social support, follow though with Grace Ann’s earlier suggestion that a consultation be scheduled with her friend, Nancy. When contacted by phone, Nancy appears eager to assist in any way she can. While frustrated, she appears fully invested. She volunteers that Grace Ann has a history of bizarre behaviors, rapid and unpredictable mood shifts, and, conversely, an inconceivable generosity. When questioned about the healing service, Nancy expresses her dismay, and questions how Grace Ann could have fallen back into sin.

“I tell her to claim her power and rebuke Satan.”

She shares an experience of taking the client to a Pentecostal minister and his wife, only to be told by the pair that Grace Ann is demon-possessed and must never be brought into their presence again. While I am comforted that I am not carrying the ball alone, I am concerned with the guilt Nancy is unwittingly inflicting upon Grace. I discuss these concerns with her. She seems to understand, and agrees to tone down the judgmental, albeit, well-intentioned, commentary. [=]

A Diagnosis Confirmed

The day of the psychiatric consult arrives. Grace Ann calls with,

“Pray for me Deborah. I’m terrified, but I know I need to go.” [=]

My worst fears are confirmed when, shortly after the appointed session, I am interrupted with a call from Dr. Sullivan, the United Recovery Systems approved psychiatrist.

“Ms. Berkley-Carter, your patient is a severe Borderline slash PTSD slash MPD. She is appropriately medicated. We can only hope to keep the symptomatology in check. She will require extensive long-term therapy.” A gentle, soft-spoken individual, he struggles as he attempts to diffuse the announcement.

“She appears to have a good therapeutic relationship with you,” was his best effort.

Dr. Sullivan offers to contact the managed care company regarding the case, and suggests we appeal their denial of services.

“I will contact her primary care provider (PCP), and will monitor medications if she wishes. If I can be of further assistance, feel free to give me a call. . . And, good luck.”[%]

Now what? I feel sick to my stomach! My hand, no, my whole body begins to shake! This can not be happening to me! It's unbelievable! I have never taken a course on MPD, I have never read about MPD, I don't want to even hear about MPD! I call a therapist friend. She offers consolation but no advice.[=] I yell at my son, who promptly yells back,

“Its your fault. You're the one who wanted to work with crazy people. I liked you better when you were a teacher!”[>]

I call a local psychiatrist to inquire about supervision, sharing with him that I am in need help in setting appropriate therapeutic boundaries. He assumes I am referring to an improper relationship with a male client, and immediately questions my “behavior.” I am indignant and lose no time in correcting his misperception. He is apologetic, and agrees to meet with me the following week. [%; =]

I contact the local bookstore, asking the clerk to order "everything that you can get your hands on" regarding MPD and or Multi perpetrator Abuse. (They are by now quite used to my "strange" requests.) Still enrolled in an Educational Specialist program at the university, I contact my major professor, requesting that I be permitted to complete a project on MPD as an independent study.

And finally, I phone my mom, informing her that I have changed my mind.

"I will be able to go with you and Dad on that family vacation after all. I'm tired, and I think I need to get away."

Permission is granted for the independent study. After arranging emergency coverage with a colleague, I pack the car with beach clothing and an oversized box of books. Day after day I sit by the ocean, my head cleared by the assuredness of the surf. I read Putnam (1984), Kluit (1985), Braun (1985), and Ross (1989). I peruse Many Voices, a monthly self-help publication for persons diagnosed with a Dissociative Disorder. I am fascinated as I review Cohen, Giller, and Lynn W.'s (1991) Multiple Personality From the Inside Out, an insider's view of the disorder. As I read, I recognize the dissociative splits, autostimulation, and hypervigilance that has been, in hindsight, apparent in Grace Ann's presentation. I begin to decipher the Delphic handwriting, and reflect upon instances where, without my even knowing, I have been communicating with an "altered personality."

As if MPD is not enough, I now find myself a disinclined guest in the obscure world of multi perpetrator abuse. Basking in the warmth of the late-spring day, I realize that I am alternately comforted and repulsed by my new-found knowledge. [o; >]

Chapter IV, Phase One: Exploratory (The First Seven Months) has addressed (a) the referral

(b) intake and initial presentation (c) the clinician's Adlerian orientation (d) the advent of Managed Care (e) Pandora's Box, i.e., the client's allegations and complex symptomatology (f) phase one treatment strategies (g) the emergence of borderline pathology, and (h) a diagnosis confirmed.

Phase Two--Standard Treatment of DID

An Introduction

Chapter IV, Phase Two: Standard Treatment of Dissociative Identity Disorder (Eight Months to Two Years) describes the conventional treatment techniques historically associated with DID. This phase includes (a) issues of safety and trust (b) a return to journaling (c) medical consultation (d) introduction of the altered states of consciousness (e) the bulletin board system of communication (f) internal group therapy (g) abreactive therapy/screening (h) the creative arts: poetry, play, and art therapy (i) issues of grief and loss (j) reconstructing a life (k) burgeoning ego strength (l) bibliotherapy (m) dissolving amnesic barriers (n) the healing power of humor, and (o) minimizing minutia: dodging the details.

Issues of Safety and Trust

The establishment of safety and trust is necessary component in any therapeutic relationship and/or setting. However, it is essential that these two factors be clearly defined, and then reiterated, when working with dissociative clients. No meaningful work, perhaps no work at all will be undertaken by the hypervigilant client until she is certain her perceptions of past trauma will not be repeated. The following excerpts provide examples of the inner world of the dissociative individual, glimpsed by the therapist only when "the system" believes it is safe to remove the protective mask. It is a privilege to be allowed into this inner sanctum.

“Dr. Debbie, I Din’t Make No Snow Angels”

“Dr. Debbie, I din’t make no snow angel. The Big Lady did. The Big Lady made the angel all the way down the hill. . . Are we in trouble, Dr. Debbie? [@; #]

The conversation has revolved around the client’s sore back, as she lost her footing during an unusual Fall ice storm and skidded, rather unceremoniously by her account, some forty feet down the backyard’s sloping hill. We are laughing as she recounts the crutch sliding past her, along with her stymied attempts at confiscating the unwieldily implement as it whizzes by. Without warning, Grace Ann heaves a sigh, dropping her head as she does so. I am at first startled, and then frightened, for it appears she has experienced some sort of vascular accident. I start to her, then sit down, as I notice a swift blinking of the eyelids, much like the rapidly fluttering wings of a hummingbird when perched upon a flower’s inviting blossom. She shakes her head as if to release the cobwebs, suspiciously eyes me, and commences to clasp her arms tightly across her chest while furiously thrusting her frame to and fro.

“We din’t mean to get the Big Lady in trouble, Dr. Debbie. . . Honestly, we din’t. . . me and Jessica was going to feed Mr. Squirrel. . . We didn’t mean to make her fall down the hill. She made that snow angel. We was just trying to help her get back up the hill.” [@; =; ~; #]

Mystified, no stunned, I sit as I attempt to gather my tenuous wits about me. Fortunately, I have now consumed all the major texts on MPD, and am marginally prepared for the “unveiling.” *(Could this be the child-like figure that sat rocking and clutching George throughout our first session?)*

“Who are you?” I ask.

“I be Little Grace Ann. I be three-and-a-half.” [*; @]

Grace Ann, the Grace Ann that I know, appears.

“I wish I could make you understand. I’m bad, bad, bad. I did everything you said, and now I’m being punished, just like my foster mother.”

The child returns, shaking, rocking, clutching George,

“I so sorry, I so sorry.” [*; @; #]

(Appendix A. 5 provides examples of this first alter’s attempts at communication.)

A Return to Journaling

My client reappears, dazed and flustered. Reaching into her bag, she produces the customary journal. Tears dripping from her cheeks, she pleads,

“This was my journal, and I don’t remember writing in it . . .

(I am presented with the following journal entry: Due to my self-imposed exile at the beach, I now recognize DID’s classic diagnostic criteria. Depression and PTSD were merely precursors of the disorder. For a complete description of dissociative symptomatology, see Chapter Two.)

Please help me, i am desperate. i hate having this tug of war inside of me . . . i hate me. . . i hate my foster parents. . . i am angry for what they did to me. i feel like they took my virginity. They took my ability to care and feel. i hate that priest. i am angry, angry, angry. i hate me. i am so ugly, dirty, filthy. i am a big nothing. Life is not worth living. i’m scared to death. . . i don’t want to feel or hurt anymore. Its better not to feel. . . Why, God was i so bad that you couldn’t give me a loving, caring family?”

“i don’t remember her name--to me she was Mommy. However, i can recall exactly what she said when she was holding me. She said, ‘i wish we could keep you. We really love you and wish you the best in the world. We realize that the social services department wants to keep you and

your brothers together and since the Reynolds are willing to take the three of you, i have to say goodbye to you, even though i don't want to give you up.' i can see her face as she said that to me with a tear in her eye. That was the last time i felt loved and nurtured.”[#]

The child returns, seemingly to add her interpretation to the story.

“Mommy loved Little Grace Ann. Mommy would rock and rock and rock Little Grace Ann, and read Little Grace Ann Gerbert stories.”[*; @]; #]

“Dr. Debbie, I not like my Daddy to give me a bath. I not like him putting medicine on my bottom. I not like my real Daddy taking pictures of Bad Jenny, fifteen-and-a-half months old. I not want anymore pictures of me in the movie star room. I not like them hurting my wrists and ankles. Judith, how do you spell ankles? And tied me with rope to the crib. They hurted my hot dog roll BAD. I not like my real Mommy, Daddy. I not like Aunt Maggie. . . They hurted me. My real Mommy, Daddy, Aunt Maggie say I be BAD, BAD ‘cus I cry.”

“They yell at me and say stop that cryin’. I not mean to be BAD. I not mean to be BAD. To make Daddy (not Daddy Francis) really hurt me. I try to ahave [behave]. I be so scared. Please help Little JoAnn. Dr. Debbie, I luv [love] you bunches. Please not hate BAD Little GraceAnn.”

“Dr. Debbie, I not rip [the] skin off scar on Big Lady Grace Ann left leg. I not the only one who be BAD. Joann, fifteen-and-a-half month old doed [did] it. Not BAD Little Grace Ann three-and-a-half.” [*; @; #]

The child implores of the client,

“Big Lady, please not go swimmin’ ‘cus [because] our real Daddy will drown us. Not Daddy Francis. I miss Mommy, Daddy so much! I be sorry I tell Dr. Debbie. I sorry I gived you a bad eye ache. I sorry I be so BAD you couldn't go to group. I not mean to make your toes hurt. I

sorry I make you cry. I try to ahave [behave]. I be so scared. BAD, BAD, BAD Little Grace Ann, three-and-a-half. Big Lady, you can not wear my pink shirt with the flower on the pocket. I hidid it. I am in your safe place. You cannot go there 'cus I be there." [@; #]

Medical Consultation

*I was wrong. I am not even "marginally" prepared for the day's exhibition. Without delay, I dial the consulting psychiatrist, defeated, and anxiously seeking a referral option. Who are Mommy and Daddy Francis? Who is Jenny, Judith, JoAnn? Who is this Aunt Maggie? What does she mean by a bad eye ache and hurt toes? What is a safe place? Where does my responsibility end? I don't know what to do! Dr. Sullivan respectfully listens, but declines the referral, assuring me that I have as much dissociative expertise as any mental health professional in the area (the thought is far from comforting). I appreciate my elevation to a doctorate, but conclude we're all in trouble, however many there are of us! My notes reflect my confusion. They insist, "DBC, reread Putnam's MPD!" [%; *; ^; >]*

Throughout our work together, Grace Ann kept regular appointments with both her primary care physician and attending psychiatrist. Their role in this case was one of prescription management, with psychotropics prescribed for symptom stabilization only. There is no medical "cure" for Dissociative Identity Disorder.

Introduction of the Altered States of Consciousness

A "Doctor of Broken Hearts"

The following weeks usher in a whirlwind of presentations. Each session is at first implausible, then inconceivable, and finally simply amazing. Typically, the client ambles in wearing weary knit pants and an assortment of brightly colored tee shirts, frequently exclaiming,

“I don’t know why I picked this to wear today. It isn’t even my color.” [*; @]

Pink appears most often, “almost” pink, pallid pink, resplendent pink. Black, peach, blue, then green and red, lots of red, which curiously, the client professes to “absolutely despise.” There is a collection of regal purples, and finally a “sunshiny” yellow. It takes a while (as the alters would later exclaim, “Dah, Dr. Debbie”), but I stagger, then stumble, upon the color-coded key of the system. (The client has previously rejected the “tried and true” method of mapping the system stating, “I don’t know what you want me to do.”)

It becomes obvious that the alter wishing to “be out . . . to share . . . to talk to Dr. Debbie,” presents with his color on top. Yes, on top, for if there is dissension, respective emergencies, or simply children scrambling for “my turn,” the client will present in multi-layers. The alter who wishes to share, or merely wins the most recent argument, wears the shirt on top. At times, the client appears with only one shirt, while on other occasions, she presents, arms outstretched in annoyance, cloaked in twelve.

The initial presentations are of “the little ones.” Jessica, age six-and-a-half (as I am frequently reminded), is a delightful minx of a child, replete with impish grin and the mannerisms of an Edith Ann. Jessica keeps me aformed [informed] of the antics (and the pain) of the others, for she alone appears to have an full awareness of the disparate internal band. (*Could this little pixie be the Internal Self Helper referenced in the conventional literature?*)

“Dr. Debbie, Big Lady Grace is reading the Parade out of the newspaper. It says no more myths about mental illness, and I hered her sayed, ‘People with mental illness [are] not hopeless.’ I hered Grace say ‘hopeless’.”

“She not hopeless, right, Dr. Debbie? She workin’ good, isn’t she Dr. Debbie? We be tryin’

to help her, all of us helpin'. She not hopeless, right, Dr. Debbie? Why she hav to think she be hopeless? . . . I luv you, Dr. Debbie." [@]

The child alters have insisted upon referring to me as Dr. Debbie, despite my constant explanations that I have not yet attained this educational status.

"Jessica, I don't have a doctorate, I'm working on a doctorate at the university."

"That's alright, Dr. Debbie, that bee's O.K. We luv you anyways. You be a doctor of broken hearts. . ." [^]

Jessica behaves as a surrogate mother, a mother hen cuckolding her little tykes while chastising, and at times, infuriating the older, more mature adolescents. She introduces Jenny and JoAnn, the system's non-verbal infants, recalling their original pain while identifying their respective cries. They, along with Little Grace Ann are (as is developmentally appropriate for most children), seemingly afraid of every unaccustomed situation, and are in need of daily care. Typical of the childrens' fears is a journal entry detailing a routine visit to the dentist. I am not certain who writes for the pre-school children.

Bulletin Board System of Communication

We have established Putnam's bulletin board system of communication, a method of identifying the most pressing needs of the internal participants. Each alter is encouraged to "speak" by writing on a slip of paper, then attaching the note on the bulletin board located in the central hallway. *(Not surprisingly, each chooses his signature color of paper and pen.)* Grace Ann has come to rely upon the now familiar handwriting(s) as somewhat of a daily planner. Ever the good sport, she attempts to structure her day around the needs of the most vocal, or needful, alter. Initially, our most pressing concern is the ever-present "eye-ache," for the alters, excited to

be free at last, have little respect for the volley they are creating within the client's head. After all, their head(s) don't hurt. They are having the time of their lives.

Internal Group Therapy

While isolated from the rest of the world, the "alters" are rarely hidden from each other. This internal dialogue, both comforting and confrontational, serves as a source of system communication. The following are excerpted accounts of this fragmented stream of consciousness.

Little Grace Ann laments.

"The Big Lady taked me to two doctors I not know. They have glasses, masks, grubbs [gloves] on their hands. They scarred [scared] me. Those doctors putted their hands in my mouth. I thinked theyed [they were] going to put their hot dogs in my mouth. They have the biggest hands and they hurted my mouth with all that pushin and pokin around." [@; =]

An evening of Bingo, which the client looks forward to and declares to be a success, creates terror for the little ones. Little Grace Ann cries out in the journal:

"I want to go to Dr. Debbie's safe place. I be so scarred [scared]. . . what I doos[does] so bad that the Big Lady taked me to the Big Hall. I seed [saw] the movie picture room. . . It's dark in this movie picture house. I never seed [saw] this movie picture house before. Why doos [does] the Big Lady take me to this dark movie picture room? [They] will take Grace Ann 3 ½ clothes off and take movie pictures of Grace Ann with no clothes on. . . Mommy, Daddy F., please come get Little Grace Ann. . . I can't find nobody." [#]

The ever-hovering Jessica comforts,

"Grace Ann, take some deep breaths. Dr. Debbie is going to help you to tell the hurts and

everything is going to be O.K.. Just let Dr. Debbie help you through the hurts. She will. Just trust her, she and your Daddy Jesus won't let anyone hurt you again. You will be in a berry [very] safe place. . . Don't worry about it now. . . go listen to Dr. Debbie's Silver Boat and relaxation [relaxation] tapes and [put] the cold pack on you eyes and try to go to sleep. You trust Dr. Debbie, don't you?" [#]

"I trust her but I scarred [scared] somebody will hurt Little Grace Ann. I don't want no more hurts." [#]

Grace, the adult, unknowingly copresent with the child, appears. Reflectively, she becomes an eager contributor to the internal dialogue. She writes,

"I just went to the bathroom and I panicked and I am wheezing. Deborah told me to give permission to the different parts of my personality to continue to talk to each other in the journal, and give amission [permission] (*is Jessica somewhere present, too?*) to leave notes for each other on the bulletin board, and there was one there and I don't know how it got there? It was written in red." [#]

Jessica again attempts to soothe.

"Grace Ann, stop and listen to me. Take some slow deep breaths. . . you are wheezin' bad. Take some slow deep breaths. I be with you, Strong Man Jesus is here with us. You are still wheezin'. Take some slow deep breaths. . . slow, deep breaths. Why are you so upset?"

"In the front is a note on the bulletin board, and I don't know how it got there?"

"We will read it later. Right now listen Dr. Debbie's voice and do what she tells you to do on the tape. Close your eyes and listen to Dr. Debbie so you can stop wheezin'." [#]

This is not the time for consolation. Grace Ann, Little Grace Ann, or an unidentified someone angrily replies,

*“Shut up, Jessica. I don’t know who Demon Judas is!” Who rote [wrote] that note? I am goin to take my Debra tapes [Debra tapes?] and go to my safe and free place and stay there until I go to see Debra on Saturday. . . Grace Ann’s safe and free place. . . My eyeballs hurts. Why I be so scared?” [#; *; ^]*

The Prosecutor Alter

Demon Judas? I don’t know a Demon Judas, either! I have noticed an angry, scowling presence fading in and out, but I thought it was one of the teenagers. I have read of internal prosecutors, children and or adolescents who job it was to handle the abuse of the system, but I never really expected to be staring one in the face! Looking up from the scribbled dialogue, I gulp, decide I have nothing to lose, and ask,

“May I speak with Demon Judas?”

I immediately regret my request, for in an instant a biting chill descends upon the suddenly suffocating room. An unfamiliar snarl is emitted from what was, a short moment ago, a frightened child. Nostrils flared, teeth bared as if readying a growl, I am confronted with an alter, a presence, a thing? Apprehension mounts as I cautiously study the figure across the room, for the client, now an unrecognizable being, is effortlessly lifting itself from the couch. Unfettered by a bad knee, the creature approaches. Cold, cold eyes lock onto mine, it cowers above my now frozen pose. Leaning forward, it methodically points an index finger uncomfortably close to my horrified eyes. Clothed in a diabolical sneer, it does not speak, instead choosing to intimidate with its fiendish movements. Slowly, as if savoring an impending

attack upon a certain victim, it touches my upper arm, then traces the length of my forearm, lifting its finger to once again point towards my unblinking eyes. Reptilian-like, the being gutturally screeches.

“You’ll never get through to me. I am Demon Judas. . . I am bad, bad, bad. . .” [^; >; *]

“I Was Never Bad?”

So begins the cat and mouse saga of Demon Judas. Detached and dissociated myself, I am confronted with my own unfamiliar inner voice. From within emerges, as if a wellspring, a surprisingly strong and undeniably certain sound. Embodied, it replies from the depths of what apparently is me, boldly announcing,

“No, Judas, you were never bad. . .”[@]

I expend great energy in artfully avoiding further contact with Demon Judas, for I am afraid, and question both my skill and initiative to handle a demon. Over the next months I choose to follow the fearful creature from afar, from the pages of the daily journal. When asked to comment on the predictable discourse, I respond intuitively, in the only way I know how,

“No Judas, you were never bad. . .”

Anger gives way to despondency, as I read,

“Jessica, i told you i’m too bad to heal, so stop asking your Dr. Debbie what to do. i do not trust her. . . i am hopeless. Your Dr. Debbie will never, did you hear me, never, be able to get me to trust her enough to tell her. i don’t deserve to heal anyway. i’ve accepted that, so Jessica, you should accept that i will never heal. i am too bad to have anything good.” Demon Judas.[#]

Upon observing the child alters meticulously forming, then baking clay figures (under the

watchful eye of the former Home Economics student, Judith), Demon Judas, writing in his signature red ink, cynically remarks,

“i think the puddy [putty] things should have burned. She shouldn’t be playing with puddy [putty] or coloring or making puzzles or playing games anyway. These things are only for good children to do. Not for bad children to do. She’s too bad to be allowed to have fun. i don’t like fun things so she doesn’t deserve them.” Demon Judas.[#]

Copresent with an understandably frustrated Grace Ann as she tearfully declares,

“i’m going to quit therapy, its just too hard,” the internal prosecutor writes,

“Go ahead and quit therapy, it’s not doing you any good anymore. You are too bad to be good. Your Dr. Debbie wants me to heal, too. But she’ll never get through to me. I do not trust her ” Judas--Demon.[#]

Ever-encouraging, Jacqueline (in green ink), chimes in,

“Ignore Demon Judas. He’s going to heal also. . . Keep working hard.”[#]

Softening, as if sensing an impending defeat, the “demon” replies.

“Jessica, you might think your Dr. Debbie can help me. But they don’t have any idea how much i was hurt. i never want to be hurt like that again. Yes, your Dr. Debbie tried to help me. She is nice but i am very scared.” Demon Judas. [#]

Silent for a period, the reluctant helper reappears on the eve of Little Grace Ann’s “Healing Day,” offering,

“Little Grace Ann needs to tell Dr. Debbie. She needs to tell it to at least one person. She was really the one that was hurt. The physical pain was so bad. She couldn’t take it and i took that pain for her. So Jessica, don’t you tell Dr. Debbie. Let Little Grace Ann tell so she can heal.

i do not trust Dr. Debbie yet. Halloween is coming soon. Little Grace Ann will start feeling like a volcano. Now Jessica, remember to keep your mouth shut. When i trust your Dr. Debbie, it will come out.” Demon Judas.[#]

And finally,

“Jessica, you were right. Your Dr. Debbie did help me. She told me I was good. [*I note the use of the upper case I*] I[m] glad she allowed me to trust her. She has no mean eyes. Just eyes of compassion. Not like [their] eyes. She’s really nice and her pretty office is a nice safe place. I like it there. Dr. Debbie told me I was never bad. So everybody call me Judas, not Demon Judas. Demon means bad. Dr. Debbie says I was never bad. . . that [they] made some bad choices and did some bad things. Dr. Debbie told me it was not my fault. . . that no one will ever hurt us ever again. I am now just Judas. I help Strong Man and all the other alters to survive each day. (*I help Strong Man? What does “he” mean?*) I help Dr. Debbie as much as I can with the ones who haven’t trusted. . . well enough to tell.” [#]

(Once again, I am reminded of the essential nature of absolute trust, and am both humbled by and fearful of the faith invested in me. Is this dependency, or simply a child trying to find his way home?)

“Barrassed Janice”

“Dr. Debbie said she wants us to talk to each other in Grace Ann’s journal. Janice, why didn’t you talk to Dr. Debbie when she asked you to on Monday?” Jessica, The Boss, quizzes in her customary block print.

“Mind your own business.” (*The handwriting is in an unfamiliar peachy-pink, the shaky cursive reminiscent of a budding adolescent’s first attempts at grown-up penmanship.*)

“You might trust Dr. Debbie, but I don’t trust her as much as you do. I have a lot a sex questions I need to know. Some of them I need to know, but don’t know how to ask Dr. Debbie yet. . . . Demon Judas (*apparently they haven’t heard the news of the name change!*) says sex is only good for those who worship Satan, and Little Grace Ann and the Big Lady won’t worship Satan,” the alter called Janice replies. [#]

“Then you ask Dr. Debbie the questions. I know the hurts [they] went through. If I ask, it will trigger those horrible things those people did.” [#]

“No Janice, that’s your job. Don’t listen to Demon Judas. The rest of us and Dr. Debbie believe that Strong Man Jesus is going to make us ONE. Strong Man Jesus is going to give Dr. Debbie the wisdom, words, to help Little Grace Ann and Grace work through all those horrible hurts . . . what she doesn’t know how to handle, she’ll ask others in the same profession for help,” replies the suddenly wise child. (*Strong Man again? Have I been relying on the wrong Internal Self Helper?*) [#]

Several sessions after the journal entry, Jessica (of course) gently coerces the reluctant young lady to make her presence known. Eyes sparkling, cheeks emblazoned with a crimson glow, I am greeted with a barely audible, and very grown-up,

“Hi, Dr. Debbie. It’s’s very nice to meet you.”[@]

Following the very proper introductions, I attempt to reassure the shy child, reminding her that she is in a safe place and can ask me anything. After a period of playful coaxing, the delightful pre-teen asks her dubious question.

“What is it that you would like to know,” I ask, expecting just about anything than what was to come

“Go ahead, Janice, you can ax [ask] Dr. Debbie anything,” chimes the resident cheerleader, Jessica.

Turning away, while cradling her beet-red face in her hands, the suddenly very worldly child hesitantly inquires,

“Dr. Debbie, where is the Big Lady’s G Spot?” [*; >; #]

Stunned, I gather my scattered wits and attempt to recall the Family Life Education curriculum I taught while a middle school counselor. As matter-of-factly as possible, I regurgitate the chapter on female anatomy, hoping to remember enough to bluff my way through. Apparently I am successful in recalling the lecture, for I am awarded with a very proper “thank you, Dr. Debbie,” at the conclusion of my mumbling.

The discourse continues. . .

“Janice, I’m proud of you talking to Dr. Debbie today. See, I told you she was nice and she will help you with any questions you have. She is very smart and she’s a lady. She has all the lady sex questions you need to know,” congratulates Jessica. [@]

“She answered a question about the G spot. How do we get Big Lady that answer?” the not so shy after all young lady asks of her younger companion.

“Ask Dr. Debbie the next time you talk to her,” was her evasive reply. [#; =; >]

“Janice, Demon Judas is wrong. God created sex to be beautiful between two people who love each other. . . Even I no [know] that,” Jessica impatiently writes in response. [#]

One by one the unlikely travelers make their presence known. Jessica (who is NEVER to miss a session) coyly suggests there is someone who would like to meet Dr. Debbie, then sets-out to ‘splain [explain] why the unwilling newcomer can not yet come forward. Over and over the little

minx teaches me of trust. Judith, the last presentation, has a difficult time with this concept of trust. . .

"I Do Not Trust You At All"

Printing, so the little child can read her words, Judith writes,

"Little Grace Ann, you should not have told Dr. Debbie. Now the people will come and get you and they will kill you dead forever. You were told NEVER, NEVER TELL." Judith.[#] And then, as if aware that i will be reading her words, she turns her fastidious red script to me. "i am Judith. i was the one who took the worst of the pain Grace Ann had to endure. Dr. Debbie, i have only spoken to you one time. i do not trust you at all." Judith. [#] (Appendix A.7.)

Encouraged by this tentative attempt at conversation, Strong Man Jesus, the internal representative of the uncommon assembly responds. It is now obvious that Strong Man is the Internal Self Helper, although in characteristic modest fashion "he" has never identified himself as such.

"Jessica, I though you were the Boss! I thought you were Grace Ann's Guide."

"Dah, Dr. Debbie. It not bees me. I not be hurted. I bees the party girl."

Strong Man writes:

"Judith, we are so proud of you for writing to Dr. Debbie. Now we want you to trust her and talk to her. I know you don't trust her much yet. We also know that you were told never, never tell anyone, and if you did tell, they would find you, no matter where you were and kill you. It's O.K. to trust and tell Dr. Debbie all the hurts you took for Grace. We know some of the hurts will be very hard to tell, but Dr. Debbie has a way of helping you tell her without having to relive the hurts." [#]

Abreactive Therapy/Screening

An abreaction, or revivification, is the intense re-living of the details of an event. Emotions, once numbed, are now jolted and painfully re-experienced (*See Chapter One, Definitions*)

Screening is a method of projecting the memory onto an external screen, a way of remembering without being re-traumatized, re-experiencing while remaining oriented to time and space. I have taught Judith to screen as a means of minimizing her painful memories of abuse.

(He, or she [I do not know the gender of this helpful alter] is referring to a method of recounting the hurts [screening] while projecting our inner imaginings onto an external screen. This projected reality helps to minimize the painful abreactions. Frequently employed by trauma therapists, screening has its origins in Object Relations Theory.)

“It’s O.K. to trust Dr. Debbie and tell her everything. You will never be hurt again. You are not in the mean people’s home. You are in Dr. Debbie’s safe office. Dr. Debbie, Dr. Sullivan, Dr. Gentry, and everybody who helps you to heal will not allow anyone to ever hurt you again. Remember, it’s O.K. to trust and tell Dr. Debbie everything. She will even show you the difference between bad touch and good touch and what a good warm hug feel like without being hurt. . . . She will teach all of you much. . . . No one will ever hurt you again, NO ONE! I am with you, Dr. Debbie, and all those that help you daily.” [#]

Strong Man continues,

“I give Dr. Debbie the strength, wisdom, and discernment on how to help you, Judith. Remember, it’s O.K. to trust and tell all to Dr. Debbie. I know all of you, but you Judith, you need to heal so you can help Dr. Debbie to help little hurting Grace Ann. She hurts a lot and Dr. Debbie needs all the help from all of you to help her with Little Grace Ann’s hurts. Dr. Debbie is

going to try to teach all of you to tell in a special way that you don't have to relive the pain. . . Dr. Debbie will keep reassuring you. I know you and all the others need constant reassurance. You will be safe. . . No one will hurt or kill you for telling. I am with you all." [#]

It is from Judith that the bulk of the Satanic drawings appear, many produced in the counseling office (without notes), meticulously sketched to enlighten the novice counselor or to clarify a question at hand. (Appendix A.8.) It is not until an ironclad trust is established and promise of absolute safety is assured that the following tale of the underworld is divulged.

"Dr. Debbie, I can never tell what happened in this circle. We were told nothing that happens in the circle can be told outside of this circle. There is no way out because there is no end to it. They told us our parent's had given us to them and they know what is happening. I will describe this picture. I need to tell what the picture is about. Little Grace Ann is in the ground covered with dirt with a grate with the Satanic symbol, or I should say, one of the symbols that they use. There is a cemetery out back of the Big Hall. The left side of the picture [is] the gray table, with the Satanic Bible and the upside down cross which represents they are hailing Satan, and worship Satan instead of Jesus. That's why they turn the cross upside down. On the top of the Satanic Bible is the most significant Satanic symbol (*Judith draws a pentagram*). That's also the symbol on the pile of dirt. It's also the symbol on the grate that is on top of the hole that Little Grace Ann is laying in face down with no clothes on. The little children that are flesh colored have no clothes on and they will be the next to be put in the ground alive face down. Then they will be covered with dirt. The small child with the white robe, and her hands covering her face, will be after the children with no clothes on. The rest of the children with the lavender robes, they may be pretty, and the children like the pretty lavender, but it really represents the power of Satan.

The second time the children come, they are given the white robes. All children are shown that rope hanging from the tree. It's like used as a threat to the children to scare them into joining. All the children were forced to watch them put Little Grace Ann into the ground, with no clothes on, faced down, then they covered her with dirt. Little Grace Ann kept screaming, "I can't breathe, I can't breathe." That's when she developed asthma and bronchitis. It was very scary and she was crying and screaming. They left her there to die. It was cold outside. It had snowed a little that day. The children with no clothes on were freezing cold and knew they would be next. The children with lavender robes only were also very cold as they didn't have anything else on under those robes. The pink and blue blanket on the ground with pink satin on the edges is Grace Ann's blanket. The people near the tree in the white robes, the one in white is her foster mother. The one in the black robe is her foster father. The other two in black robes are Father Stafford and the social worker who took her away from Mommy and Daddy F. Now Grace only remembers one horrible night that Father Stafford hurt her physically, emotionally, spiritually, and sexually. The pain was so unbelievable in every area, I took the pain for her. Yet, I'm not allowed to tell anyone ever what happened or they will find me and kill me. Big Grace could not take anymore pain from those mean people. Many times, she would go to her safe place even before they would leave the house on Saturday nights. She hated going there so bad. If she ever got to go out with her friend Terry and her Mom and Dad, Grace always had to be home by five p.m., and many times they wouldn't even let her go with them. Dr. Debbie, I can't tell you anything else yet because I don't trust you enough yet. How do I know you won't call the detective on us? Jessica, Jennifer, Strong Man Jesus, Judas, Jacqueline, and Jaqua all say its O.K. to tell and trust you. But I don't trust you like they do yet. They even say you will teach me

about good warm hugs from bad touch. But how do I know that you won't hurt me? I've never known what a good hug or good touch feels like. Dr. Debbie, do you think there is any help or hope for me?" [* , @; #; =; ~; >]

And then later that same week.

"Dr. Debbie, Strong Man Jesus told us that on Thanksgiving we all had to write you what we were thankful for. The only thing i am thankful for is that i took the severe physical, sexual, and emotional pain for Grace Ann. If i didn't take the pain for her, it was too much for her to take. She would be dead today. I never understood what they meant by "i need to come". . . i hated living in that house. When they had hurt us more than any of us could ever stand, i ran away. i slept in a bowling alley for three days until the manager called the police, then the social worker said we had to go back to the foster home. i refused, then i got to live at the Y.W.C.A. Because i hate and i can never tell, there's no hope for me. But i am thankful that you can help the others. i am so scared i wish i could tell and trust you but they promised if we were to ever tell anyone they would find us and kill us. So see why we can't ever tell? i see how the others are starting to feel better after telling and trusting you. i am very sad all the time."[#]

The Creative Arts

Poetry

Throughout our year together we have diligently searched for an appropriate group for Grace Ann, for with the exception of the Weight Watchers Meetings, she has little contact with the outside world (Referenced in Chapter Four, Phase One.) After several attempts at attendance (she reports sitting in the car until the group is over), she makes it into a group called HOPE [Help of People Everywhere]. As a result of that one meeting, she writes the

following, printing it on yellow, butterfly- embossed paper. I note the use of the upper case I in the manuscript, and wonder if she really feels "whole," or is this simply a printer's attempt to correct her grammar. Grace Ann writes.

The Butterfly

If I truly love the butterfly, I must care for the caterpillar. Before this great change comes about., I must first identify in spirit with forlorn creatures as this. I am crawling instead of soaring, withdrawing from the world to hide away in my own little cocoon. Time passed and I heard of a program. . . a tiny crack in my shell appeared. . . HOPE was timid. After a few meetings, the hard shell begins to crack, even more and I came out into a new way of life and a wonderful world where I absorbed the warmth of fellowship and understanding from any new found. As I emerged from the depths of despair into this great family of loving people, I tried to learn how to give a message--still suffering and sick. Like the butterfly, I try to leave with each person some of what others have given to me, so that they may reach for this new way of life as well.

We in therapy have much in common with the beautiful butterfly. Long before the time of Christ, the butterfly was a symbol of resurrection and eternal life. Many of us in therapy have found this "new life" indeed. . . and the butterfly is a visual aid to remind us that we no longer think, feel, or act as we once did. We were trapped in a cocoon of darkness but have wrestled our way out into the sunlight. The butterfly denotes both gaiety and happiness. Chasing often is fruitless, for like the butterfly, they flit away. But if we become still and "at one" with God, luckily, a butterfly will light upon our shoulders. WE all need to be quiet and give ourselves time to cultivate a resilience of spirit.

There are some who think of the butterfly as a symbol of their life---Eternal beauty and freedom after they come to know God through life's experiences. To some, the butterfly is a symbol of rebirth. The wings of the butterfly teach us to be proud of our accomplishments. The reborn find a special significance in the life of the butterfly, which begins as an ugly, worm-like, fuzzy creature. . . emerging into a thing of awe and joy through God's GRACE AND LOVE.

The butterfly is on earth a very short time, and it spends most of its time fluttering from flower to flower. Taking pollen from one and giving to the other, making sure that each shares [his] life with others. . . and seeking to make the world more beautiful (after it is gone than when it came) . . . Hopefully, that is what you and I are trying to do as well.

Behold a small egg, then a loathsome worm . . . the caterpillar skin is thrown off and it is shut up for months as if it were dead in a tomb before it bursts forth from its imprisonment and comes forth a fragile, lovely butterfly. I became a loathsome crawling worm. Death practically ensued me and I wove a cocoon around me, shutting myself away from God and life for months . . . even years. . . with no interest in living at all. Glory be though, the same GOD that performs this miracle in the chrysalis is even more pleased to transform you and me any time, any where, any how.

I was once entangled and twisted until the light of God's Grace and Love penetrated my heart.

Join together in the practice of thanking God for something every time we see a butterfly. . . a spiritual symbol of a happy, enlightened soul . . . a reminder of each individual's life of eternal beauty and freedom after they come to know GOD!

Smile, God loves you and so do I!!!

By Grace Ann Hughes

Play Therapy

Grace Ann has insisted on stocking a small storage room at the rear of our office with "kid's things." We have an assortment of bears, Snow White and the Seven Dwarfs, The Velveteen Rabbit, Bingo Games, Twister, Bubbles (*Little Grace Ann's favorite!*) and every imaginable children's book. She regularly presents for therapy early, so she can "hang out" in Dr. Debbie's "special place," a place where children "never be hurt."

Art Therapy

Grace Ann has purchased forty-eight one-pound bars of modeling clay, because "I liked the colors" (*Upon reflection, I now realize every color in her system was represented in the clay.*) We contract for nightly art time, with each alter having a favorite creative pursuit. "Color crayons," watercolors, glitter, rolls of construction paper, and colored chalk are available at home, and now, often to my dismay, at the office!

Issues of Grief and Loss

Child and Family Services

As the alters gleefully scurry around, the client's depression abates. No longer debilitated by the asphyxiating disease, she comes alive! Unwilling to remain a passive victim, she embarks upon a fervent search for 'The Truth'. Over the next six months, repeated attempts are made by the client to obtain documents from her past. At long last, the Child and Family Services

records arrive, alleged by Grace Ann to be replete with errors, "blatant lies," deletions and unexplained blocks of unaccounted for time. The mounting anger, at times all-consuming, changes to fury. "I hate them, hate them, hate them," she cries. She wants justice, a retribution. Agitated, she can barely control her tremulous voice.

"For all this time, I thought she didn't want us. . . I was told we were bad, and that she gave us away." *The forty-four year old social services records provide a distinctively different account of earlier events.*

The client's mother, a Polish Catholic from a large immigrant family, had met and married the "smooth-talking" Mr. Hughes after the War. The couple were married in a Protestant ceremony, at the husband's request, despite the vehement protestations of her church and family. The case worker writes,

"The family is strongly opposed to the mixed marriage and very pessimistic about the possibility of its working out."[~]

Mrs. Hughes is described by the intake counselor as "a rather dull looking woman whose very bad teeth detract from her appearance." She notes that the mother has presented for services due to the husband's frequent absences, apparent lack of concern for the family's welfare, and financial non-support. Mrs. Hughes alleges her husband to have offered, "[Why don't you] kick me out?" She reports, however, that she is reluctant to do so because, (a) she is unemployed, speaks very little English, and fears she can not adequately provide for her family, (b) feels that her husband is ill, and would otherwise not be treating his family with such disdain, and (c) quite simply, she loves him. On a more personal note, Mrs. Hughes does complain of her husband's sexual needs, which she feels are excessive. [~]

Mr. Hughes continues to refuse “marital help” and denies any association with his now destitute wife and three young children. To make matters worse, the agency is apprised that he has impregnated a young Jewish girl. He has married for a third time, again without the benefit of a divorce. He subsequently abandons this third untimely union, forcing the young Jewish girl to seek assistance for herself and her as yet unborn child. It is at this point polygamy charges are filed, with Mr. Hughes “sentenced to a year in the House of Corrections.” It is reported that “. . . he also faces a neglect of family charge.”

Alone, overwhelmed, and grieving the loss of her marriage, the young mother’s mental health begins to deteriorate. Deeply depressed, her behavior becomes increasingly erratic. The agency is sufficiently concerned for the children’s welfare to remove them from their mother’s inadequate care, placing them in three respective temporary foster homes throughout the city. (It is reported that the mother has been seen knocking on the neighbor’s doors late a night begging for food for her children.) In referencing the client’s placement, the social worker writes,

“Grace Ann is doing very well at the Francis’. [They] are extremely outgoing, permissive, and accepting foster parents, and are giving her a great deal of loving care.”

Having lost her husband, children, and home, and alienated from her family of origin, Mrs. Hughes, no longer able to cope, is hospitalized in a state mental facility. Records indicate that she is diagnosed with “Dementia Praecox, Mixed Type, necessitating continued hospitalization and electro-shock treatments.” [~]

During the summer of 1951, eight scribbled letters are received by the agency, each reflecting a mother’s worry for her children as well as her desire to come home. As the treatments continue,

decompensation can be observed. Within the year, there is an increasing instability and burgeoning mental demise.

July 21, 1951

“... please come to take me out of this hospital. Try to get my wedding ring... and my blue coat... I miss the children very much. Please try to have my yellow pocketbook. My kirchief. I got to go pay my rent. I haven't paid it since April.” [-]

August 1, 1951

“I got to get home. I have been hear long enough. I got to get home. The children been away from home since April or May. I got to get home... please come for me... I've gotter go home and pay my rent and bring the children home. I would like to go home. All the people go homes. I want to go home too.” Stefie “I want to go home.” [-]

August 10, 1951

“I have been hear for four months, and its been about time I went home. Don't you think so. Cause I want to take care of the three children myself.” [-]

As the electro-shock treatments continue, the obvious decompensation can be observed. Within a few short months of hospitalization, she is declared “to be insane.” As a result, her children, now lost to her, become permanent wards of the court.

“Little has been heard from of the children's relatives,” therefore, upon the receipt of the insanity decree, the children are removed from their temporary placements and located, as a family unit, in permanent foster care. They are reared as devout Catholics, as notations of catechism studies and first communions are scattered throughout the altered document. Grace Ann scoffs as she sarcastically reads such accolades as.

“... the children’s medical, dental, and clothing needs have been met. They continue to receive excellent close and loving care in [their new] foster home,” and,

“... we have helped each of these fine young people to achieve their goal and supplemented their earnings when necessary with some financial assistance, and they always knew of our care and psychological support for them in their endeavors.”[~]

I search the document for indications of abuse. The only suggestion that all is not as well are references to Grace Ann’s broken ankle (alleged by the client to have occurred when tied down), a large bald spot on the left side of the oldest brother’s head (alleged to be the result of an attack by a bat-wielding foster mother), and eerily, a notation dated 1963.

“Because of [an] emergency situation, [the second brother] had to move to another home.”[~]

Grace Ann sobs as she reads,

“Each child regularly receives a card with two dollars for his birthday. It is always signed, A Friend.”[~: >]

My eyes focus upon a short paragraph, apparently the impressions of either the agency’s intake officer or the social worker initially assigned to the case. The unobtrusive notation reads,

“... much of the trouble began when she [Mrs. Hughes] became pregnant with Grace Ann who is now a year old. . . I wondered about her feeling for this child. . . Mrs. Hughes talked about [the older brother] as the favored one. She stated, ‘Grace Ann doesn’t count around their house.’ ” [~] [I can not imagine a social worker recording any such statement about a small child! Inwardly, I am horrified that Grace Ann must have read this, but she does not acknowledge it and I do not ask!] [>]

“Grace Ann doesn’t count around their house?”

This one line in a forty year old social services report causes me to return to my office library, to refresh my memory on Object Relations Theory. I search for Cashdan’s (1988), Object Relations Therapy--Using the Relationship, recalling, from a previous class, the author’s emphasis upon its use with severe pathology. I also find, tucked in a corner while waiting to be read, Almaas’ (1990) The Pearl Beyond Price. (See Chapter Two)

Object Relations Theory: Reconstructing A Life

As I read, I see Grace Ann everywhere! She appears in Klein’s “splitting,” Fairbain’s “early infantile and mature dependency,” Mahler’s “separation-individuation,” and Kernberg’s “bipolar intrapsychic representations.” It becomes increasingly clear to me that at least the borderline piece (the piece that’s driving me crazy!) of Grace Ann’s “pathology” is the by-product of her inconsistent, and wholly ungratifying childhood. (For a more thorough review of Object Relations Theory, See Chapter Two.)

The Role of Forgiveness

Cashdan references Johnson (1985), who suggests,

“The final, necessary step [in therapy] is forgiveness: forgiveness of what happened, forgiveness for what is happening, forgiveness of what may still happen” (Johnson, p. 298).

In retrospect, I find it interesting that, without cognitively understanding “why,” I choose to introduce our work together by reading Doleski’s The Hurt, a tale of “letting go.”[>]

My own fatigue is higher than ever. While I continue to have a small case load, this client requires, demands is more like it, an inordinate amount of time. Nothing in my educational background has prepared me to be harrassed, maligned, threatened, verbally abused, and

stalked. I feel trapped! I begin wearing a sterling necklace, a filigree oval fashioned to spell the word JOY. It reminds me of life before Grace Ann Hughes.

Burgeoning Ego Strength

The “Surviva”

Defiantly, Grace Ann orders new license plates, emblazoned with the word SURVIVA.

(Interestingly, a purple bow also adorns the aging vehicle.) When questioned why the velvet bow has been affixed to her hood emblem, she responds incredulously, perplexed that I don’t already know,

“Because, purple is Strong Man’s color, and he protects us.”[@; =]

(Purple is indeed the symbol of royalty within Christian faith. Strong Man is not only the client’s Inner Guide, he appears to mimic a holy figure as well!)

An Angry “Surviva”

The Survivor’s Connection, a group of alleged sexual abuse victims bound together by their need to refute the encroaching False Memory advocates, forwards a listing of attorneys having an expertise in ritual multi-perpetrator abuse. Fueled by what she feels are corroborating testimonies, an incensed Grace Ann contacts attorneys from coast to coast. It is on one particular spring time day that she presents with her personal video recorder, announcing,

“We have been talking to an attorney who specializes in Ritual Abuse. She might take our case. We want to introduce ourselves.” [@]

Grace Ann proceeds to unfold a tripod, attaching the camera while checking and rechecking its position within the room. Seating herself on the floor, Grace Ann begins,

“We hope you can help us.” [+]

Anxious to help, I count backwards from five to one in an attempt to alleviate as much discomfort as possible from a "switching" headache.

Jessica appears, insisting,

"Take off your shoes, Dr. Debbie, bee's comfortable. I's a party girl. I never be hurted. I bee's the boss, 'cept Strong Man Jesus says he bee's the boss. I bee's the boss after him. I came about when Donnie beed [was] born. Grace Ann bee'd six and a half and she not know how to take care of no baby, so I bee'd borned. Changed the baby's diapers, washin', washin', washin' (Jessica impersonates a child, vigorously washing a baby's hair), cleaned the baby's hair. Only one thing, I not bee'd out as much as I like." [+]

Then, turning to me while pointing to the camera, she apprehensively inquires,

"Is she gonna help us, or is she gonna report us to the cult? Judith be really scared. She be scared of [the] movie pictures. She ripped her skin off." [+]

Assisted by the copresence of a terrified Judith, she continues the self-appointed mission.

"I have to tell you about Baby Jenny and Baby Joann. They already telled their hurts. They be in a safe place in heaben [heaven] with Mommy Francis, rockin, rockin, rockin. Baby Jenny be hurted by her real Daddy, he hurted her hot dog roll. Baby JoAnn, she got hurt really bad. Her real Daddy taked [took] her to the hospital [hospital]--had twelve sutures--Daddy blamed his brother." [+]

Apparently its someone else's turn, for Little Grace Ann places pink shirt on top of Jessica's pink shirt of a darker shade.

"I thought you only worked with me today. I tried to hide everybody else's shirts. What I do to make my Daddy not like me no more. Why he not be happy when I comed home from the

hospital? Bad Grace Ann. I maked my Daddy hurt me. I maked all the people at the bad foster parents hurt me. They taked me away from Mommy and Daddy Francis. (*pouting*) Mommy rock her. I be bad.” [+]

Anticipating a turn for the worse, I remind her,

“Bad things happen, but Grace Ann was never bad.” [+]

My attempt at consolation proves fruitless, as the now predictable decompensation continues.

“Judith Brown, she died. They put dead, black rose petals all over her. I tried to help her get out. They said I killed her. They said it be my fault. I killed her. I sorry. I berry, berry, sorry. I be so scared. I hided all the shirts. I hided them in Big Lady’s safe place. Mommy teached Grace Ann how to tie shoes, tie bow and everything. Mommy says she wishes to ‘dopt [adopt] all of us. Daddy buyed Little Grace Ann ice cream.”[+]

(Jennifer places peach shirt on top of second pink shirt.)

“Dr. Debbie, I’s wheezin’. I didn’t put that bird on the car, Dr. Debbie. I didn’t, honestly. I feel like I’m smothering, ‘cause I told about that thing in the yard [*She is referencing a dead bird allegedly placed in the front seat of the client’s car and a Satanic book found between the outside and storm doors*].”

“It makes you feel like you can’t breathe.”

“Slow down, Jennifer, big breath (*someone uses the inhaler*). [We’ll continue] when you’re ready, 5-4-3-2-1, when you’re ready,” I offer.

“Grace Ann, slow down, take deep breaths, it’s Judith. That’s a girl, take deep breaths.”

“Judith always helps me, Dr, Debbie.”

“She does a good job helping you,” I offer.[+]

"I's Janice."

"We need Jennifer. Lets do that again."

"5-4-3-2-1."

"I's Jennifer. I's nine-and-a-half. . I didn't know how old I be 'cause we didn't never have birthdays. Strong Man Jesus told me. Strong Man Jesus has been with us all along, since Baby Jenny. This is my color, peach-orange [*pointing to her tee shirt*]. I comed about 'cause she couldn't take the pain they did to her on Halloween. That ritual on Halloween and every three months. Every twenty-first they do the ritual and I get very scared. I'm scared somebody will be killed if we tell what happened to us. I usually cancel my appointments, but I didn't this time."

"Dr. Debbie. can she help us get better?" [+]

Turning to the camera, as if speaking to the unsuspecting attorney;

"Dr. Debbie's been helping us but it costs the Big Lady all her savings money, and now we don't have enough money to buy groceries."

(Regressing, voice tremulous, eyes darting. . .)

"It's dark, the only way you can tell if its day is to look through the crack in the ceiling."

I attempt to diffuse a certain abreaction.

"Jennifer, stop, look around the room. Look at the chair, the window. Where are you, Jennifer?"

"Oh!" (*wiping perspiration and heaving a sigh of relief*). We're in Dr. Debbie's pretty room, the safest place in the whole world."

"Thank you, Jennifer, for sharing your story," I interject. [+]

"I love you, Dr. Debbie."

(A purple shirt is removed from the canvas bag. Slowly, it is pulled over the head and meticulously arranged over the by now, shrinking frame.)

“I’ve been helping Strong Man Jesus. I used to be Demon Judas, do you remember that, Dr. Debbie?”

“Is she going to help us, Dr. Debbie? Can we trust her. Is she going to cost us a lot of money? You know Jacqueline, she’s going to be concerned about that.”

“Do you want to tell her how I used to be bad and I’m not bad anymore?”

“You were never bad, Judas,” I reply.

“They put the fireplace poker. . .”

(Judas, not to be confused with Demon Judas, removes a purple pen and pad from Grace Ann’s canvas bag. Shaking, he draws a remarkable likeness of a pointed staff).

“They put it in Grace Ann’s hot dog roll. She screamed and screamed and screamed. She couldn’t take the pain, so I taked the pain. Now I don’t have to worry about it no more ‘cause I told Dr. Debbie. Now that I told Dr. Debbie, I don’t have to be Demon Judas anymore. Now I help Strong Man Jesus. I help everybody now.”

“Dr. Debbie got to me first . . . You were smart, Dr. Debbie!”

“Maybe I was just scared, Judas,” I suggest.

“I didn’t mean to scare you, Dr. Debbie.”

“Yes you did, Judas,” I kiddingly reply.

(He chuckles while shaking his head, for he knows this to be true.)

“Well, I did, but it didn’t work.”

“I don’t know what we would do without you Judas,” I remark.

“I was just trying to make you scared so you wouldn’t talk to me. They told all of us over and over, if you tell what they did to you, everyone that you love will be killed.”[+]

A speeding ambulance, sirens wailing, is heard through the office window. Judas shrinks, arms outstretched, as preparing to fend off an invisible attacker.

“Judas, that’s an ambulance going to help somebody,” I attempt to reassure.

(Judas, turning inward to a listening Judith).

“Carol Ann holds a lot of the programming. *(What does that mean?)*

(In a detached voice).

“If you tell what we do to you, everyone you love will be killed.”

With a shake of her head, Judas (I think it was Judas) continues,

“They told each one of them--they would show them eyes--that they put eyeballs in everybody. Dr. Debbie said that’s not true. They didn’t put eyeballs in us. Do I have to show her the scars, Dr. Debbie?”

“No Judas, you don’t have to show her the scars,” I hurriedly reply, in an attempt to stave off an unveiling before the camera. [+]

A carefully folded royal blue shirt is removed from the now infinite bag.

After a great deal of preparation, I am greeted with a peacefully lyrical,

“Hello Dr. Debbie,” the voice inordinately dissimilar to those of the previous presentations.

“We have big shirts, cause we lost weight.”

“How much weight have you lost?” I inquire.

“We used to weigh 489 ½ pounds. Now we weigh 274. We still have to lose a lot. We went

to the restaurant with Nancy, and our pants fell down. We could have been on America's Funniest Home Video. Guess who got embarrassed?" [+]

Pausing, apparently to refocus her thinking, the alter named Jaqua offers,

"Dr. Debbie, the Big Lady's still drinking a lot of water."

"How much is she drinking now, Jaqua? I ask.

"She's upset. Sometimes [she drinks] three-and-one-half gallons a day. . . We used to take about twenty showers a day 'cause we used to feel dirty and shamed and bad inside, and we drink a lot of water [because of] those men peeing in our mouths. I don't know how old I am 'cause I came about when Grace Ann was a little baby." [+]

Attempting to circumvent a decompensation, I ask,

"Your job is to help her feel clean?"

"[Yes], but she still drinks so much water. She says she feels dirty inside all the time. I try not to let her take so many showers. She's only been taking two a day lately. That's much better. I have to wash all these clothes. . . One week she drank twenty-nine gallons of water. . . That's a lot of water "

"When is the Big Lady gonna stop feeling so dirty and shameful and bad inside?" Dr. Debbie.

"I hope very, very soon," is my feeble reply. [+]

"Jaqua, the Big Lady asked that this session be taped. Do you mind if this is taped for you?"

"No, Dr. Debbie, so long as no one gives it to the police or someone from the Big Hall, or sells it. People did that all the time. Someone always had a camera. I don't know what happened to the pictures "

"What would they take pictures of?"

“They would take pictures of tying Grace Ann to the grey and marble table like this. . . She’d be tied like this. . . They had straps. (*Jaqua rubs her ankles, blinking as if seeing the discoloration for the first time*).

“We’re getting an abreaction already, Dr. Debbie, did someone already talk to you about this?”

“No, I don’t think so,” I reply. [+]

“They strap your ankles down. While they have you strapped down, the wife would hold your nose like this, and they [would] stick their (gagging) . . . in your mouth. It would make you sick and want to throw up. I tried to help her ‘cause she feels so dirty inside. They would pee all over you. It’s gross. I feel dirty all the time (*gagging, then slurping water from the plastic travel cup*).

“Who would like to talk next?” I ask, attempting to diffuse the potentially volatile situation.

“I guess Janice.” comes the muffled reply.

“Janice? . . . My ‘barassed friend, Janice?”

“She gets ‘barrassed easily,” Jaqua, fading away, replies.

“Thank you, Jaqua. I appreciate your hard work.”

“I just wish we could stop her from drinking so much water. I know it makes her skin look good, but she’s drinking so much water. Dr. Debbie, will she ever stop drinking so much water?”

“Well, she’s not drinking twenty-nine gallons now is she . . . then we’re already improving!”

[+]

(*Jaqua [I think] again examines the Big Lady’s ankles*)

“Oh, I shouldn’t have told. I shouldn’t have told. They’re going to find out I told. It’s bruising already.”

Attempting to introduce an alternative explanation for the bruising, I offer,

“That’s what usually happens when [the Big Lady] gets tied up in a bed sheet.”

No longer able to hear me, she implores,

“Are the coming to get us, Dr. Debbie?”

“No, no one is coming after you. Maybe you had a bad dream.”

“We didn’t have no bad dreams,” she, retreating from her fog- like state, vehemently counters.

“We been sleeping good the last two nights. Love you, Dr. Debbie. Thank you for not giving up on us” [+]

“5-4-3-2-1. . . I would like to talk to my friend Janice. . . Hi, Janice.”

“Hi, Dr. Debbie.”

Janice turns around on while continuing to sit on the floor so that her back is facing the camera.

“I’m too ‘barassed. I can’t look at people.” she announces as she covers her head with Grace’s navy jacket.

“What would you like to ask the attorney?”

“If she could help us,” was her muffled reply.

“How would you like her to help you?”

“Help us to put our foster mother and father and Father Stafford in jail, and help the Big Lady get back some of her money that she took out of retirement. . . call the Child and Family Service and tell [them] they shouldn’t have left us with [those people].

“What else would you like to tell her, Janice?”

“That when you have your monthly bleed, they do a special ritual. They take blood out of a hole right there (*points to right inner arm*). They put it in a gold chalice and drink it. They say Hail, Beelzebub, Hail Satan. They ask you if you’re ready to join. If you say “no” they tie your feet and hands to the silver and grey table. The men stick things in your hot dog roll. Sometimes the women come to the house and they do bad things you don’t like. .”

“Thank you for sharing that with us, Janice. . . (*I wonder how the unsuspecting attorney is going to feel about this unsavory bit of news?*) Now take a big breath. . .” [+]

“Who needs to talk next?”

“I guess Judith,” Janice sighs.

“I’ll take this off.”

She pulls the jacket up and over her face, meticulously folds it, and places it in the canvas bag.

“Grace Ann feels like she’s smothering. I get ‘barassed, but Grace Ann feels like we’re smothering her. That’s Judith’s shirt. She likes Mickey Mouse.” [+]

Janice places the red tee shirt with the Mickey Mouse logo on the pocket over her head.”

“We have an awful lot of shirts on.”

“You certainly do, Janice.”

“O.K., ready?” I ask. “5-4-3-2-1, I would like to speak with Judith.”

I am greeted with a heavy, labored breathing. Judith looks around the room suspiciously, eyes darting to and fro. Her eyes lock onto the camera.

“[Are you] going to sell that, Dr. Debbie? . . . I think they sold pictures that they took of us to other people.”

“Dr. Debbie, we almost didn’t get her here.”

“Really?”

Little Grace Ann wanted the whole time today. She’s ready to work, Dr. Debbie, now that you reassured us.”

“Judith, tell me about your arm,” I ask upon observing the irregular red abrasions.

“When we hurt, we pull the skin off,” she glumly offers.

“What were you hurting about today?”

“I was scared someone was coming from the Big Hall to tape us, “ she replied.

“Has anyone from the Big Hall ever come to this office?”

“Never!”

“Has anyone ever hurt you in this office?” I asked.

“This is the safest place in the whole world,” she replies.

“Then you have nothing to fear,” I convincingly declare! (*Upon review of the videotape, I question whose nerves I was attempting to soothe!*)

“Strong Man Jesus has been protecting us,” she asserts.

“Dr. Debbie, somebody knocked three times last night. You told us to take a picture but the Big Lady was stubborn-headed and wouldn’t go to the door. Three times three times. Big Lady wouldn’t go to the door.”

“I’m glad she didn’t go to the door. . . I don’t want you to be unsafe in any way,’ I said.

“You want me to talk to that lady?” she asked.

“I want you to tell that lady what it is you do,” I reply.

“I help Dr. Debbie with everybody,” she smiled.

“We have been on our own since we were fourteen-and-a-half. We stayed in a bowling alley for three days.”

“Why did you do that, Judith?”

“We just came out of the hospital. We were in the hospital for twenty-two days. [They] never came to see us.”

“Why were you in the hospital,” I inquire.

“Because they told me that I had a baby and they took the baby with a coat hanger. . . told [the hospital] we fell on a picket fence. . . the social worker told the Big Lady that they ripped us thirty-seven times ”

“Do you remember when she told the Big Lady that?” [+]

“May, 1992--Mother’s Day. The Big Lady thought she was dead. The Big Lady had written her a long letter in 1977 when we came back from Honduras (a missionary trip in which the client was assigned nursing duties). She never answered any of our questions. . . (*digressing*). . . that’s when I took over. She had to work. She could work ‘till six if she kept her grades up. We worked at the five and dime and lived at the YWCA. We got out of school at twelve. I helped the Big Lady study. I helped her ‘cause she was tired. I helped her study to go to L.P.N. school. I helped her study for four years of college. . . She worked full time and went to school full time. . . she was so tired. . . (*reflecting on the hospitalization*) They threw away the records January of 1994. It had been thirty years. The [hospital] social workers came every single day and asked

what happened. . . We told them we fell on a fence. . . They said you don't get thirty-seven tears from falling on a fence. . ." [+]

She begins to sob.

"Is there anything else you would like for us to know right now," I redirect in an strained effort to thwart the inevitable abreaction.

"I just want us all to get better . . . I would like to see the social worker put in jail. . . she should not have put us in that foster home. . . I feel so dirty sometimes that I could just rip off my skin." [+]

"Who would like to talk next," I inquire.

"I guess Jacqueline," someone of an unidentifiable origin offers.

The client removes green shirt from bag

"When I think about those things the men do, it makes me sick. I think I'm going to throw-up. They should put him in jail (father). We called him one time and he's seventy years old and can't keep a job and [is] married for the tenth time. I'll keep trying to help you, O.K., Dr. Debbie?" [+]

"Whenever you're ready," I instruct the nameless entity.

"5-4-3-2-1," I count.

"Dr. Debbie, Judith's taking some deep breaths," was the rasping response.

"Whenever you're ready, that will be fine."

"Hi, Dr. Debbie!"

"Jacqueline, we're taping this," I cautiously inform the alter.

"I know that, Dr. Debbie," she indignantly responds.

“What would you like to tell the attorney about your situation?”

“I have helped the Big Lady since she was fourteen-and-a-half managing her finances. I did a very good job until recently. When we started therapy our insurance company punished us the first year and only paid for five sessions and we had to use our savings and our retirement. Now we had a little problem with Jessica ordering everything that she sees that’s free. They keep sending things and we have to send them back. . . I know we owe you a lot of money. . .the Big Lady is used to giving people money. She doesn’t even have enough money to live on. We’re going to have to move in with Nancy if we don’t get some money soon. She took cash advances to pay her rent She hasn’t paid them.”

“How can we help you?” I ask.

“I hope this lady will help us to put our money back in savings and pay off our therapy bill. And help the Big Lady to have money again. . .Big Lady used to save a lot. I still help her with her money but it will only go so far.”

“You’re doing the best you can,” I attempt to offer as consolation.

“I expect you will always help her.”

“She needed it.”

“Could you slip on Strong Man Jesus’ Shirt?” I inquire. [+]

“This is Strong Man Jesus’ shirt,” she reminds me as she removes the violet shirt from its hiding place at the bag’s bottom.

“He helps everyone.”

“I don’t think you told us why everyone’s name begins with “J,” I recall.

“Strong Man Jesus will have to tell you that,” she chides.

“Boy, we have a lot of shirts on.”

“Love you, Dr. Debbie.”

“5-4-3-2-1, may I speak with Strong Man Jesus?”

“Hi, how are you, Strong Man Jesus? What would you like to say?” [+]

There is a surreal metamorphisms within the room. A peaceful countenance appears. A soothing, tranquil voice emerges.

“That I have been with Grace Ann since the beginning. I’m still with her today, even though right now she doesn’t think so,” He non-judge mentally responds.

“She’s kind of angry with me. That’s O.K. I understand.”

“Why is she so angry,” I honestly question.

“She doesn’t understand why I let her go through it. She doesn’t realize I was with her. I’ve been with her since the beginning.”

“All the alters have names that start with J after the Apostles,” he remembers, “and some of them are from the (first foster) family--Jennifer, Jacqueline, Jessica. . . from the happiest time of her life . . . I’m helping you every day because I know this has been hard on you. . . you’re doing a very good job.”

“What would you like from [the attorney]?”

“If she could help her get some of her money back. Enough to pay off her therapy bill. And put her money back in her savings and retirement. She’s worked very, very hard. So she won’t have to work ninety hours a week again.”

“She’s worked very, very hard the last two years,” I offer, “she just hasn’t been paid for it.”

[-]

“You’ve worked very hard, too. Mommy Francis asked [me] to pick you special,” he serenely extends.

“Please tell Mommy Francis I’m doing the best job I can . . .”

Noticing a bit of yellow peeking from the resident bag, I ask,

“What is this yellow shirt all about? Yellow is not one of our colors!”

“No, this is not one of our colors, but we’re going to have sunshine in all of our lives again. Everybody’s going to heal and be healthy and whole. The Big Lady is not going to stuff her feelings anymore like she used to. And Little Grace Ann is not going to rip her toenails off, and Judith is not going to rip her skin off, and Janice is not going to be ‘barassed anymore, and Jaqua is not going to wash and drink so much, and wash all those clothes. And we’re going to have a new knee. Yellow is for sunshine, and we’ve never had sunshine in our lives, ever, ever, ever.”

“Well, with Strong Man’s help, we’re on our way,” is all I can think of to say. [+] *I am comforted that I am not alone.*

My Safe, Free Place

Several weeks following the taping, the client presents with a small drawing, and the following journal entry:

“. . . i have realized . . . [that] i have been escaping to my safe, free place on the prairies with the green grass, sun shining, the pretty mountain, and i was free. i have to tell Deborah. i have never been doing this more. Why am i escaping to my safe, free place so much?” [#]

The following months have ushered in a new freedom, a bevy in inner activity. With the dissolution of the previously ironclad amnestic boundaries, the turmoil turns to the chatter of internal communication. A moratorium on quiet is declared. Open season is declared on

chatter. While not unhappy, Grace Ann is thoroughly perplexed, and regularly presents with a new adventure—a new tale to tell.

Bibliotherapy

I prepare a tape of the alters' favorite stories. Carlson's (1984) I Like Me, the story of a persevering pig who likes her curly tail, round tummy, and tiny little feet, and who greets the mirror each day with, "Hi, good-looking," brimmed with self-esteem and is relished by the younger children. Murphy's (1983) God Cares When I'm Thankful, (one of the "library books" purchased by Strong Man Jesus and Judas and inscribed with purple ink) typically brings comfort. Gil's (1990), United We Stand: A Book for People with Multiple Personalities (donated by Jessica) covers such topics as "Am I Crazy?" "Do I have to Talk to My Inside People?" and, "Who Can I Tell?" and is included as an educational resource. Wallas' (1985), Stories for The Third Ear: Using Hypnotic Fables in Psychotherapy ("The Seedling: The Story for a Client Who Has Been Abused as a Child, Journey From A Frozen Land: The Story for an Obese Client," and "The Little Elephant Who Didn't Know How to Cry: A Story for a Client with Borderline Personality Disorder") are recorded to address, and hopefully soothe, the client's turbulent unconscious. However, the favorite, by far, is Adam's (1990), The Silver Boat, the story of a little girl with MPD who teaches us to face the forest by reaching for the inner self helper within us all [o]

Dissolving Amnestic Barriers

We contract for each of the alter to have a time. Jessica likes to color, Jenny and JoAnn to play with Play Dough, Demon Judas wishes to paint. . . Judith to draw on her sketch pad. . .

Each child is encouraged to look for the blue light, to reach for the strength, at least for now, hidden deep within.

(Following a therapy appointment.)

“Where has this day gone?” she writes, as she lay in bed with Jessica’s relaxation tape in her ears and a coloring book on the bed. [#]

“Well, I feel at peace, yet exhausted with a very bad headache. Let me see what I can remember about my session with Deborah today. I first sat on the couch, left my journal, three tapes for Deborah on the chair, then there was a fourth tape I didn’t remember putting in my book bag. It said.

“To Dr. Debbie’s Professors.” It was printed. That puzzled me. The next thing I remember, Deborah was reading my journal and it seemed like she was reading forever, yet I know I hadn’t written very much. . . . I asked Deborah what she was reading, when I know I hadn’t written much. She said,

“Jessica had written her a lot. . . . I fell asleep listening to The Silver Boat. Now let me see if I can remember what Deborah told me today. . . . She told me she spoke to UBS. I told her I still don’t understand all this??? What happened to [her] when all these other parts of her personality took over? Why couldn’t [she] just go to her safe and free place without creating all these different names for different parts of her personality? . . . Then, why can’t I remember what Deborah and I talked about? [#]

Deborah told me she talked to Jessica. She has the biggest job of helping every one on the right path. Deborah said,

“Jessica is six but is the strongest one and she helps all the other out.” I don’t understand but

i'll trust her for now. I just don't want her to send me to someone else. i'm so scared she won't want to help me to heal anymore, because i've been such a headache to her. i trust her more than anyone. . . She's the only one I feel free to ask or tell her things and she won't hurt or judge me. They next thing I remember Deborah telling me is that she spoke with Janice and she is real shy. . . Deborah said that she spoke with Demon Judas and she is even going to help him heal . . I hope she can do that, but I don't even know who he is. . . The next thing I remember her saying is that everyone did a good job talking to each other. . . Deborah then told me to get a bulletin board and give all alters or different parts of my personality permission to leave notes to each other. I told her I already have a bulletin board. Deborah says give them permission to continue to talk to each other in my journal and give them permission to leave notes to each other. I have to trust her, even though I don't understand all this. I am so confused, I just want to go to my safe place and stay there forever until this whole thing is over. I wish I understood MPD but I don't and it frustrates me. I guess when I am ready to handle things, Deborah will let me read as much as I can about it. . . But i am scared. . . i am very confused." [#]

I note the mixture of the upper (underlined for emphasis) and lower case I's, and am encouraged that Grace Ann is beginning to understand, at least intuitively, about the condition that originally 'saved' her, but is now pillaging her life. []*

The Town Crier

Jessica, the pseudo-self helper, and resident "Town Crier," presents for most sessions ready and willing to report on the group's most recent clandestine affair. "I's be here, Dr. Debbie," is the beacon call [@; >]

I am aformed [informed] of the Big Lady's whereabouts between our twice weekly meetings,

whether she has behaved [behaved] or “beee’s really, really bad.” I hear of Little Grace Ann’s midnight freezer raids, of the half-gallons of Breyer’s ice cream and the loaves of bread she inhales in a futile attempt to alleviate her pain. I am told of Judith’s night terrors, the bruises, blisters, and mouth ulcers that mysteriously appear after she has survived the latest sieved memory of events long past. I am told that The Big Lady “be really, really, shamed,” because her now familiar financial insufficiency doesn’t allow her funds to pay, or pay-on, the mounting therapy bill. [@; ^; #; =; ~; >]

We enjoy stories of Janice’s budding sexual curiosity, of the “berry cute boy she see’d,” and the unexpected blush that steals its way across the Big Lady’s bewildered cheeks as the result of the chance encounter with an oblivious (*thankfully*) teenage boy. We hear of Little Grace Ann’s exploits at the mall, of her attempts to simulate Dumbo’s ears by wildly flapping her crutches in the air while running in and out of the toy store. A sophisticated Judith attends a book signing, the object of which is to obtain a book for the Big Lady’s birthday. Well, Judith is unfortunately not alone, for when her turn arrives at the author’s desk, the internal family insists that the book be dedicated to them as well. [*I can only imagine the look on that poor soul’s face!*] [@] Jessica shuffles in with a video of The Big Lady’s ‘zaleas [azaleas] in tow. Popping the day’s entertainment into the VCR, she proceeds to narrate, first to me, and then to the others who are evidently watching from within.

“ . . . one color for everybody. See, JoAnn, see Little Grace Ann. Here’s a red one for Judith. Strong Man Jesus, see, white and purple. Janice be scared, but that be alright.

“Look, Janice, Strong Man Jesus is all around you. . . be protecting you. . . you be alright.”[+]

“Dr. Debbie, I underlines the big I’s. Don’t you think that’s progress for the Big Lady?”

“Doesn’t that mean that her self esteem[m] is better? Dr. Debbie, the Big Lady has a new feeling that she wants to ax [ask] you about. But she is ‘barrassed to ax [ask] you. So maybe Janice can ax [ask] you. . . the Big Lady has the feelings and she not understand the new feelings. How you spose [supposed] to talk to the Big Lady and splain [explain] what she needs the answer to, when she be to [too] ‘barrassed [embarrassed] to ax [ask] you? Janice wants to talk to you to [too]. How you gonna [going to] talk to both of them at the same time? You the therapiest [therapist], right? You hav [have] to figure that out, that[s] not my problem.” [@]

“Big Lady Grace called Dr. Dolores [an on-call supervisee] and axed her to ax you why she had such a terrible eyeache and she felt exhausted. Dr. Delores told Big Lady Grace that Deborah said for her to listen to the tape, and she will know why she had an eye ache. Dr. Delores told Big Lady that Deborah said to tell you, you worked very hard today. Well, Dr. Debbie, Big Lady put the new tape that you read to us in her little walkman with the ear phones. Well, the minute, second, Little Grace Ann heard you reading to all to us, she says,

“I here [hear] Mommy reading Gerbert and the Christmas Story about Jesus. I here [hear] her voice reading to me but I not see her. Where she be? . . .” [@ ; # ; =]

Judith takes over the story.

She got so excited that Mommy is reading to her, she was running all over the house looking in drawers, boxes, everywhere for her. However, she did not cry like that bad hurts cry. That hurts our hearts so much and we don’t know how to make the 3 ½ little hurt Grace Ann stop hurting. . . Now we have a new problem. Little Grace Ann thinks that your voice is Mommy’s voice. She is really excited. She kept telling us to play the story of Mommy reading Little Grace Ann the Gerbert Story and the Christmas Jesus Story. She kept asking to have it played over and

over and over and over. Each time she asked to have it played, all of us together, including Jennifer, said,

“Little Grace Ann, Dr. Debbie want to talk to the Big Lady.” [@; #]

We told her this over and over. All of us together from the time Dr. Delores told her to listen to the tape until she finally went to sleep at 4:47 a.m. . .”

“We have a serious problem, Dr. Debbie.”

“We can not get Big Lady Grace back. . .”

Little Grace Ann is as stubborn as Big Lady Grace. . . However, Little Grace Ann’s leg does not hurt and she is a very active 3 ½ year old --energy, endless energy. She never stopped until 4:47 a.m. She said,

“Where Mommy be and who all those other names on the tape? Do they be the bad people? I not know them she would say. Dr. Debbie, it was all of us but Little Grace Ann does not recognize all of us, she’s so excited to hear Mommy’s voice. . . [@; #]

Big Lady was in her safe place the whole time. . . Little Grace Ann was so excited she got herself wheezin’ and had to use her inhaler. . . WE still could not get Big Lady Grace back, every other time since you taught us how to get [her] back it worked, but not this time. It was from two p.m to 4:47 a.m. that Little Grace Ann was out. Not crying, just excited to hear your voice. . . I told her,

“Little Carol Ann, this is Strong Man Jesus and Judas talking to you. . .” [@; #]

We were really firm with her. After fourteen hours of this endless energy, bundle of joy, we told her,

“Now listen, Little Grace Ann. Mommy is in a safe place called heaven, and one day you will see her again, but for right now, me, Strong Man Jesus and Judas are taking care of you.”

Finally, we were both very firm with her, because we were all getting tired and we know when we finally would get Big Lady back, she would have a terrible eyeache and a lot of pain in her hurt leg. Fourteen hours of Little Grace Ann’s endless running around. . . she finally went to sleep and so did all of us, in hopes of when she woke up, we would have Big Lady back. No such luck! Guess who is awake and running to the bathroom with the crutches. You guessed it. Little Grace Ann. We all told [her] while when was sitting on the toilet,

“Little Grace Ann. Dr. Debbie wants to talk to Big Grace Right Now!”

No luck. We did not get Big Lady Grace back. Jessica again tries to call your answering achine [machine]. Jessica tells Little Grace Ann,

“You have got to take a shower because you have to go and see the doctor today.”

Little Grace Ann asks,

“Are we going to see the nice lady doctor?”

So we tell her,

“No you are not going to see the nice lady Dr. today. You will see her on Thursday.”

Grace Ann says, “When Thursday be? I like pretty lady.”

“Dr. Debbie, Little Grace Ann is finally starting to trust you. Amen. . . So be it. . .” [@; #]

Well, Jessica has no luck with getting Little Grace Ann to take a shower. So Jaqua tries to get her to take a shower because she has to be at the leg doctor’s at 9:50 a.m. Little Grace Ann wants to take a bath. So Jaqua fills the bathtub for Little Grace Ann. Well, Little Grace Ann, not Jaqua, does not have a hurt left knee. So Little Grace Ann takes a bath sitting in the tub. Jaqua

helps her wash her hair. She wants to play in the bathtub but she has to be at the [doctors]. Then she says,

“What this chair doing in the bath tub? What this monkey bar doing on the side of the tub? You can’t [get] your legs through that little bar. What that for?”

Well, Dr. Debbie, she had us all laughing because she doesn’t understand that Big Grace has a hurt left knee. None of them or us have a hurt left knee. So there she is, cute as she can be, sittin on the floor of the bath tub while Jaqua washes her hair. So then we try again to get Big Lady Grace back. No luck. Jaqua gets Little Grace Ann out of the tub, dries her off, and dresses her so we can go the Drs. office. Well, Dr. Debbie, you’re not going to believe this. Jennifer and Judith take Little Grace Ann and dry and fix her hair pretty to go to the [doctor]. Then Jaqua helps her brush her teeth. While they are all doing these things to get her ready to see the [doctor], Jessica is trying desperately to call you to ask you what we need to do to get the Big Lady back so she can drive us to the [doctor], because she is the only one who can drive. [@; #]

“What we gonna do?”

So everybody together [was] really firm with Little Grace Ann. She’s had her bath, she’s dressed and her hair is fixed, so now all together we say,

“Little Grace Ann, Dr. Debbie needs Big Lady Grace back right now to drive us to the Drs. office.”

Little Grace Ann is standing by the door with her coat on. We get Big Lady back. We all here her say,

“Boy, do I have a terrible eyeache, where are my crutches, my leg is killing me?” [@; #] Big Lady drives up to the [doctor’s] office, and we get there at 9:30 a.m. The waitin’ room is full of

people. Big Lady Grace doesn't get called to the [doctor] until 12:45 p.m. We had a long wait. Little Grace Ann kept trying to come out. We could not let her get out in front of all those people and the leg [doctor] because you know Little Grace Ann would throw those 'sticks' as she calls them of the floor.

Dr. Debbie, we all kept the Big Lady out until we see the [doctor and] she drove to Revco to get some Cortaid. She asks the young man at the register which isle would the Cortaid be on so she wouldn't have to walk all over the store. He went and get it for her. Well, then she asks the man where the . . . sanitary pads were. Well, he says,

"I'll go get them for you so you won't have to walk over there," and she was the only customer in the store and he had time to help her. When he comes back to the counter, Janice is very 'barrassed Big Lady's face is red as a beet because Janice is so 'barrassed. So to get him away from looking at how red Janice's face is, Jacqueline asks the man where the Silly Putty is and where the Hugs are, because we needed to get some for Dr. Debbie and her clients and all the children, since most of us now know what good warm hugs are from bad touch. (Except Little Grace Ann, Jennifer, and Judith haven't felt what a good warm hug is and how good it feels inside when you give us one.) [@; #]

Not to be outdone, Jessica continues with her version of the evening's events.

. . . Berry dark, cold, and windy out. Dr. Debbie, we had a serious problem. Big Lady was laying on her bad with the blue ice on her eyes, 'cus her eyes hurted real bad and she not understand why they hurted so bad, 'cus she not amember what she did in therapy. She also not understand why she be so tired. . . Dr. Delores splain to her what she did in therapy. She also not understand why she be so tired. . . Dr. Delores slain to her what you telled her to 'splain 'bout the

alters. Big Lady getted scared and her hart be beetin' realy fast. She really getted panicked. She be shakin' really bad. I maked her split so I could runned in the livin' room so I could get the new tape you made for us. Big Lady be wheezin.' I kepted telling her to take slow deep breaths, but she be wheezed so bad she had to use her 'nhaler. . . she put on that alaxation tape with the blue ice on her eyes. She listened to the alaxation tape five times afore she stopped shakin'. She started to go to sleep on her bed and I put the new tape in the 'corder. Well, the first story about Gerbert that you readed us on, who do we get? Little Grace Ann. We, I called your 'achine every fifteen minutes and nobody answered the achine. What happened to your 'achine, Dr. Debbie? We could not getter Big Lady back and it be 4:47 a.m., dark, cold, and windy out. Finally, since we had a serious problem, not bein' able to get Big Lady back, she sayed,

"Little Grace Ann, go lay on the bed so you can hear the new stories Dr. Debbie reeded us."

[@; #]

She say,

"I not no Dr. Debbie, but I will listen to Mommy reed the stories, where Mommy be? I hered her but I not see her. Where Mommy be?"

She kepted axin' the same question over and over so we all tell her we be taking care of you, Little Grace Ann. Jus listen to the tape, since we not getter Big Lady we all asided to tell Little Grace Ann jus listen to the new stories. . . Finally. . . she felled a sleep. She never cried, thank goodness. We hurt for her when she cries so hard. But now we had a new problem. She thinks Mommy readed the stories. She kepted saying,

"I wanna hered Mommy read Gertert story and Christmas Jesus story."

"Who bee'd Jesus, Little Grace Ann sayed?"

So Strong Man Jesus and Judas sayed,

“Little Grace Ann, we all be takin’ care of you. Mommy be in a safe place called heaven and one day you will get to see Mommy.”

Little Grace Ann sayed,

“I no that be Mommy readin’ to Little Grace Ann, I want to here the Gerbert and Christmas Jesus Story.” [@; #]

I comment to Jessica that I enjoy her story, but that there are “a few” words I just don’t understand. Ever-compliant, she presents for the next session with, none other than, “Jessica’s Dishunary:”

The Healing Power of Humor

Jessica’s Dishunary:

“This bee’s the personal Dishunary [dictionary] of Jessica, the Boss, 6 ½ years old. Judith and Big Lady, keep your Paws off. Judith, I is usin’ your [red] pen. Just ‘cus you always tell me to use the Webster’s dishunary. I Not like Webster’s and I telled you and telled you I not like Webster’s. so now I goin’ to right my own dishunary agin’ ‘cus you keep hidin’ the one’s I rite. So now I even goin’ to use your pen to git back at you Judith!” [#]

Alongs--This means it just alongs to the rite person who owns it. Anybody who owns somethin of there very own. It alongs to themselves.

Ahave--This beee’s when bossy Judith yells at us “Be good, ahave.” The opposit of being bad is to ahave.

Alphabetical order appears to be out of the question !!!

Zalyer-My pretty pink one that I planted with everbody is so bootiful. We hav our own colors that

Judith help us all plant. Judith can be nice sometimes, 'cept when it comes to doin' our home work and helpin' Good Little Grace Ann 3 ½ to print neatly. Sometimes Judith is so bossey. But we all really doo's luv her.

Professors--It bee's men and woman [women] whoo's goes to skool for one hundred years. They wares white starched shirts, black and grey suits. Some of them getted kind of old. They combes there hair from there left ears over balled heads to there rite ears. It's looks stupid. They look better balled [bald]. *[I can't wait for the folks at school to hear about this. There goes my doctorate right down the tube!]* Professors be verry smarted and use hugh [huge] words that you not no how to say let alone not no how to spell. I wanna bee's smarted like Dr. Debbie one day, but to hav to go to those stiff, starchy professors scarres me. I glad Judith will hav to bee's the first one to goes. We watch how she doo's, then we acide [decide] if we gonna goes to Dr. Debbie's smart skool. Big Lady be smarted to. She be smarted in the medical field. I not wanna take care of people who throw up all over me. Yuh! [yuch?] I gonna be like Dr. Debbie who helps people to tell theys hurts and tells people it not be there fault, not they not be bad. I wanna help put sunshine in peoples life like Dr. Debbie doo's to all of us.

Abreaction--It's bee's when the Big Lady gets a bruise, blister, 'cus one of us tell Dr. Debbie our therapiest. A therapiest is a berry berry SPECIAL lady who bee's kind of like our Dr. Debbie. You luv your therapiest cus she bee's smart to help children whos' bee's sexually, verbally 'bused, ritually 'bused, bye the witches at the Big Hall . . . *(I note the script is becoming larger and disjointed, and assume a fusion is occurring.)* I not like mean people like her whos' hurts Good little children. I getted off. [#]

"Jessica, use your spell master," chides Judith.

“Mind your own business, Judith.” [#]

Back to my meanin of a therapiest. A therapiest is (Ha! Ha! Judith, you missed a word!) a nice person who teaches us the difference tween bad touch and good touch. N [And] she teaches us the difference tween bad hugs and good warm carin hugs. The good hugs makes me feel all warm and fussy inside. I like gettin good warm hugs from Dr. Debbie and Dr. Joann, Dr. Delores, Dr. Sarah, Dr. Nancy, the secretary . . . , [#]

She comments on her discomfort with my former office.

I not like that office. It has not windows. It beee’s too small. . . It stinks, beee’s smoky, and was berry, berry dark. We all hate dark . . . Back to my meanin of a therapiest. . . is a person who reads children story’s. . . nice story’s, not bad witch type stories. I not like those witch stories. They be grosse. I like Dr. Debbie’s stories that she putted on the tape so we can go to sleep at nite. Dr. Debbie’s stories keep Little Grace Ann quite [quiet]. Back to what a therapiest beee’s. She has to go to smart school to get smarted. Professor teacher’s are even smartered than she beee’s. She doesn’t make me do lots of jobs like Judith.

“Jessica, it’s 8:00 p.m. . . Time to go to bed. After you read Little Grace Ann a story I’ll read you one,” writes Judith. [#]

“I not want you to read to me. I will read to Little Grace Ann, but I wants Jennifer or Janice or Strong Man Jesus to read us another Bible Story. Not you Judith, you always beee’s so bossy.”

Good night. I will rite tomorrow after I say my prayers. Strong-Man Jesus always says we hav to say our prayers afore we go’s to sleep. Good night Strong Man Jesus, Judas Jaqua, Baby Jenny, Baby Jo-Ann, Jennifer, Janice, Job, Jacqueline, Big Lady, and you, Judith. I luv Dr.

Debbie better in you, Judith. Good night Dr. Debbie, Dr. Jo-Ann, and Dr. Debbie's professors at the smart skool," Signed, Jessica, The Boss, 6 ½.

Dr. Debbie. Doo's you know (see Judith I spelled no's rite) what agape luv beee's? Agape luv is unconditional luv. Jessica The Boss 6 ½. [#]

Jessica's Dishunary also includes a developmental chronology.

The Ages

Baby--Birt to five year old.

Pre-teen--6-12 years old.

Teenager--13 years old to 19 years. These beee's the worstest cus P.M.S. Whatever that beee's.

Young Adult--20-30. Get married, hav a mad passion night of sex (Whatever that beee's).

Antique Years--31-50 years. This beee's where Dr. Debbie, Big Lady, Dr. Jo-Ann. . . beee's. . . antiqued!

Old Age 51-70--This where Mr Karl, *[my husband]* Nancy *[her friend]*. . . beee's.

Prehistoric Age--This beee's where Miss Madeline and Mr. Hall *[my parents]* beee's. . .

Monkey Age 101-200 --I not no anybody *[this] age. [#]*

. . . *as well as a bill.*

"Dr. Debbie, we all asided for you to send Big Lady a bill for us cus we couldn't get hold of you to help us getted Big Grace back. We all asided to charge Big Grace and Little Grace Ann. Please send a bill to them from us. We worked hard. We aserve it."

Little Grace and Big Grace

Strong Man Jesus 65 x 29 hours \$1885.00

Jenny 65 x 29 hours 1885.00

Jo-Ann 65 x 29 hours	1885.00
Judas 65 x 29 hours	1885.00
Jaqua 65 x 29 hours	1885.00
Jacqueline 65 x 29 hours	1885.00
Janice 65 x 29 hours	1885.00
Jennifer 65 x 29 hours	1885.00
Jessica 65 x 29 hours	1885.00
Judith 65 x 29 hrs	1885.00

Big Grace--We chargin her.

Total for 10 people. Z bein charged \$1885.00 for Little Grace Ann and Big Grace

Grand Totals \$ 37700.00 [#]

Thirty-seven thousand, seven hundred! I would be willing to settle for the five thousand, (and counting), unpaid therapy bills that I already "know" I'll never see!

Minimizing Minutia: Dodging the Details

Throughout our work together, we would begin to gather momentum, only to be set-back with another tale of woe. Countertransference, my getting caught in Grace Ann's stuff, was my constant, if unwelcome, companion. It is only when I have been able to "rise above" the details, true or not, that meaningful change takes place. The following accounts represent but two of our many difficult moments; the first, Bob, the tale of love lost, and the second, The False Memory Debate, accusations of dishonesty opening wounds not likely to heal . . .

Bob

Judith, beginning to trust, writes of an engagement to a hometown boy killed the week before his discharge from Vietnam.

... he was killed when [a] land mine blew up I didn't want to believe it, three days before he was to come home. Why? I wouldn't believe it when Bob's mother told all of us. It hurt so bad, I couldn't even cry. I believe even then I went to my safe, free place. Then I stuffed the hurt with food and tried to make myself [believe] it wasn't true--but no more letters came. Two months later two men came with a box wrapped with brown paper with his parents name on it. They handed the box the size of about a shoe box to Bob's parents. They said,

"This was all that was found of his belongings." [#; *; @; ~]

[His mother] opened to box with all of the family in the living room, including me. All that was in the box was his dog tags and an I.D. card with his picture of him on it. I was numb. . . I would not admit to myself that he was dead. But I never got another letter from him. I just packed it away in my closet. I kept telling myself maybe he was a P.O.W. The longer it got that I didn't hear from him the more I worked and stuffed the lonely disbelief feelings. I gave back all the shower gifts. I sold my never worn wedding gown. We canceled everything, the hall where we were going to have the reception. [They] wouldn't give us back our money. Nor would the caterers give us our money back. The florist hadn't done the flowers yet. We had to call everyone and tell them the wedding was off and why. Everyone was so shocked. Many people told me, Bob and I were made for each other. After the memorial service, I worked longer and longer hours and kept eating, I packed away the whole experience. I never discussed it or dealt with it until today when Deborah asked me about it. I just packed it back in the back of the closet

with all the rest of the hurts in my life. Today I cried over it for the first time since I packed it away. . . my diamond is at the bank. One day if I need the money I might sell it. But I guess, there's still a ray of hope that he might be alive. Deborah said,

"I've been working with you since November, and you never mentioned this to me."

"It was me, Dr. Debbie. I was the one who was engaged to Bob. The Big Lady hardly knew him. The Big Lady doesn't like boys, but I do. It hurt my heart." [#; *, @; ~]

A consult is arranged with Dr. Gentry: This is just too much. No one person could possibly have gone through this much abuse. [%] First her father, then her foster parents, then, of all things, a cult? And don't forget the priest, Father Stafford. I'm beginning to think she relishes her victim role, and wears her pain well. Dr. Gentry, incredulous as well, agrees. I discuss with her the emerging theory of the False Memory Syndrome, and agree to forward to her the most recent research into the "syndrome." As usual, her parting words are,

"Hang in there." [%]

I never remember feeling so lost, or so sad.

The False Memory Debate

The phrase False Memory Syndrome is permeating the dissociative literature. Hopeful at last that I can couch this God forbidden tale within some sort of theoretical framework, I search for data on this enigmatic syndrome, and settle upon the following:

In an apparent attempt to quell the "Kafkaesque eeriness" enveloping trauma and memory, (Wylie, 1993, p. 3), The Family Therapy Networker devotes a significant portion of its September/October 1993 edition to the False Memory Debate. Yapko's "The Seductions of Memory," cautions the trauma therapist to stay clear of "suggestive procedures," (p.33), insistent

questioning and, encouragement to “confront your past,” (p. 32). In “Facing The Truth About False Memory,” Calof presents an opposing view of the “syndrome,” as it has now come to be known. Calof defends the treating professional, insisting the controversy has surfaced due to a basic misunderstanding of the nature of therapy. He states:

The false-memory critique treats extreme examples of bad therapy as if they were mainstream practice. It seems to arise from basic misunderstandings of what therapy is and what therapists do. It assumes there is some economic pay-off in implanting memories of abuse when nothing of the sort has actually taken place. It ignores the fact that people who have been repeatedly abused tell their stories reluctantly and disbelieve themselves. Taking on the identity of a trauma survivor brings far more stigma than specialness (p. 41).

In “The Shadow of a Doubt,” Wylie introduces the False Memory Syndrome Foundation (the grass-roots organization comprised of accused family members and disbelieving professionals), and presents the current theories surrounding the debate. While she offers Gardner’s references to alleged victims as “angry paranoids,” (p. 23), and Ganaway’s view of the accuser as an individual involved in a delayed adolescent rebellion (p. 23), it is her references to Loftus work that catches my eye. Loftus rises above the issue’s emotionality--she does not become embroiled in the debate. As an authority on cognitive processes and eyewitness memory (p. 23), she posits that memory, like anything else, is subject to “inaccuracy, fabrication, confusion and alteration,” (p. 23). She cautions that in accepting “all repressed memories as literally true” (p. 23), professionals inadvertently harm those who have been the victims of childhood sexual abuse.

I can understand Loftus’ view. While I breathe a sigh of relief for I have, not even once, introduced the concept of abuse nor persisted in a line of questioning regarding Grace Ann’s allegations. I wonder, however, if her “fundamentalist family” has done the same. Frankly, I

am pleased to find some, even remotely plausible, explanation that will extract me from the emotional hotseat. Hearing these stories, session after session, has taken its toll! I ceremoniously [and sanctimoniously?] prepare my conversation with Grace Ann. This is logical, this makes sense. This will help her to feel sane. [^]

Our next session arrives. Grace Ann listens politely to my stammering explanation. I am troubled, for I fear she will assume I am offering a challenge to her credibility. She contributes no alternative interpretation, so I assume she agrees with my assessment.

Two days later. . .

Ever the underdog, I am presented with an exquisite, but unusually cut diamond (alleged by the client to have been purchased by her fiancé in Thailand), a yellowed McCall's sewing pattern of a wedding gown, circa 1968, and a series of wedding cards inscribed,

"To Grace Ann and Bob." [-]

She then produces (from the bottomless canvas bag), a baptismal certificate and a newspaper clipping, and proceeds to cross-reference the date and diocese of her confirmation with the dates and service location of the now convicted priest. And finally, to my utter, and scarcely contained horror, she presents me with a photograph, dated the previous month, taken outside of my office. The snapshot is of a black hearse, equipped with the license plate, "To Die 4," issued from a state some one thousand miles away. Staring, malevolently into the camera, is a straggly-haired, grey-bearded, unkept man with a scornful countenance and cold, cold, eyes. As the icy chills run up and down my spine and nausea shrouds my now hypervigilant body, I appreciate, within the eye of my understanding, what it means to have "safe eyes."

Within the week, the local police are contacted. A plain clothes officer arrives at the

appointed hour, hearing a large cardboard grocery box filled with "evidence." I am shown the journal of an alleged Satanic worshiper, along with a Satanically emblazoned jacket of a young man purported to be mysteriously killed the previous summer. I am informed of two "local cults," under surveillance by the authorities, and shown Polaroid photographs of ritual gathering sights. I am shown photos of dismembered animals arranged in sacrificial patterns. I am told by the officer in question that he, himself, has ceased "this work" due to physical threats (phone calls, beheaded birds placed on the hood of his car, Satanic literature postmarked from distant addresses) to his family and himself. I am advised to be cautious, not only of those unknown, but of the client as well, as individuals "programmed" at an early age generally report back to "the cult." I am admonished to install an office security system, to arrange for an unlisted number, to move my locked car to a lighted area as dusk descends, and to be careful. A friend brings a key chain with pepper spray, insisting that I go nowhere without it. Emotionally torn, I reluctantly entertain the possibility that a dark side really does exist, that I may indeed be bargaining with evil. [>]

Chapter IV, Phase Two: Standard Treatment of Dissociative Identity Disorder (Eight Months to Two Years) has addressed the conventional treatment approaches that were used in my work with Grace Ann. It has included (a) issues of safety and trust (b) a return to journaling (c) medical consultation (d) introduction of the altered states of consciousness (e) the bulletin board system of communication (f) internal group therapy (g) abreactive therapy/screening (h) the creative arts: poetry, play, and art therapy (i) issues of grief and loss (j) reconstructing a life (k) burgeoning ego strength (l) bibliotherapy (m) dissolving amnesic barriers (n) the healing power of humor, and (o) minimizing minutia: dodging the details.

Phase Three: A Transpersonal Approach

(Third Year)

Introduction

Chapter IV, Phase Three: A Transpersonal Approach (The Third Year) provides an overview of (a) a turning point, i.e., the shift from conventional treatment of Dissociative Identity Disorder to an acceptance of Strong Man as Inner Guide, and (b) the healing, the account of Strong Man's facilitation of the integration process.

Upon reflection, I realize that I have "known" Strong Man for a very long time. He has never officially introduced himself as Grace Ann's Inner Knower or Spiritual Center. I, in my naivety, assumed The Party Girl held that distinction. After all, she did introduce herself as the Boss. I believed her!

Since the day of our first meeting, Grace Ann has emphatically, and consistently declared, "Deborah, I need to work on my spiritual journey!"

*During phase one, I dismissed her request as inconsequential in the light of her severe pathology. In phase two, I begrudgingly followed Strong Man's lead, primarily because he obviously knew far better than I the needs of the internal band. Without even being aware of it, I have learned to defer to his wisdom and guidance. I find myself looking forward to his presence, ostensibly due to the therapeutic information he can convey, i.e., the details of the day's happenings or the level (and origin) of someone's pain. In all honesty, I am comforted by his support and encouragement for my struggle, and feel a sense of peace when he "appears." (For an account of my emerging transpersonal awareness, see *A Therapist's Journey in Appendix B.*)*

A Turning Point

As if intuiting my discomfort (or abandonment), Strong Man's letters begin to arrive.

Dear Dr. Debbie,

Grace is very scared. She's received seven phone calls from one person and two from another reminding her that October 31st is the feast of All Hallows. She, Grace, will not answer any more calls when the caller ID says "unavailable." She's been doing her Spiritual Journey. She reaches deep within. She says.

"Strong Man Jesus, Mommy and Daddy, please just hold me."

She does this every time she doesn't know how to handle a situation. She's trying to create a safe place by asking me and Mommy and Daddy just to hold her. . . She doesn't understand anything that's going on. She is so fearful. She hates this month and just wants it to be over. She wants to go forward and get healthy. Please, Dr. Debbie. Help her! I have so much planned for you

Strong Man Jesus [~]

To Dr. Debbie from Strong Man Jesus and Judas,

What is ritual abuse?

Betrayal is too kind a word to describe a situation in which a father says he loves his daughter, but claims he must teach them about the horrors of the world in order to make her a stronger person, a situation in which he watches his own daughter and he participates in rituals that make Little Grace Ann feel like she is going to die. Little Grace Ann experiences pain that is so intense that she cannot think, her head spins so fast she can't know who she is or how she got there.

All Little Grace Ann knows is pain. All she feels is desperation. She tries to cry out for help,

but soon learns no one will listen. No matter what she does the pain will not stop. No matter how loud she cried, Little Grace Ann can't stop or change what is happening. [They] order her to be tortured and they tell her that she needs the discipline, or that she has asked for it by her misbehavior. Betrayal is too simple a word to describe the overwhelming pain, the overwhelming loneliness, and the isolation Little Grace Ann experienced. [~]

As if the abuse during the rituals at the Big Hall [wasn't enough], Little Grace Ann experienced similar abuse at home on a daily basis. Sometimes nine to ten times per day. When she tried to talk about her pain to Father Stafford, she is told she must be crazy. He tells her,

“Nothing bad has happened to you. You must have had a bad dream or watched a horror movie ”

Each day as the pain and torture gets worse, she begins to feel more and more like she doesn't know what is real. Little Grace Ann stops trusting her own feelings because no one else acknowledges them or hears her agony. Soon the pain becomes too great. She learns not to feel at all. She is robot-like. This strong, lonely, desperate Little Grace Ann starts to give up the senses that make all people feel alive. Little Grace Ann begins to feel as though she is dead. Sometimes she wishes she were dead or that Mommy [or] Daddy would come and rescue her. For Little Grace Ann there is no way out. She soon learns there is no hope. As Little Grace Ann grows older, she gets stronger. . . [and] learns to do what she is told with the utmost compliance. Little Grace Ann forgets everything she ever wanted, except the loving, nurturing care Mommy [and] Daddy gave her. No one could take those very precious memories and the love they give her and showed her through their eyes. . . They loved her dearly. When the social worker took

Little Grace Ann from their house, she and they cried much. They always wondered what happened to her. She was daily in their thoughts and prayers. [~]

Little Grace Ann never let go of those precious memories. . . Her biological father took her virginity from her when she was just eleven months old. The painful life she lives still lurks, but it is easier to pretend it is not there than to acknowledge the horrors she has buried in the deepest parts of her mind. Any friends or relationships are overwhelmed by the power of her emotions. Little Grace Ann reaches out for help, but never seems to find what she is looking for. The pain continues to get worse. The loneliness sets in when any feelings return, she is overwhelmed with panic, pain, and desperation. She is convinced she is going to die. Yet, when she looks around her, she sees nothing that should make her feel so bad. Deep inside her she knows something is very, very wrong, but she doesn't remember anything. Little Grace Ann thinks,

"Maybe I am crazy." [~]

Little Grace Ann creates a safe place within her mind. She goes to the prairie where the grass is green, there's mountains that reflect the cloudless blue sky and she is running free. . .

A cult is a group of people who share an obsessive devotion to a person, such as Satan or an idea. Many cults use violent tactics to recruit, indoctrinate, and keep members. Ritual abuse is best defined as the emotionally, physically, and sexually abusive acts performed by family members and by other cult members. Most violent cults DO NOT openly express their beliefs and practices, and they tend to live separately in noncommunal environments to avoid detection.

Little Grace Ann, like some other victims are abused outside of the home by nonfamily members. . . Little Grace Ann needs to tell what [they] did to her. . . Some adult ritual abuse victims often include grown children who were forced from childhood to be a member of the

group or cult. Some other adults and teenagers are people who unknowingly joined social groups or organizations that slowly manipulated and blackmailed] them into becoming permanent members of the cult. ALL cases of ritual abuse, no matter what the age of the victim, involve intense physical and emotional trauma. [~]

Violent cults, such as the one [our biological father and foster parents] belonged sacrificed humans and animals as part of religious rituals. They used torture to silence Grace Ann and others. Unwilling to join or participate, ritual abuse victims like Grace Ann feel they are degraded and humiliated and are often forced to torture, kill, and sexually violate other helpless victims. The purpose of the ritual abuse is usually indoctrination. This cult intended to destroy these victims like Grace Ann's free will by undermining their sense of safety in the world and by forcing them to hurt others. [~]

A number of people have been convicted on sexual abuse charges, such as Father James Stafford and her biological father. In most of these cases of sexual abuse, there were also reported elements of ritual child abuse. Grace Ann could and needs to tell about being raped by gourd of adults who wore robes, costumes, and some even masks. She was forced to witness religious type rituals in which animals were tortured or killed. Grace Ann was told she killed other children. She did not, yet they brainwashed her into believing she did.

The Big House. . . had secret tunnels etched with upside down crosses and pentacles along with stone an marble alters and candles in a make-believe cemetery where rituals and burials of live children occurred. [~]

Some people suggest that the tales of ritual abuse are just myths and mass hysteria. However, what Grace lived through was no myth. She survived it with my help, Strong Man Jesus, and all

the other alters who took the pain of the different rituals. It was so painful, physically, emotionally, and spiritually, for her that these alters were created within her mind. Her first alter is Jenny, eleven months old, the next is JoAnn, fifteen months old. Her biological father raped her and stole her virginity from her. I kept her fighting to live, and have been with her since she was eleven months old. . . I have great things in store for her to do once she is whole and healthy. However, she has much to tell and so do all the alters before I can use her for my glory. . . along came Jessica 6 ½. She was never hurt. [Her foster parents] had a baby boy thirteen years after their daughter was born. [They] were very disappointed that it was a boy, as they wanted a girl to use as a breeder as [the daughter] was used as a breeder. They made Little Grace Ann 6 ½ care for [the child]. She was only 6 ½ and knew nothing about the care of a baby. So Jessica took over and helped her care for [the new baby boy]. Jessica is the part of Little Grace Ann who is happy go lucky, playful, loves to meet new people. She is the internal helper and tried to keep all the alters safe. She is a joy and the very fun-loving part of Grace Ann. However, her heart hurts and she'll cry when Little Grace Ann, Judith, or any of the other alters relive something painful in therapy. [-]

Appearing to address the system within, as if to reassure the younger children.

Dr. Debbie has taught the older ones to screen. Little Grace Ann does not understand how to do screening. Sometimes some of the other alters start to relive the pain. However, Dr. Debbie is sensitive and has the wisdom to discern this and will stop them so they don't have to relive the pain. Dr. Debbie is very good at knowing how far to push each alter and when to stop.

There is another alter that came about before Jessica. It was Demon Judas. He was always told how bad he was and believed it. He took the pain for Little Grace Ann when [they] took a

very hot fireplace poker and put it up her vaginal area. The physical pain was so severe, he took the pain for Grace Ann also. Until Dr. Debbie told him he was never bad, and it wasn't his fault, he tried to scare Dr. Debbie. At first she was even scared of him, but she had the wisdom to work with him and now he is just Judas. Since Demon means bad, he knows now he was never, never bad. He helps me and Dr. Debbie. [~]

He continued to take a lot of the physical, emotional, [and] spiritual pain for Grace Ann until Halloween of 1957, when they performed a special ritual done only on Halloween to young girls to get them to join. Grace Ann could not take the pain. It was so excruciating that Jennifer was created. She absolutely hates Halloween. Well, they all hate Halloween. They put their little legs up in stirrups and scrape[d] out their vaginas with serrated spoons. They all hate Halloween because of the different rituals that were performed before a young lady started her monthly menstrual cycle. Once she starts her menstrual cycle, another type of ritual occurs. It is very painful; they take blood from the vagina and put it in a cup and all drink it. To back track a little, when infants are given their bottles, they mix formula, milk with blood so the children will get accustomed to the taste of blood. This started with her real birth father and aunt who lived with her parents to help with the children while her mother worked in the garment factory.

Dr. Deborah, I want to tell you I will be there with you helping Grace Ann through those horrible hurts her real father did to her at eleven and fifteen months. She really loved her Daddy until he raped her. Sometimes what he did to her, she would laugh because he played with her clitoris. When if felt good she would smile and laugh and then when he hurt her she screams and bangs her head. Watch her eyes and all of her body movements. Keep pushing her until she tells you about both those hurts. She needs to tell at least one person about them so those earliest

hurts can start to heal. Once she works through those hurts, she'll then have to tell you the rest. She has many hurts she has stuffed inside and told no one. Once she can verbalize the hurts the hurts to at least one person you will continue to see her heal and be healthy. She'll try many times to change her subject. Just keep her with each hurt. I know at times she has been frustrating for you, but she is a fighter, and you and she will win. This will be your most rewarding patient you will ever work with. At present she is very confused and frustrated, because she doesn't understand the whole thing. She has a big fear you will send her away to someone else. Keep re-assuring her no one will ever hurt her again. She fears people touching her, except, she says you taught her the warm good feeling of a Good hug from a Bad touch. Later when you think she's ready, maybe send her to a massage therapist, but make sure she is ready for it. Jessica is her strongest part. . . I am with you always when you work with your patients. As she named me "Strong-Man Jesus." Some of the hurts she's been through will make you wonder how she survived. I was with her all the way. But she was determined to live for me and tell everyone about Jesus and how she became a survivor. I know things are hard on both of you at present but she will be such a joy to you later once she has dealt with all the hurts. Keep pushing her.

Strong Man Jesus and Demon Judas [~]

It is at this point that I turn within, desperately seeking strength and direction, not only for the client, but for a now beleaguered "me" as well. (See A Therapist's Journey in Appendix B)

Upon reflection, it is because of this inner journey, this time of deep deliberation, that the process emerges with a life of its own. The tone of this therapeutic "encounter" changes, not

because of my scholarship, but in spite of it. It is in this manner that the redemptive transformation begins, a transformation impacting not only the client, but the therapist as well!

The Healing

The time of atonement has come. Thirty months have passed, thirty months of outrage and woe, disbelief and bewilderment, joy and resolution. Fear and loss have faded away, ushering in a new awareness, a reconciliation for a greater good. Emotions, welcomed and unwelcomed, are encountered.

A Joyful Preparation

“Dr. Debbie, Strong Man Jesus says to ax [ask] you, you could ‘splain [explain] it to us all. . . everybody listen up, give Dr. Debbie some ‘aspect [respect].” [@]

It is a time of giggles and twitter. The system has come alive, each facet having at last been released from the austerity of the mind's overbearing classroom. It is a happy time, of finger painting and bubbles, play dough and ‘color crayons,’ Humpty Bumpy and Jessica Rabbit. Even the older alters, struggling to provide a voice of reason and restraint amongst the enchanting chaos of the elementary parade, are emersed in their own predictable adolescent endeavors.

The enthusiasm is contagious. Democracy rules. Each has a moment, begrudgingly respectful of every comrades craving to, at last, be free. Birthday parties, an enigma to the internal captives, are gleefully celebrated. Judith, of course, provides each alter a signature cake. We revel in everything—a daffodil peeping through the mid-winter's snow, a robin gorging on crusts of bread, the antics of “Mr. Squirrel.” It is Strong Man who reigns in the unlikely band. Always the director, He gently chides us all not to not lose sight of our purpose.

“Aw, Strong Man Jesus, come on, haves some fun.” [@]

Ever the gentle overseer, Strong Man Jesus serves as comforter and guide. A child can simply announce.

“Strong Man says,” and the assembly lines up, little faces turned upward “in an attempt to gather instructions from the Master Planner.” I can almost see His knowing smile.

“It Hurts My Heart to See Them Cry”

Since the tiniest alters can not give voice to their anguish, they continue to experience short-lived, but agonizing periods of pain. It is decided that they, Baby Jenny and Baby Joan, will be the first to be given “A Healing Day,” the first to know long-denied freedoms. Jenny and JoAnn are to “be taken home to Mommy,” for the memories of the Good Mommy and Daddy have sustained them throughout their otherwise traumatic lifetime. They are reminded by their big brothers and sisters that happiness is a birthright, that goodness can and does exist.

There is a flurry of activity: Jobs are assigned. I, as therapist, feel as inept as a first-year teacher in a faculty meeting. As the Principal, Strong Man Jesus is designating responsibilities. I, too, am accepting his instructions, for He is in charge, and EVERYBODY recognizes Strong Man knows best.

The much heralded day arrives. Judith arrives for the early morning appointment, laden with a garbage bag brimming with carefully selected props for the upcoming production. One by one, bears of every size and color are removed from their non-illustrious transport. A crutch, a bottle of alcohol, red and white paper, a sofa pillow, and even the office trash can are commissioned into service. The preparations continue, as each bear is first meticulously labeled with the name of a child, health professional, or alleged perpetrator, then thoughtfully arranged around the room. The crutch becomes an instrument of torture, while the trash can assumes the

role of a toilet. The now familiar red batacca is placed within arms length of the pink-shirted Judith.

I watch, at first perplexed and then, in horror, as oversized rubber bands, packing tape, and even a toy gun are produced. Judith seats herself on the floor, and ever the mother, attempts to quiet my obvious apprehension.

“Dr. Debbie, the babies are going to do what you told us to do. They’re going to feel their pain, and with Strong Man’s help, let it go.”[@]

Strong Man Knows Best

Terribly relieved that Strong Man is still in charge, I willingly accept my role of observer in the unfolding drama. Judith fades into the indistinguishable infants. A strip of packing tape is yanked from its roll, and horridly placed across the mouth. Rubber bands are wound around the wrists and ankles. Struggling to lie down, she (or they) attach the remaining length of each elastic band under the leg of the room’s two overstuffed chairs. Prone and held captive by the innocent chairs, I first question, then understand, that I am observing an infant being tied down. I watch as she rails and struggles against the imaginary assailant. Breaking free, she points to, then slaps the “perpetrator bear” labeled Bad Daddy Hughes, all the while screaming ,

“Mama, mama, mama, mama, mama, mama. . .” [+]

Still secured on three sides, she picks up the pillow with her one free hand, places it over her face, and simulates the act of smothering. Obviously unsuccessful, she casts aside the pillow, and again affixes the tape. Breaking free of the chair legs, she pulls herself to the trash can, now designated as a toilet, and, grabbing a bear marked Baby JoAnn, acts out an attempted drowning, repeatedly thrusting the bear, head first, into the invisible water.

Gasping, the wordless epic continues. Writhing and clutching her vaginal area, she simulates a forced penetration. Over and over she is violated, all the while screaming and wincing with pain. The bear marked Baby JoAnn is slapped, ostensibly because she is unable to stop crying. I notice that I am no longer an observer, but an unwilling participant. Unaware of my involvement, I find myself providing a verbal commentary for the sickening mime, and am corrected by a violent shaking of the head if my narration has gone astray. [+]

She frantically searches, then finds the red paper named "Blood." Assured that I have a full understanding, she places the child's construction paper under her vaginal area. She motions wildly, as if to insinuate the presence of profuse bleeding. To my utter disbelief, she reaches for the alcohol bottle, then pretends to pour its contents over the effected area. I do not question, but do cringe as my imagination soars. Who would do such a thing to a child? It is as if she hears my unspoken thoughts, as she screams,

"No dada, no dada. . . bad medicine, bad medicine." [+]

The carefully scripted mime continues. Blood is now all around. The toilet now becomes a bathtub, as a frantic attempt to stop the bleeding is undertaken. Unsuccessful, Bad Daddy wraps the screaming child in a blanket (Janice's peach blanket is whisked into service). Bad Auntie gruffly holds the hurting child as Bad Daddy drives to the hospital's emergency room.

The Doctor Bear caresses Baby JoAnn while the Nurse Bear forcibly throws Bad Daddy Bear out of the room. The Nurse Bear takes over, attempting to soothe the screaming child while she is injected by a pink ink pen labeled anesthesia. Quieting, the baby whimpers as one by one, twelve sutures are applied. The surgery completed, the baby is tenderly wrapped in a piece of white paper, i.e., a diaper, and is cuddled and rocked by the loving health professionals.[+]

Exhausted and sobbing, the children seek a final retribution. Seizing the batacca, they systematically select a perpetrator bear, beat the hapless creature mercilessly, then flings the surrogate abuser from of the room while screaming hate, hate, hate. Grace Ann continues, bear after bear, until, wheezing and rocking to and fro, she cries,

“Mama, where’s mama.” [+]

Sixty-seven very long minutes have passed. The traumatic memories are at last owned, experienced, and let go.

“No one can ever hurt JoAnn again,” I soothe, while the client, now labeled Mommy is rocking a tiny white bear (bedecked with the customary pink bow) named Jenny.

“Mommy is rocking Baby Jenny?” I ask.

She nods as she searches in her bag, producing the familiar children’s story, L Am Growing. She has chosen a developmental story; apparently intuitively aware of the need to leave this stage behind. Continuing to rock the whimpering child, she lies down on the floor.

The reading has a calming effect upon the tiny alters, for as page after page is turned, the furious rocking slows to a gentle motion and then, to what appears to be a peaceful slumber.

“Baby JoAnn rocked by Strong Man Jesus and Mommy,” she sleepily conveys.

“I need to say goodbye to you, JoAnn. No one will ever hurt you again,” I offer. [+]

From no where, the words of a children’s lullaby enter my mind, strangely, I feel, since the simple lyric has not been sung since my own two children were small boys.

Lulay thy little, tiny child
 Bye bye, lulee, lulay.
 Lulay thy little tiny child
 Bye bye lulee, lulay. [+]

The rocking ceases. The previously labored breathing, once fitful and erratic, becomes blessedly, peacefully even. Minutes pass. I tiptoe around the room, rearranging the furniture, rescuing unsuspecting stuffed animals from their transgression. Finally, the resident town crier awakens, stretches and yawns, then matter of factly states,

“The babies be with Mommy. They bee’d rocking. . . They bee’d O.K. Thank you, Dr. Debbie, for not terminating us.” [+]

Little Grace Ann

Two months have passed. The alters have pampered Little Grace Ann, sacrificing their time “out” for her, empowering her, granting her that which is every child’s birthright, the gifts of joy and love.

The appointed day is here. Ever the protector, Judith arrives wearing Grace Ann’s pink shirt, tears streaming down her troubled face.

“She went through a lot of things, Dr. Debbie. Are we going to have to tell it all?”

“We’re gonna miss her, Dr. Debbie,” she whispers, as she, ever maternal, continues to grieve her impending loss.

“Before she leaves us to go with mommy, I’m going to ask each of you to tell her goodbye,” I less than enthusiastically offer, for I too am somewhat wistful.

“Thanks Judith, for taking such good care of Little Grace Ann.” [+]

Anticipating the difficulty of this day, I have picked a red rose from my garden. I present this token of affection to Judith.

“Nobody ever brings us flowers,” Dr. Debbie.

“5-4-3-2-1. I need Little Grace Ann.”

“I din’t mean to make Judith cry all night. She says she can’t go with me to Mommy.

Looking withing, she tearfully implores,

“Judith, you happy for Little Grace Ann?”

A nodding Judith gazes upward.

“She says yes, Dr. Debbie.” [+]

Little Grace Ann presents with her version of The Hurt, dated April, 1952, neatly contained within the pages of a pink, spiral-bound notebook. She begins,

“I not like the water pipe, [the] handcuffs. It be berry, berry dark in the closet . . . had to stay in closet all night. . . then he came to get me in the early am. . . if you not cry, i’ll take you out. . . he say, I going to make you feel better. . . he tickled me. . . telled me to rub his hot dog. . . remember. not to cry or i’ll put you back into the closet. . . I try not to cry, but I cry inside and go to my safe place. I told you not to cry. . . now you have to go back to closet. . . he dragged me up the stairs and threw me back into the closet. . . my hot dog roll. . . you bad, bad girl. . . Jennifer, 9 ½ takes the pain for me.” [#; +]

Reluctant to become an unwilling participant in an unnecessary abreaction, I interrupt,

“We talked a lot this week about all the bad things that have happened. You wrote to me [in] two notebooks. Is there anything else bad you need to tell me?” I ask.

“Just that [they] made [older brother] hurt me when I was tied on the bed with the ropes. I love [him], but why he have to do that to his sister?”

“You say I a good girl now,” Dr. Debbie.

“You’ve always been a good girl,” Little Grace Ann.

“The things they told you were never true.”

“You said I could go be with mommy. I want to do like JoAnn and Jenny dooed. Strong Man Jesus says I have to do one thing. I haves to look in the mirror and not say I be ugly and bad [+]. *She removes the stuffed toy, Humpty Dumpty, a Christmas present given to her by the older siblings, from the canvas bag. While she has delighted in their thoughtfulness, she has been reluctant to play with the stuffed egg due to his mirrored belly.*

“Grace Ann. You never be a bad girl and you not ugly. Strong Man Jesus be with you since your Mommy and Daddy not be with you. It not be your fault. Judith, thank you for taking care of Little Carol Ann like a mommy should. I thank you for always reading me stories when I have nightmares. I love you, Judith. Keep the happy Grace Ann in your heart”(sobbing).

“Jennifer, tell Dr. Debbie all your hurts, you’ll feel better when you tell them. You have to tell, O.K.. Jennifer?”

“Janice, you get ‘barassed all the time. I love you so much, but I want to go be with mommy. I’ll stay in you in my heart, O.K.?” [+]

Placing Humpty Bumpy tenderly out of harms way, she picks up the red bat and, looking around the room, states,

“I don’t know which one to do first. . . don’t know which one I hate most.”

“I’m mad at you for. . .” she cries, as she gives voice to a lifetime of emotional pain.

Furiously, without remorse or restraint, she beats, until finally, depleted and wheezing, she whispers,

“Thank you Judith, Jessica, Jennifer, Strong Man Jesus, for giving me the strength. Now I want to go be with mommy. I don’t want to hurt no more.”

“Dr .Debbie. can you readed to Grace Ann?” she tiredly implores. [+]

Covering a small portion of her body with the peach, satin-trimmed baby blanket, she reclines on the floor.

“Can you see mommy?”

“Uh, huh,” she nods while smiling.

“Will you give her something for me? Will you give her this yellow rose?”

“She sayed thank you, Dr. Debbie. She’s very proud of me. She sayed she and Strong Man Jesus picked you special.”

Kicking off the worn pink, summer flats, she, never opening her eyes, says.

“Goin` to put on [the] white shoes mommy byed me.”

“Dr. Debbie, she says keep pushing the Big Lady hard, O.K., Dr. Debbie.

“Little Carol Ann, we’ve got to see you pout,” I chide.

Beaming, surrounding with an angelic glow, she lovingly mimics her long-lost mommy.

“Come on honey, I rock you,” she tenderly consoles.

Then addressing me, while never opening her eyes, she informs,

“Strong Man say he always be with us, since we be babies . . . I sorry I gived you a headache.”

[+]

Gently arousing herself, she removes not one but two books from the ever present canvas bag. Familiar with the drill, I proceed to read LAm Growing and The Hurt. Curling-up, cradling Humpy Bumpy and Mommy’s yellow rose, she resembles a contented cat in blissful repose. . .

“Grace Ann is going to grow up to be happy and healthy, and never has to go back to the bad people, or think of the bad people, not ever, ever, ever.”

Is there anything you need to say, [Grace Ann]?

“Thank you Dr. Debbie, thank you Strong Man Jesus. I love you.”

“Bye, Bye, Little Grace Ann,” I tearfully say, as I prepare to sing the soothing lullaby.

Incongruence reigns, for within the still sleeping countenance, a familiar pixie-like voice can be heard.

“She looks peaceful, Dr. Debbie. No more hurts for Little Grace Ann,” she whispers, seeming to be reluctant to arouse the napping child.

Then, without a moments hesitation, Jessica bolts upright, startling me and disrupting the surrealistic ethereal calm of the room.

“Ooh, [a] yellow rose. . . it’s bootiful. I glad I don’t have to do that. Where the comb be, I need to comb my hair ”

“We bringed bubbles to celebrate, Dr. Debbie. She worked hard, Dr. Debbie. No more hurts for Little Grace Ann. Now you know whose turn it be?”

“It be Jennifer’s,” is my reply. [+]

I can see the blushing cheeks, and almost feel Jennifer cringe.

Jennifer

August 28th arrives. Jennifer, wearing the trademark peach tee shirt and Little Grace Ann’s tiny gold cross (a gift from Mommy and Daddy), presents with a large shiny apple “for the teacher.” Handing me a journal dated 1961, I notice she has meticulously identified seventy hurts. Relieved that so much work had been done outside the session, I hopefully inquire,

“You’ve done such a good job of writing these out, is there any need to read them today?”

Grimacing while shaking her head, she replies.

“No. Dr. Debbie ”

“Is there anything else we need to remember?”

“It just scares me if I see any symbols. If we go by the recycling place, I see the symbols. The symbols scare me. That scares me, the symbols (graffiti).”

“After today, the symbols won’t scare you anymore,” I optimistically suggest.

“All these voices kept flashing in my mind and strong Man Jesus said I could just write them out for you.”

“Dr. Debbie, [you] said one time that MPD was a curable defense to a very extreme trauma. Thank you, Dr. Debbie and Strong Man for showing me how to laugh and have fun. . . . We are one with Strong Man Jesus’ and Dr. Debbie’s help.”

“I want to get all the anger out. . . . Strong Man Jesus asks me to look in the mirror. . . . They all said we were ugly, ugly, born of a bad breed. . . . that your real parents didn’t want you. That’s not true.”

“What do you need to have happen today to put this behind you?” I ask.

“Get the anger out,” is the now standard reply. [+]

Locating Grace Ann’s Humpy Bumpy; Jennifer defiantly gazes into the eggs mirrored belly. Oblivious to all that surrounds her, she, in a most grown-up voice, solemnly states,

“Strong Man Jesus says you have to look in the mirror. They all said you were ugly, ugly, ugly, and they all said you were born of a bad breed. That your parents didn’t want you and your other foster parents didn’t want you. They all lied to you, too. That’s not true. Strong Man Jesus said that you’re not ugly, that your real mother really wanted you, but that she couldn’t take care of you because she had a nervous breakdown because of our Father. The other foster family that took care of Little Grace Ann really loved us. They loved us and wanted us. . . . Strong Man

Jesus kept us alive . . . [Strong Man Jesus] says I don't have to be hurt anymore. . . ." [+]

Jennifer spends a relatively short time pounding the perpetrator bears with the renowned red batacca. At the conclusion of this mini-session, she asks if she might be able to stay awhile, as she is just too tired to return home. Fortunately, we have chosen an unused office for the healing, so she is covered with a blanket more adequate than the customary tiny baby blanket and left to regain her strength. The office manager keeps a constant vigil, for she remains in peaceful repose, smile upon her sleeping face, for the afternoon. Unfortunately, we can only afford her five hours of this uncustomary bliss, for the end of the work day has arrived and we, also exhausted by the day's events, must go home.

Barressed Janice

October 3rd is chosen for 'Barressed Janice's Healing Day. Arranging the room to accommodate the now familiar production, Janice, in a private world of her very own, addresses the father and priest bear as they are removed from the now weary garbage bag.

"Today is October 3, 1964. Dr. Debbie said I could set up for my healing. . . You'll never put your hot dog in my hot dog roll ever, ever, ever again. . . . You can't hurt Dr. Debbie either. . . . You're so mean. . . ."

And to Mrs. Lang, the Social Worker bear,

"I don't like you, I hope you get put in jail. . . . You should never have taken us away from the [nice foster family].

"How many other children did you do this to? . . . Don't let children see their mothers and fathers. . . . You can't ever put any other children into homes to be hurt ever again. . . ." [+]

To the aunt bear, the aunt with whom the client's elderly mother now resides.

“I don’t like you either, you won’t let us see our mother. . . Dr. Debbie says it’s O.K. to cry, that when you’re hurting. It’s O.K. to cry. . .”

Janice carefully assembles HER books, those that have brought meaning and support to her pre- adolescent curiosity. Where Do Babies Come From, Why Boys and Girls Are Different, How You Are Changing, and Love, God, and Sex are among the treasured selections. It’s My Body, a children’s book of empowerment, is allocated to a place of honor. [+]

“I will miss you, but thank you, Jessica, for always making me laugh, and for helping me play, cause we never could play. . . for teaching us how to color and play bubbles. . . Jessica, pretty soon you can come to be with us. . . you make my heart so happy. . . but right now you have to help Judith. . . I love you, Jessica. . . Jessica you helped us all.”

“Judith, thank you most of all for helping . . . You’ve been the strongest one. . . you’ve been like a mother to us. Don’t be afraid to tell Dr. Debbie. . . Thank you for taking us to Dr. Debbie’s safe pretty room where we weren’t so scared. . . Thank you for always helping us in school and everything. Thank you for helping shy ‘baressed Janice.”

“Thank you Dr. Debbie for telling me it’s O.K. to cry and for never giving up on us. . . Please help Judith to heal, too. Dr. Debbie. Please help the big lady. Teach her like you teached me. Judith, Strong Man Jesus, please take care of Dr. Debbie, O.K.? You can help a lot of children. I wish you could be our mother. . . that you could come live with us. . . It’s O.K. to cry.” [+]

Presentations are made all around. A plaque, engraved with the alter’s names and healing dates, is placed on the playroom door. A tiny gold crib protecting a smiling, sleeping child, is unwrapped. Attached to either side of the treasure is a blue engraving. The first announces the babies healing day, and the second, to my astonishment, tells of Jaqua’s. I had not been aware

that Jaqua, too, was fifteen months old, and could spontaneously integrate once an alter with shared memories was relieved of her hurt.

Jacqueline, aware of Janice's need for have a birthday party, supplies an assortment of balloons, color-coded plates and napkins, and a chocolate sheet cake (all of our favorite) decorated in Strong Man Jesus' colors. Pictures are taken to preserve the happy occasion. Once again Little Grace Ann's Humpty Bumpy is placed into service. [+]

“Janice, you have to do what Strong Man Jesus told you to do with that mirror, don't you forget to do it. Grace Ann. . . I'm going to come to be with you soon. . . We love you, Little Grace Ann, but we know that you're with mommy and you're tired 'cause you've been hurting for a long time. . .”

“Judith, you were so pretty and you were a good nurse. . . you have Strong Man Jesus' eyes. Tell Dr. Debbie all your hurts. . . I know you're scared to death, but tell her all your hurts. . . Thank you Judith for helping Janice. . .”

“Since we have already gone over all the hurts, what needs to be done today so you can be healed?” I ask.

“We're going to be able to see all the babies. . .”

“You're going to have a very important job, Janice. . .” [+]

Pulling a purple tee shirt onto her body, she indignantly addresses her internal advocate.

“Judith, I is working. . . Strong Man Jesus said we can wear his color. . . we going to be with Strong Man Jesus and Mommy and all the little children that they killed. . . [Foster mother], you were wrong. . . [You told us] if we looked at the mirror [it] would break. You were wrong.

Strong Man Jesus says he doesn't make ugly children. . . I'm not ugly. . . We don't crack mirrors "

"Grace Ann, you'd better move over 'cause I'm gonna come and sit on Mommy's lap with you."

"You have an important job. . . we're going to need you to help us," I offer.

"When you see the Big Lady get 'barrassed, you know it's me. . . Thank you, Dr. Debbie."

"You're more than welcome, Janice."

"Dr Debbie, would it be alright if I lay on the sofa with the Big Lady's George, because only good people can sit on the sofas and Strong Man Jesus says we were never bad. . ."

"You know you're welcome to sit on the sofa," I genuinely reply.

"No more stomach aches, no more nightmares, no more bruises. My goodness, I think I'd like to come with you, [Janice]!" [+]

Clutching George in one hand and a picture of mommy in the other, the soon to be integrated alter crawls to the couch, proudly positioning herself as if having just received an honor.

"Judith and Jessica, make sure you work as hard as you can," she encourages.

"Strong Man Jesus and Mommy, I'm coming to see you."

I sit in a thankful silence. I watch as she peacefully sleeps, the multi-colored balloons floating overhead, the ever-protective George tucked lovingly under an arm. I feel as if I to have exited reality, and have, without ever moving, stepped into a impressionist painting, where everything is muted and surreal. As her chest gently rises and falls, in an unhurried rhythmic repose, I feel my own breathing calming as well. I am certain that her tranquil smile is now mine.

“Who is with us?” I ask the sleeping soul?

“All healed Janice,” is the serene response.

“Thank you Dr. Debbie, thank you for everything.”

“Goodbye, Janice,” is my heartfelt reply. [+]

The “Aprise”

Blissful, jubilant, and elated can not adequately describe our enthusiasm. Dr. Nancy (the secretary), thrilled by the lessening interruptions, asks if I can do this with all our more challenging clients. Dr. JoAnn and Dr. Dolores, counselors in training, request updates at each staff meeting. Dr. Gentry, Grace’s primary care physician, phones to share in the good news. Grace’s friend stops by to thank us, to share that Grace has been exceptionally calm, has ceased stuffing her food, and for the first time that she can recall, is sleeping restful and well. It is decided that the final integration will take place on Grace’s birthday, some two-and-a-half weeks away. No longer amnesiac, Judith, fourteen-and-A-half and Jessica, The Boss, have decided to join the others in the system, while Grace has requested that Strong Man Jesus, her inner self helper, not take part in the final fusion. Still angry at God for “allowing me to go through this,” Grace is honest in her unwillingness to forgive. She is also uncomfortable with her post-integration coping skills, and feels it is to her benefit “not to have to do this alone.”

Judith and Jessica are joyful in their preparations, busily scurrying around as if orchestrating an Olympic-caliber event. Judith, typically the adolescent voice of restraint and reason, appears resigned to defeat, and is half-hearted in her attempts to reign in her mischievous friend. Amazingly, one seems as excited as the other, as together they smugly announce their impending surprise.

“I not tell Dr. Debbie. We has a ‘aprise for you. . . Judith says I not tell.” [@]

The long-awaited day arrives, the culmination of three years of rewarding, but intensely emotional work. Judith, attired in Strong Man’s purple tee shirt and sporting Grace Ann’s very precious Australian black opal and diamond ring, arrives early to prepare for the upcoming performance. Once again the animals are placed in a semi-circle, all within Grace Ann’s easy reach. Another cake has been prepared, this time with yellow icing,

“ ‘cause Strong Man Jesus says we gonna have sunshine in our lives.”

Unable to contain her infectious enthusiasm a second longer, Jessica again blurts,

“We have a ‘aprise for you, Dr. Debbie,” and hands me a slender box wrapped in a child’s purple construction paper.

“Remember what you always said, Dr. Debbie, that the greatest gift we could give our therapiest bee’s our own healing.” [+]

Inside the box is a lovely heart necklace, engraved with the initial, D. I decide this is no time to resume my lecture on gifts.

As I look upward to thank Miss Jessica for her kind gift, I find myself face to face with Strong Man’s unmistakable, omniscient smile. Holding a carnation tinted in purple, he lovingly offers,

“Dr. Debbie, this is to remind you that I am always with you.” [+]

I am touched by (their, her, his?) thoughtfulness, and make a mental note to place both gifts in a place of honor in remembrance of this day. This has indeed been a wonderful ‘aprise.

After three years of being one step behind, I should have known better, for this is hardly the final act of the play. . .

As I gaze into the contented, peaceful, tranquil smile, I begin to understand the meaning of "Your Serene Highness." A pink rose appears. Knowing that pink is neither Judith's nor Strong man's signature color, I am at first perplexed, then dumbfounded.

"Dr. Debbie, I have something special for you. . ."

Lowering His head, he removes the purple name tag, selecting from the garbage bag a small pink and white bear labeled Little Grace Ann. Eyes sparkling, a tiny voice is heard to say,

"Hi, Dr. Debbie, I be Little Grace Ann. Judith says I come to her healing. I rested up and Judith axed if I could come . . ." [+]

Am aware that tears are streaming down my cheeks.

"I be sleeping for a long time. I sleep on mommy's knee. Jenny and JoAnn be sleeping, too, and Janice be taking care of all the babies. . . Strong Man Jesus said I could come back and be with Judith 'cause that was her 'quest. That's what Jessica sayed.

"I tell you what [Little Grace Ann], this is one surprise. I didn't know you could do that!" [+]

"Strong Man said I could," she quietly offers.

"Strong man can do anything he chooses. . ."

"Dr. Debbie, Mommy be rocking, rocking, I don't even have to pout . . ."

She revives the all too familiar petulant pout.

"She's helping Janice find other children. . ."

I am given a small present, less than neatly wrapped in pink construction paper. Inside is a picture of Humpy Bumpy, "all put back together again."

Little Grace Ann proceeds to give me two additional roses, one for Baby Jenny, the other for Baby JoAnn.

“Strong Man has to take Little Grace Ann back to Mommy,” she says. No fear or discontent can be heard in her voice.

“Strong Man really surprised me.”

“Were you ‘apriized,” the uncharacteristically quiet Jessica chimes in.

“I was apriized,” is my reply.

“How will I know when your talking to me?” I genuinely ask.

“You’ll know when you’re working with little children. I will come and help. . . when you see my eyes, they look like mommy’s .”

“They are sparkling right now,” I assert.

“I’m all healed. I love you Dr. Debbie. . .”

“O.K., Strong Man, take me back to mommy.”

As if an afterthought, she comments as she sees my eyes settle upon Judith’s small gold cross. A gift from mommy before taken “to the bad foster home,” Judith tells of hiding her precious token of better days in the heat register so her foster parents would not take it from her. Several months ago, I had answered a call from a sobbing Judith, devastated that she had lost mommy’s cross. Pointing to the inexpensive but ever so precious necklace, all healed Little Grace Ann explains,

“It’s Judith’s cross. Judith losed it, but mommy helped her find it. Jessica taped it on her hand.” [+]

Once again there is a drop of the head. Blinking, I am face to face with an old friend, Jaqua.

“Jaqua, I haven’t seen you for awhile.”

“Thank you for helping us and helping the Big Lady. Thank you so much for never giving up on us.”

“How are you feeling now, Jaqua?” I ask.

“I’m wearing the Big Lady’s opal. Judith asked me to. I’m happy, Dr. Debbie.”

I am handed a peach carnation. Familiar with its owner, I ask,

“Barassed Janice, are you still blushing?”

“Dr. Debbie, mommy helped me find all the babies. . .and they were all whole and happy.”

“How do you feel, Janice?”

“I feel very good, Dr. Debbie.”

“I’m so glad. It’s so good to see you smile.”

“Strong Man Jesus ‘splained [*do I hear Jessica?*] it to us all and Jessica is the only one who doesn’t understand.”

“Jessica will probably never understand,” I chuckle.

“What did Strong Man say?”

“Dr. Debbie, he said that when we all got rid of our hurts we would still be [a] part of Grace, not the Big Lady, and all the good things about us. He said that she needs a lot of help because she has all these new feelings that we took for her and she doesn’t know what to do about them.”

[+]

Attempting to inject a degree of humor into this suddenly somber occasion, I ask,

“So, is Grace going to be a real pill?”

Little did I know that I would live to regret that statement.

“Love you, Dr. Debbie.”

“I’m so glad you’re happy,” is my final reply.

Lowering her head, she removes the peach name tag, stating,

“Strong Man, you have to get whoever is next.?” [+]

I watch as a beige stuffed bear is re-labeled, Judas. I am again presented with a purple flower.

“The first time I saw you, you looked mean, Judas”

“I almost ran from the room.”

“You scared me so bad I wanted to cry.”

“You scared me so much I almost changed professions. . .”

“The lesson you taught me. . . was to go to go for the pain first.”

“I wish you could tell that to Grace. She’s not willing to get help, Judas offers.

“No more mean looks, Dr. Debbie. . . you remember that in your therapy.”

“I figure if it worked for you, it will help for someone else.” [+]

We have now resorted to using Snow White and the Seven Dwarfs. Judas picks up a dwarf, formerly Sleepy, now named Jennifer, and fading away; Jennifer states,

“I don’t have to go through another bad Halloween.”

Handing me a pink carnation, she continues,

The Big Lady thinks she’ll be healed by Christmas. She doesn’t know she’ll be healed by her birthday.

“Uh, oh, I didn’t talk to her. I guess I messed up on that. It will be a surprise.”

A green carnation appears next. Familiar with its owner, I remark,

“Hello. [its been a] long time!”

Turning to Grace's friend, Nancy,

"Thank you, Nancy, for helping the Big Lady when she didn't have any money."

"Dr. Debbie, we're going to help you get organized. The Big Lady has taken all of her money out of her savings. . . out of her retirement, too."

"I didn't know that, Jennifer, I'm worried . . ."

"Don't worry about it Dr. Debbie, Strong Man Jesus will provide for us."

With a nod of the head, Jennifer turns to the half-empty garbage bag, removing, none other than the Velveteen Rabbit, alias, Jessica, The Boss.

"Hi, Dr. Debbie.

"Guess who!" I reply, amazed that some things never change.

"How you bee'd?"

"I bee'd fine, thank you."

"Dr. Debbie, I din't tell the secret that Little Grace Ann was coming back, first time I kepted a secret!"

"I be a party girl. Strong Man Jesus sayed I could still be a part of Grace but not the Big Lady. Strong Man Jesus say, Jessica, 'you be getting a little stubborn-headed like Judith and Big Lady.'"

"Hurry up, open presents Dr. Debbie!"

"We love you bunches, Dr. Debbie. Twelve kisses and hugs to you."

"Dr. Debbie, you'll hear me 'casionally. . . We're going to all be together, and we're going to be Grace. I still rite in Jessica's dishunary. It not bee'd Grace's dishunary. I luv you bunches, Dr.

Debbie. . . Judith, don't you be scared. You gonna be all right. Then you and me be with Strong Man Jesus. You're gonna be fifteen, not fourteen and a half."

"Dr. Debbie, one last time, would you teach Jessica how to get Judith?"

"Not in this lifetime, Jessica."

"Oh, alright, Dr. Debbie," she huffily responds.

And in a blink of an eye, the Party Girl is gone. [-]

"I Want to be with Bob"

"Dr. Debbie. I'm scared. Strong Man Jesus told me I have to tell you one more thing."

Judith presents me with a red rose, then, a yellow rose as well.

"Would you give this [yellow rose] to the Big Lady?"

Looking around the room,

"That's the first time I got balloons. They have Strong Man's colors."

"Who got them." Dr. Debbie?

"Who do you think got them, Judith."

"Strong Man Jesus, he can do anything."

Anxious and somewhat melancholy, Judith sighs, then matter-of-factly states,

"I want to get it over with, Dr. Debbie." [+]

Reaching into the now empty plastic bag, she removes a poster. Since this is new to me, I inspect the picture closely. Standing on a hillside is a young girl with braided hair, about Judith's age. Facing what appears to be a field, or prairie, the child stands, hands clasped behind her back, head hung as if in despair.

“This is Judith’s prairie. No one could hurt us [there]. Now I don’t need this picture because we are not alone anymore.” [+]

One by one she pounds the captive bears. Then, turning to me, she offers,

“Strong Man Jesus is going to help you talk to people. . .”

Turning inward to Strong Man,

“Thank you, Strong Man Jesus, for letting everyone come to my healing. Strong Man Jesus, will you hold Judith and Jessica and let her [them] be a part of the Big Lady? She doesn’t know how to sew, or to do anything.”

And then addressing herself,

“Judith, you’re not stupid no matter what they said. You’ve got to help Grace deal with all these feelings ”

“Dr. Debbie, I’m ready to be with Strong Man Jesus. Thank you, Dr. Debbie.

“Why are you crying?” I ask. “This a happy time.”

“Now will you help the Big Lady, Dr. Debbie?”

“I’m tired, Dr. Debbie.”

As I nod my head, she turns within,

“Jessica, we have to go to a party.”

Always ready for a party, Jessica, one more time, springs into action.

“I luv you Dr. Debbie. Do you still know Jessica?”

“I’ll always know Jessica,” I reply, with a mixture of joy and sadness.

In referencing the alters reappearance in order to help Judith to the other side, Jessica asks,

“How’re you going to write this in your paper, Dr. Debbie?”

“I have no idea, Jessica, I don’t think I’ll even try. No one would believe me anyway.” [+]

I am reminded of Dorothy in The Wizard of Oz as Grace, formerly known as the Big Lady, situates herself of the office sofa. Lying down, she clutches Strong Man’s balloons, the Velveteen Rabbit, alias, Jessica, a picture of Mommy, and the remainder of the garbage bag’s toys. I half expect a tornado to rush in and whisk us all away to the safety of Auntie Em. Has this been all a dream?

“I love you all very much. . . I’m still going to help you, Dr. Debbie.”

Tearful once more, I begin the now standard lullaby. I now know the meaning of the Biblical phrase, “The peace that passes all understanding,” for I know no words to adequately describe the serenity in the room this day. I listen, as Grace’s internal chorus chimes in for the song’s second verse--

Lulay, thy little, tiny child,
Bye, bye lulee, lulay. . .
Lulay, thy little, tiny child.
Bye, Bye lulee, lulay.

Then, in the barest of whispers, I hear,

“Dr. Debbie, I can see Bob, and he’s whole. And the other soldiers are whole, too. Thank you, Strong Man Jesus. Thank you all.” [+]

Chapter IV, Phase Three: A Transpersonal Approach (The Third Year) has included (a) a turning point, i.e., the shift from the conventional treatment of Dissociative Identity Disorder to an acceptance of Strong Man as Inner Knower. It has also reviewed the narrative account of (b) the healing, Strong Man’s facilitation of the integration process.

Phase Four: Termination and Referral**A Tremendous Breakthrough**

Christmas 1994

Dear Dr. Debbie,

Grace Ann has had a tremendous breakthrough . . . She was able to sit on a stool in the handicap bathroom and look in a mirror for the first time in her life and see me, Strong Man Jesus. In the mirror she saw GOOD Little Grace Ann's 3 ½ happy face. She saw Jessica's 6 ½ year old face and recognized [her]. She recognized all their faces. She was sitting totally nude, and Janice 12 ½ years old got 'barressed from the top of [her] head to [the] soles of her feet. Janice made Big Lady Grace put on a shirt. Jessica 6 ½ helped Janice. . . Reaching down, I have shown her a little of all these good strengths. . . from Good Little Grace Ann 3 ½ to Judas 14 ½.

Thank you, Dr. Debbie.

Strong Man Jesus [~]

Ever determined, Grace Ann has been successful in ferreting out long-lost relatives, and has wrangled herself an invitation to spend the Holiday season with Mommy and Daddy's (the good mommy and daddy!) granddaughter. Not only is she joyously returning home healthy and whole, she will be spending Christmas as a part of a family. She is 'beside herself' with happiness! Thrilled to "be normal," as she puts it, she invests her long-denied energy and enthusiasm into baking her famous pound cakes and altruistically wrapping cross-stitch presents for friends she has not met. Several therapy sessions are scheduled only to be canceled, as she "just does not have time." It is a vevv happy time. . . {*: ^: #: ~}

The early winter passes uneventfully. Grace Ann attends one hour of therapy per week, partly due to financial issues (she has long since exhausted her “mental health allowance” allocated by United Recovery Systems, and has amassed an enormous bill, which I “know” will never be paid), and partly due to my concern with her still excessive dependence. She joins an Adults Molested As Children (AMAC) group, and is faithful in her Weight Watcher’s attendance. *(She meets Richard Simmons, and basks in his encouragement. She even gets a kiss!)* She resists returning to church, stating,

“I still haven’t made my peace with God!” [#]

When asked if she is ready to integrate the final alter, Strong Man Jesus, she vehemently shakes her head and refuses to speak. . .

Aftermath

March arrives, and with it, the Winter Solstice. The phone calls, long-since ceased, return with a vengeance. While the caller identifies herself as Grace Ann, I begin to wonder if the integration is “breaking-down.” Concerned, but unwilling to return to our previous level of therapy *(No way! I have no intention of going there again! The constant calls, the barrage of letters, the never-ending supply of journals)*, I arrange for the client to attend a Life Skills program sponsored by the local social services department. She attends one session, but is allegedly told she is not suitable for group membership. I arrange for her to work with an adult therapist through the community services board. She presents for several sessions, but refuses to return. I contact Grace Ann’s psychiatrist in hopes of gaining therapeutic support. None is forthcoming. [=; %]

Strong Man Jesus calls.

“I’m trying to help you, Dr. Debbie. She’s so angry with me. She can not hear my voice. She has shut me out. Pray for her, Dr. Debbie. It breaks my heart to see her in so much pain.” [=]

By now, Grace Ann is on a mission. Incensed that “children are still abused every day,” she, without my knowledge or approval, contacts her now eighty year old biological father (whom she has not seen in forty-four years), demanding that he lend her the five thousand dollars needed to retain an attorney to, of all things, sue him! When (*not surprisingly*) he refuses, she proceeds to badger him with allegations of her own molestation. He hangs up! [=]

The stressors mount. Grace Ann is informed, by letter, that she no longer has a health-care position. The facility, as has been rumored, is indeed shutting its doors. As of the end of March, she has no job, and consequently, no health insurance. [~]

Dr. Johnson, the kind and empathic orthopedic surgeon, has been diagnosed with a neurological disease rendering him unable to operate. As a result of his misfortune, Grace Ann is referred to a colleague, who, upon reviewing her medical history, informs her he is unwilling to perform surgery on “psychiatric patients.” [=]

The mental free-fall continues. I am now the recipient of a barrage of angry attacks.

“Why did you integrate me?”

“You liked my alters, but you can’t stand me.”

“Don’t talk to me about no Strong Man Jesus!” [*; ^; =; ~; >]

The calls continue. Boundaries are, once again set. Behavioral contracts are signed. Grace does not, or can not, comply.

The crowning blow comes in May when, Grace Ann hears of her father’s death. The inner turmoil rages as she tries, unsuccessfully, to forgive him for his neglect. Once again she attempts

to contact her mother, this time to simply wish her a Happy Mother's Day. This time it is her mother, not her aunt, who answers the phone. Delighted, Grace Ann proceeds to introduce herself, only to be interrupted with,

"I don't have no children. Don't call here again!" [=; @]

A Thwarted Hospitalization

We continue in this tenuous, haphazard fashion until June, when, in what has now become a typical encounter, Grace Ann announces she has phoned the licensing agency, informing the counseling board that I have stolen one hundred thousand dollars of her money. Incredulous, I attempt to speak rationally with a tantrumming, irrational adult. Unsuccessful at penetrating the client's armor, I ask *her [forcefully]* to leave the counseling room. She refuses. I arrange to hold the following session in the adjoining office. While in session with an unsuspecting client, Grace Ann continues to hold the room hostage while screaming obscenities at the top of her lungs. I interrupt the second session to again ask her to leave the building. She again refuses. The screaming continues. I inform Grace Ann that an Emergency Custody Order will be necessary if she does not vacate the premises voluntarily. She leaves, but upon returning home, proceeds to place call after threatening call to the office. Finally, the day, as well as my patience, are exhausted. I contact the local police, requesting they transport the groundless, illogical client to the local hospital for a mental health assessment. According to the intake records, she arrives, viciously vocal, threatening the police officers as well as the staff consultant. A four-hour Emergency Custody Order, then twenty-four hour Temporary Detention Order is ordered, with a commitment hearing scheduled for the next morning. As is required by law, Grace Ann is to be

examined by a hospital physician prior to the hearing. Her personal physician is informed of her involuntary admission. [%]

Nine a.m. arrives. I enter the padded detention room, along with the transporting officers, the judge, Grace Ann's court-appointed attorney, and the staff physician. (The psychiatrist chooses not to attend.) Grace Ann is questioned as to the purpose of her behavior the previous evening. In a low-pitched, repentant voice, she sorrowfully offers she would never have acted that way if I had only returned her phone calls. All eyes turn to me. I feel the fury rising, as I confront her with the most recent ludicrous accusation. Her attorney objects to my retort. I am overruled, and advised by the judge to avoid unsolicited information. The staff physician is questioned. She reports no unusual findings, and volunteers she has contacted Grace Ann's psychiatrist, who also, does not support an involuntary hospitalization. My turn finally arrives. I first turn to the staff physician, asking if she has attended to the self-inflicted cuts and burns I "know" are there. Somewhat abashed, she replies, "no," but agrees to attend to Grace Ann's physical needs as soon as the hearing is over. I attempt to explain that the client has MPD, and that, while I have no idea which alter created all the fuss, she has simply switched to a different state of consciousness in an effort to avoid hospitalization. My feeble explanation is met with quizzical stares, a shuffling of feet, and silence. [%; >]

Grace Ann is released, with an admonition from the judge to behave herself. I, openly furious, spin on my heels and stomp out of the room, through the corridor, and into the deceptively sunny day. Upon reaching my office, I am informed that the hospital has called to arrange for Grace Ann's next appointment. Shaking as I dial the number, I, far from subtly, inform the innocent receptionist that there will be no more appointments, that they let her go, and she's their

responsibility now. I do not ask, but am told, Grace Ann is once again rocking . . . rocking . . . rocking, while chanting, over and over,

“Dr. Debbie told us no one would ever hurt us again! . . . She lied . . . Why does Dr. Debbie hate us so?” [>]

Termination

I've just had it! I can not continue the merciless work. I feel like the Little Red Hen, with no one to plant the wheat or bake the bread but everyone willing to come to the table. I have resisted hospitalization after hospitalization in an attempt to best serve Grace Ann's needs. What about my needs? No one seems to be particularly concerned about my mental health! I asked for help with Grace Ann, and in my heart, I know if the hospital would have forced an admission, I would be able to work with her still. All she needed was a "time out," a time to once again gather her ego strength and accept direction (and comfort) from her own inner knower. She has all her answers within her, yet she refuses to "listen." I don't know if I'm madder at her, or for her.

I have learned a very bitter lesson from the "thwarted" hospitalization, a lesson that has made me even more determined to terminate with Grace Ann. I have asked for help, time and time again, and none has been forthcoming. Should I continue with her, were I able to continue with her, I have no reason to believe I would receive assistance now.

I proceed to make referral after referral. No therapist, not even one, will accept her. She, unbelievably, is terminated by Social Services due to, you guessed it, repeated boundary violations. Her primary care physician, realizing I can not longer put out the fires, locates a

Baptist minister with some sort of a counseling background. Grace Ann begrudgingly begins with him, only to cease treatment.

I agree to hold three, only three, termination sessions over the next month. They prove to be bittersweet, for I, too, miss the client I knew so well and had grown to admire. However, my deep intuitive sense (my own inner knower?) tells me I can no longer meet Grace Ann's needs. Perhaps if from Day One I had been more experienced in establishing, and enforcing boundaries, I would not be so "burned-out." It is obviously too late to repair that damage now. The transference is just too entrenched. The fatigue is all-consuming. The dull, thudding headaches seem to never go away. The frustration is overwhelming. I, like the "old" Grace Ann, have become hyper-vigilant, a ringing phone now causing every muscle to tense. A mild paranoia has set-in, for I expect to be harassed the moment I walk through the office door. Easily agitated, I find myself struggling to curb my tongue. I am working hard not to allow Grace Ann's antics to permeate my caseload. It is a difficult time.

Grace Ann presents for these termination sessions clad in a grey. It is not until the last meeting that I jolt upright in recognition! The alters had always attended sessions attired in one of their many signature colors! No one ever wore grey! What does this mean? (*My immediate impression is that grey is the color of uncertainty!*) Tentatively, for I don't want to open this door, I ask,

"Whose color is grey?"

My former client looks down, wrings her hands, and whispers a barely perceptible,

"Mine . . ."

"But who are you," I ask, even though I really don't want to know.

“I am Job,” was the feeble, and repentant reply.

Job, well how appropriate! Grace Ann’s internal family now includes the long-suffering servant from the Bible.

I listen to the tale of this latest alter’s creation. According to Job (*copresent with Strong Man Jesus*), Grace Ann’s hospital ordeal had again triggered memories of confinement and abuse, leading her to dissociate. Job had been created so that she could once again escape to her “safe, free place.”

Strong Man entered the conversation, dejectedly shaking his head.

“I pleaded to her to let me help her. . . . She wouldn’t listen Dr. Debbie. She’s shut me out of her life.” *Apparently Grace Ann continues to be repelled rather than comforted by her own inner helper’s presence!*

It is with a great deal of sadness that I learn the entity that had been responsible for all the hospital ruckus was not Grace Ann as I had thought, but the newly created alter named Job.

The Conclusions

Chapter IV, Phase Four: Termination and Referral (The Final Six Months) has described the last stage of the therapist’s work with Grace Ann Hughes. It has celebrated the initial exhilaration of a tremendous breakthrough. It has concluded with the more somber path through (a) aftermath (c) a thwarted hospitalization, and (d) termination.

Chapter Five

Inductive Analysis

An Introduction

Chapter V provides an inductive, chronological clinical analysis of the case, and is divided into the four phases outlined in Chapter Four. The analysis explores each phase of the treatment process, the client's response, and, in retrospect, its effectiveness. Phase One: Exploratory (The First Seven Months) addresses (a) the referral (b) intake and initial presentation (c) the clinician's Adlerian orientation (d) the advent of managed care (e) Pandora's Box, i.e., the client's allegations and complex symptomatology (f) phase one treatment strategies (g) the emergence of borderline pathology, and (h) a diagnosis confirmed.

Phase Two: Standard Treatment of Dissociative Identity Disorder (Eight Months to Two Years) provides an analysis of the conventional treatment techniques historically associated with DID, along with their application in this case. This analysis addresses the first and second sub-areas of investigation cited in Chapter I, which are, the treatment of Dissociative Identity Disorder by traditional, psychoanalytic/medical model psychotherapy, and the functions of the "altered states of consciousness" within the client's personality system. The following areas of treatment are discussed: (a) issues of safety and trust (b) a return to journaling (c) medical consultation (d) introduction of the altered states of consciousness (e) the bulletin board system of communication (f) internal group therapy (g) abreactive therapy/screening (h) the creative arts: poetry, play, and art therapy (I) issues of loss and grief (j) reconstructing a life (k) burgeoning ego strength (l) dissolving amnesic barriers (m) the healing power of humor, and (n) minimizing minutia: dodging the details.

Phase Three: A Transpersonal Approach (The Third Year) provides an analysis of the evolution from a traditional medical model approach of treatment to that of a transpersonal orientation. This analysis addresses the remaining two sub-areas of investigation cited in Chapter I, which are, the functions of the Internal Self Helper (ISH) in the integration of the client's fractured self, and the theoretical orientation of the therapist along with its impact upon the treatment process. Phase Three describes (a) a turning point, i.e. the shift from the conventional treatment of DID to an acceptance of Strong Man as Inner Guide, and (b) the healing, the narrative description of Strong Man's facilitation of the integration process.

Phase Four: Termination and Referral (The Final Six Months) provides an analysis of the period following the last integration. It includes the initial exhilaration of (a) a tremendous breakthrough, then follow a more somber path through (b) the aftermath (c) a thwarted hospitalization, and the emotional toll of the eventual (d) termination. In conclusion, Chapter V offers transpersonal psychotherapy, with its emphasis upon ego transcendence, as a feasible alternative in the treatment of Dissociative Identity Disorder.

A chronological clinical analysis is utilized in this case. The ongoing comparison between/among emerging categories of information is essential to "develop an understanding that encompasses all instances of the process, or case, under investigation" (Denzin & Lincoln, p. 202). Interpretation is necessary to understand the relationship between the specific and the whole (Kincheloe & McLaren, In Denzin & Lincoln, 1994). Interpretive theory represents "a set of subjectivist assumptions about the nature of the lived experience and social order" (Holstein &

Gubrium, In Denzin & Lincoln, p. 262). It consists of “images, theories, ideas, values, and attitudes [that] are applied to aspects of experience, making them meaningful” (p. 263).

Phase One: Exploratory
(The First Seven Months)

The Referral

Grace Ann Hughes was referred to me, sight unseen, one rainy November day. While I was more than delighted to have a client, perhaps any client, I certainly was not professionally prepared for the events to come. I had no baseline, no norm by which to couch acceptable therapeutic behavior. In addition, I added “insult to injury,” in essence, invited abuse by allowing her to contact me at home. In retrospect, I may have, inadvertently set the stage for the boundary violations that were to come.

There was a positive aspect to this referral. Grace Ann, recently discharged (I believe quite prematurely) from a sexual abuse treatment program, benefitted from my new status as a private practitioner, as well from my willingness to provide unconditional support. It remains a very real possibility that she would have been remanded to long-term care, possibly even institutionalized, had I not been such a acquiescent resource.

Intake and Initial Presentation

Grace Ann’s intake and initial presentations, erratic as they were, were handled professionally and with compassion. Whether “all in her head” or not, she was in real pain, and I was genuinely afraid for her well-being. However, I feel confident that at this initial stage, countertransference was not an issue, i.e., my concern and dismay did not transfer to the client. Grace Ann reported many times during our work together that, although she did not trust me completely during these

early days, she felt I was a compassionate, non-judgmental individual who would provide the single consistent niche in her otherwise fragmented life.

The client's history was taken through the use of Dr. Fred Adair's Biographical Index Blank. Upon reflection, the structured interview format of this document may have stabilized these initial sessions, adding substance to what otherwise might have been a therapeutically inconsequential period of time.

The Clinician's Adlerian Orientation

Adler's Individual Psychology prepared me well for this introductory work with Grace Ann, for it addressed both the panic disorder and the painful depression. Grace Ann was discouraged. She was searching for significance. It appeared her adult life was permeated with Adler's Basic Mistakes in the Private Logic, erroneous beliefs based upon half-truths and outright fabrications. Among these basic mistakes, these immature representations of the child's world, were cognitive distortions, minimalizations, overgeneralizations, devaluations of self-worth, perfectionistic views of life and its demands, and the introjection of faulty values. Conflict, primarily internal in her case, had served to immobilize her. She experienced herself as stuck, when, in effect, she may have been unwittingly creating her own antagonistic feelings, ideas, and values. At this point in the therapy, Grace Ann appeared to me, to be the creator, not the victim, of her painful emotions.

Perhaps most compelling was Grace Ann's inadequate lifestyle. Void of social interest, she seemed to lack the courage needed to meet Adler's Life Tasks of love, work, spirituality, and an understanding of her place in the universe. From an Adlerian perspective, her degree of social interest could be equated to her level of psychological dysfunction. While she quite obviously existed in a world of her own choosing, Adlerian's have observed that, even in cases of extreme

pathology, an individual does not relinquish social interest in its entirety. To develop a clearer picture of Grace Ann's current isolation and despair, we would turn to her primary socializing unit, the family. *(For a more thorough review of Adler's Individual Psychology, see Chapter II.)*

The Advent of Managed Care

Managed care proved to be the bane of our existence. It was indeed an unfortunate time to become ill, for there was no room in a brief system's school of thought for an individual with this level of pathology. I am reminded of Jean Banks' admonition to refrain from addressing issues of trauma. Especially frustrating were Grace Ann's declarations that in twenty-plus years of monthly insurance premiums, she had only been hospitalized, briefly, once.

Our work was hindered by the current trend toward managed care. While there is no doubt spiraling medical costs must be checked, it would have been most helpful if an independent review process had been established. *(We were allowed to appeal to the insurance company.)* Long-term policy holders, such as Grace Ann, who had demonstrated a history of respect for the system, could have been rewarded accordingly at the onset of a catastrophic illness.

(Note: My extraordinary contempt for the continued abuse at the hands of Grace Ann by her managed care company was expressed in a meticulously documented letter, sent to the head of the U.R.S. medical staff, and copied to her primary care physician, psychiatrist, and my attorney. Within a few short days, I received a call from Jean Banks, requesting that I join her for lunch. However, before a date could be arranged, The U.R.S. Managed Care Contract was canceled by Grace Ann's employer. Coincidence or not, I was happy to see them go . . .

Pandora's Box

Grace Ann's complex symptomatology, i.e., morbid obesity, intrusive flashbacks, and allegations of sexual abuse would have proved difficult to manage if I had been a seasoned professional operating under optimal circumstances. While my Adlerian mixed-bag of techniques served me well, I recorded in my case notes that I [was] more successful (*and [met] with less resistance*) when I abandon[ed] my well-manicured therapeutic plan, and instead, [chose] to follow the client's lead. I also noted my discomfort with this awareness. Upon reflection, it seems obvious that Grace Ann's unrelenting symptomatology forced me to fine-tune my observational skills, and to rely as heavily upon the subjective skills of creativity and intuition as I did my clinical training. As has been stated previously, the complexity of this case led to a subjective inquiry, and consequently marked the beginning of my own inward journey.

Initial Treatment Strategies

Traditional psychology has long regarded Dissociative Identity Disorder as severe pathology, a psychological aberration, the body's defense against the repetitive trauma of emotional/physical/sexual abuse (Kluft, 1985; Putnam, 1989; Ross, 1989). Treatment has typically involved a long-term, psychodynamically-oriented approach, the goal of which has been the integration of the individual's fractured self. Numerous and seemingly paradoxical techniques may be employed, with little consensus among the therapeutic community as to what constitutes to most effective treatment modality Braun, 1985; 1988). Fortunately for Grace and me, most treatment strategies employed during our work together proved appropriate and beneficial, for the frequency and duration of the panic attacks decreased, the depression abated, and her overall affect improved. In retrospect, the single exception was the untimely administration of the DES

and DDIS, whose direct questions regarding issues of abuse, I believe, contributed to an immediate and severe decompensation.

Bibliotherapy was invaluable during all phases of Grace Ann's treatment, and provided an effective avenue by which to address the inner family's varied developmental needs. Particularly helpful were Doleski's (1983) The Hurt, Adams (1990) The Silver Boat, Gil's (1990) United We Stand: A Book for People with Multiple Personalities, and Lobby's (1990) Jessica and the Wolf. Journaling, while perhaps overused by the client, proved to be a ready path of communication among the altered states of consciousness, as well as between the system as a whole and me. Grace Ann was instructed from *day one* to journal, but not to re-read the emotionally-charged material. Upon review, I am most pleased with my insightful admonitions, for the written word provided an emotional outlet while minimizing the likelihood of re-traumatization. In addition, her carefully recorded journals provided an accurate and thorough account of our work together.

The food addiction recovery program/group served three purposes. First, by forming this group, I was able to provide Grace Ann an opportunity to develop social interest, a long-time deficit area. Secondly, the program, which I named The Many Faces of Addiction, was not limited to overeating. Instead, it was designed to address the cycle of addiction itself, and encompassed not only food, but compulsive exercise, overspending, drug and relationship dependence, and workaholism. By couching her morbid obesity within the addiction model, Grace Ann gained a clearer understanding of the never-ending cycle. A self-avowed "workaholic, walkaholic, and foodaholic," Grace Ann frequently applauded the applicability of this treatment regimen. *As an added bonus, Grace Ann's weight dropped steadily throughout our work together. At termination, she had shed almost half of her pre-therapy pounds!*

The introduction of cognitive restructuring techniques was greeted by Grace Ann with, “Well, I’ll try,” and proved to be only marginally effective in symptom stabilization. In retrospect, these techniques were introduced early in treatment, at a time when Grace Ann’s ego strength was at its lowest ebb. Perhaps the strategies would have been more beneficial had they been introduced at a more appropriate stage of the treatment process. Grace Ann was simply too fragmented to respond to cognitive direction. In retrospect, these suggestions were developmentally inappropriate for the, as yet, unrevealed altered states of consciousness.

Of all the techniques utilized, experiential exercises, the affective ‘experiencing’ of an emotional trauma, proved to be Grace Ann’s favorite. She embraced the big red bat (*the battaca*) with intensity and fervor. To my pleasure and surprise, she requested that she be allowed to take one of the bats home, “so I won’t have to call you every time something comes up.” As I have stated previously, “needless to say, I [was] enthusiastic in my donation.”

While Grace Ann practiced her affirmations only sporadically, the Guided Imagery I entitled A Walk in a Country Garden was played numerous times each day. (Several audiotapes had to be recorded due to the wear-and-tear). I initially expressed concern that the seemingly obsessive use of the relaxation training procedure, recorded in my voice, might be based in a continued dependency upon me. Whatever the original intent, the broad effect was positive, and resulted in the creation of brief periods of relative peace, a respite from her otherwise tortured self.

The Emergence of Borderline Pathology

If there was a certain downfall in our work together, it would clearly have been my inability to consistently address the seemingly limitless boundary violations. Upon reflection, Grace Ann’s excessive dependency needs would have been far better served had I restricted the number and

and length of therapy sessions, limited, or perhaps, denied phone calls between sessions, refused all calls at home, and declined all requests (*no matter how innocent*) to discuss my family and/or personal life.

While the imposition of clearly defined boundaries appeared unnecessarily harsh at the time, Grace Ann would have benefitted greatly, like it or not, from the establishment and consistent implementation of ironclad therapeutic guidelines. As I have stated previously, I simply had no appropriate reference as to what constituted appropriate boundaries when dealing with this extraordinary level of pain.

Dissociative Identity Disorder: A Diagnosis Confirmed

Grace Ann's PTSD/Borderline/MPD diagnoses forced me to become proactive, to vigorously seek out information on the treatment for these conditions, for nothing in my academic training had prepared me for these, complex and unrelenting, diagnoses. Consequently, the treatment techniques that I gleaned from my extensive research proved valuable. Not only did the definitive diagnosis demystify, and in some odd way, normalize, Grace Ann's erratic behavior, it served to provide a much needed sense of direction for both the client and therapist. The end result for me was a reduction in fear and a sense of heightened competence.

Phase Two: Standard Treatment of Dissociative Identity Disorder

(Eight Months to Two Years)

Standard Treatment Techniques

Upon reflection, Grace Ann's investment in the healing process may well have been the function of her trust in both the therapist and the therapeutic process. Safety and trust, within the treatment room, were neither compromised nor up for debate. This assurance may have set the

stage for recovery from the debilitating PTSD symptomatology. It also helped her overcome her fear of what she felt was the “craziness” of Dissociative Identity Disorder. However, in retrospect, I believe the absence of clear boundaries may have sent Grace Ann a mixed message, may have threatened her sense of safety, and ultimately, contributed to her untimely demise. In retrospect, my inexperience with borderline symptomatology combined with the intensity of her acting-out behaviors (e.g., up to thirty angry phone messages per day, unscheduled appearances at the office door, and refusal to leave the premises following her *scheduled* appointments), prevented me from setting therapeutic boundaries with the clarity and firmness she needed.

As referenced in Chapter V, Phase One, journaling continued as an invaluable treatment tool throughout our work together. This technique provided an emotional outlet for Grace Ann, a means of dialogue for the inner family, and a source of information for me.

The introduction of the altered states of consciousness began in earnest with Little Grace Ann’s declaration of, “Dr. Debbie, i dint make no snow angels!”

One by one each member of the unlikely band unveiled his previously hidden self. A review of the dissociative research (See Chapter II) has suggested a client will remain in therapy for an average of 6.8 years prior to the initial alter presentation (Putnam, 1989). Grace Ann was in treatment with me for less than one year before Little Grace Ann trusted me sufficiently to let down her guard. Therapeutically, I am most proud of this stage of treatment, for once trust was established, the presentations flowed freely.

Two techniques fostered communication among the alters. Putnam’s (1989) bulletin board system of communication allowed the altered states to address the host, Grace Ann, to express their needs and desires, and at times, to tattle and act like, well, children. The hallway bulletin

board resembled a reporting station, the place “everyone” went each morning to organize the day. While the bulletin board provided a means of communication to the “outside world,” internal group therapy (Putnam, 1989), the dialogue among the altered states of consciousness, provided a means of communication for those on the inside. The behavior of this inner family resembled that of any other. Some days bickering continued nonstop, while on others, there was a sense of unity, each member exhibiting a fierce loyalty to the system that was her home. Internal group therapy proved to be a vital precursor to the eventual dissolution, and ultimate integration, of the altered states of consciousness.

Abreactive therapy, also known as screening (Putnam, 1989; Ross, 1989), allowed Grace Ann to revisit the trauma of her past by projecting the painful image onto an imaginary, external screen. Prior to introducing this technique, Grace Ann’s intrusive memory recall virtually ruled her life. Once she learned to screen, she was able to gain control of the unrelenting triggers by recalling the event, processing it (*without becoming immersed in its emotional content*), and letting it go. I must confess I had doubts as to the effectiveness of this technique prior to presenting it to Grace Ann. However, the abreactions were so painful, emotionally and physically, that I decided to give it a try. It proved to be one of the most useful, and frequently utilized, of the standard treatment techniques.

The creative arts: poetry, play, and art therapy were helpful in many ways. The hands-on therapies provided a physical outlet for Grace Ann’s oftentimes fragile emotional state. If she was too distraught, or fragmented, to verbalize her feelings, she could at least draw. Art therapy supplies were never more than a stone’s throw away. The expressive therapies allowed her to tap her creativity, to quiet her restless mind, and frequently, to access her inner family. The

therapies allowed her to explore a very different facet of her adult personality, for her lifetime of eighteen hour nursing shifts had left her little to seek out alternative avenues of expression. The creative arts were highly effective in reaching the developmental needs of the child alters, and, as an added bonus, the children thought they were great fun! Grace Ann, too, began to take pride in a side of her she never knew existed.

While grief and loss issues permeate traditional psychotherapy, they are especially poignant to the clinician working with dissociative individuals. Grace Ann mourned her mother's abandonment, a lost childhood, the alleged abuse by those she had trusted, the loss of what life "should" have been. It was vital that these issues be addressed if Grace Ann was to be spared a lifetime of subjective sadness. We relied on Cashdan's (1988) Object Relations Therapy to help Grace Ann reconstruct the pieces of her shattered life. Obviously, she had experienced inconsistent parenting, splitting, unstable bipolar representations, and many years of ungratifying relationships. (For a thorough review of Object Relations Therapy, see Chapter II.) Cashdan had stressed forgiveness, deserved or not, as a necessary component in healing. Bibliotherapy again surfaced, as Grace Ann and I again turned to The Hurt, Doleski's (1983) tale of redemption and forgiveness. While her heart may not have been in it, Grace Ann gave it her best shot! She was often heard repeating the affirmation, *"I forgive you for not being what I needed you to be. I forgive you and I set you free."*

Interestingly, Grace Ann's list of her transgressors never included God. When questioned about this, for I been told many times that she "felt angry and distant from God," she vehemently replied, *"How could a loving God allow those things to happen to little children. . . I'm still angry at God. I know I shouldn't be, but I am. I hate Him for what those people did to me!"*

The traditional psychotherapist working with an individual such as Grace Ann would seek to foster the development of ego strength (Is this another name for the Internal Self Helper?) Oddly enough, Grace Ann's ego was strengthened by her simmering anger. She was angry with her mother, and then with the system that took her away. She was angry with Child and Family Services, allegedly a protection agency, for allowing her brothers and her to remain in an abusive foster home. She was not angry, but furious, with the False Memory Syndrome Foundation. How dare they accuse her of lying! However, instead of the anticipated decompensation, Grace Ann reached deep within and channeled her outrage into pro-activity. She was on a mission! I observed a now burgeoning ego strength as she determined to right the injustices of her past.

As Grace Ann's ego strength increased, there was a slow, but steady, dissolving of amnesic barriers (Braun, 1985; Kluft, 1985; Putnam, 1989; Ross, 1989). As trust in me, in each other, and in the process grew, her mind's artificial walls, originally constructed to guard against trauma, and then fortified due to repeated violations, began to crumble. Honesty ruled, and for the first time, I felt as if we were on the same ship, sailing in the same direction. In addition, we learned to rely upon the healing power of humor, for the childrens' light-hearted antics provided a much needed respite from our sobering weekly grind. It was a joyful therapeutic time.

Dodging the vivid descriptions of Grace Ann's early life proved to be an ongoing, and at times, marginally successful feat. When I was able to rise above the details, Grace Ann's "truths," a forward momentum could be maintained. However, when the allegations were incredulous, or Grace Ann was in insufferable pain, empathy, perhaps sympathy, took precedence over good therapy. Emotional set-backs invariably occurred. Upon reflection, my inability to steer clear of

the land mines was a clear by-product of my inexperience. Had I been more seasoned, we both would have been better served.

Phase Three: A Transpersonal Approach

(The Third Year)

A Turning Point

Dissociative Identity Disorder as an Altered State of Consciousness

Psychology has historically equated an altered state of consciousness (ASC) with severe pathology, i.e., psychosis, Borderline Personality Disorder, Paranoid Schizophrenia, or Dissociative Identity Disorder (Braun, 1985; Putnam, 1989; Ross, 1989). Accepted as a means of survival in the latter, these dissociative altered states have characteristically been viewed as ego-bound fragments of infirmity, acknowledged for their regressive rather than transcendent capabilities (Walsh & Vaughan, 1993; Boorstein, 1996; Scotton, Chinen, & Battista, 1996). While some cultural traditions have valued an association with the transcendent, Western psychology, rooted in the personal, has typically medicalized an individual's supra ordinary experiences (Walsh & Vaughan, 1993).

An extension of Maslow's humanistic psychology, the transpersonal paradigm does not reject the choosing, creative, self-actualizing capacities of mankind espoused by psychology's third wave, but instead expands the traditional, materialistic, scientific paradigm to encompass the extraordinary (trans) experiences of the individual (Walsh & Vaughan, 1993). Psycho-spiritual in orientation, the paradigm accepts an individual's perceptual reality, subjective in nature, as interpretive. Consciousness is viewed as multidimensional, with the ordinary waking state but one place of awareness (Boorstein, 1996; Scotton, Chinen, & Battista, 1996). A non-ordinary state of

consciousness (NOSC) is regarded as a highly valued dimension of the psyche, with the expansions of self-boundaries known to provide inexplicable insights. Therefore, consciousness restructuring (Tart, 1973) does not accept as inevitable the onset of a pathological state. Instead, the NOSC is viewed as a change in the relationship between self and ground which can indeed result in regression, but which may shift a person towards spiritual growth or transcendence as well (Washburn, 1995).

The Causality Debate: Traditional, Medical Model Approach

Adherents of the traditional/medical model approach might suggest Grace Ann's Dissociative Identity Disorder/Post-Traumatic Stress/Borderline Personality Disorder diagnoses represent the most therapy-resistant known to mental health practitioners, i.e., the ultimate mental illness. The practitioners of this school would likely attribute Grace Ann's pathology to (a) a genetic and/or biochemical organicity (after all, her mother was diagnosed with Dementia Praecox, the precursor to modern day Schizophrenia), (b) incompletely processed memory fragments, i.e., the winter solstice, sensory stimulation or, (c) polyfragmentation, i.e., non-metabolized, multi-layered memory fragments (Kluft, 1985; Putnam, 1989; Ross, 1989). The current prevailing school of thought has gone so far as to dismiss Dissociative Identity Disorder as legitimate pathology, choosing instead to couch the symptomatology within the framework of the borderline personality (Wilson, 1998 [psychiatric consult]). However, I believe, if one has ever met a Dissociative Identity Disordered individual, one will discharge, posthaste, this therapeutic viewpoint. There are borderlines whose symptomatology mimics that of DID, but Grace Ann, in my opinion, was certainly not one of them.

Transpersonal Assumptions

However, when examined through a transpersonal lens, the case may be offered, not as fatalistic pathology, but as (a) an extension of Maslow's (1964; 1969; 1972) peak experiences, i.e., an individual's innate capacity to surpass the limits of the bounded ego, (b) Grof's (In Walsh & Vaughan, 1993; In Boorstein, 1996) spiritual emergency, i.e., healing through activation of the central archetype, (c) Wilber's (1977; 1979; 1980; 1996) pre/trans fallacy, the erroneous assumption that the mystical/trans-rational state is simply a pathological manifestation of, or perhaps in keeping with, Grace Ann's fundamentalist Judao-Christian convictions, (d) Washburn's (1994; 1995) regression in the service of transcendence, i.e., the "withdrawal" of the Dark Night of the Senses, and "spiritual awakening" following the Dark Night of the Spirit. From a transpersonal perspective, each of Grace Ann's altered states of consciousness (couched in environmental, physical, intellectual, soul, and spiritual experiences) would be acknowledged, not as psychosis, but as varying planes of awareness, i.e., multidimensional reality. This restructuring of consciousness would allow Grace Ann, if she so chose, to honor her innate drive toward an ultimate state, even under the most thwarting of life's circumstances (Wilber, 1977, 1979, 1980, 1996; Washburn, 1994, 1995).

The Role of the Internal Self-Helper

Although victims of the dissociative experience frequently report the presence of internal self-helpers, spirit guides, deities, or spiritual beings who claim to have transcended the abuse, traditional psychotherapy, embedded in the personal realm, has minimized, often derided their role in ego restoration. The emergence of these enigmatic inner sources of wisdom is acknowledged throughout dissociative literature, however, little consensus exists among traditional/medical

model professionals as to their function within the client's personality system. These supra-ordinary states of consciousness are frequently identified, but seldom explored. As a result, the role of ego transcendence in the treatment of this severe pathology remains controversial, and in need of further research.

Traditional psychology's stance toward the internal self-helper aside, this alter may, depending upon one's theoretical orientation, be viewed as psycho-spiritual in nature. Allison (1974) characterized this altered state of consciousness as an inner voice of wisdom, "so unique a relationship, it has to be experienced to be believed" (as quoted in Putnam, 1989, p. 203). Interestingly, Allison reminded us we can find this internal self helper in non-dissociative identity disorder patients, as well as within one's own self.

Putnam (1989) described the internal self helper as the spiritual center of the individual. Kluft presented the inner knower as a "serene, rational, and objective commentator and advisor" (Kluft, as quoted in Putnam, 1989, p. 202). Comstock (1987) attributed mystical qualities to some North American inner helpers or centers. Ross (1989) offered, "Some therapists feel that the centers have transcendental abilities including healing and psychic powers" (p. 114). He later addressed these supra ordinary states of consciousness from his own perspective, describing them as "watcher angels in our culture" (Ross, 1995, p. 201), and hypothesized that is was most helpful for a therapist treating this severe pathology to possess an artistic and spiritual discipline.

Since 'Strong Man Jesus' certainly fits these positive descriptions from the literature, given his wisdom and equanimity in guiding Grace Ann's integration of the other alters, it is only natural to consider him as a transcendent rather than regressive altered state of consciousness. By

employing Washburn's concept of regression in the service of transcendence as presented in Chapter Two, the Internal Self Helper can be seen to perform both functions. Thus the perspective from transpersonal psychology is more heuristic and has greater explanatory power than does the standard medical model view in the case of Grace Ann, and, given the literature on internal self helpers, perhaps for Dissociative Identity Disorder clients in general.

The Clinician's Theoretical Orientation

I reflect upon the life of Grace Ann Hughes as I snatch a precious few early morning moments in my garden. The peace that I encounter here is so unlike anything Grace Ann, in her fragmented state, has ever known. Strong Man, Grace Ann's Internal Self Helper, has provided her only solace and respite. Serene and ethereal, He has served as protector, guide, healer. . . the Source, the Ground. Strong Man has championed the unlikely band, applauding or chastising the internal family as He deemed necessary. It was to Him that each member turned for guidance and reassurance. It was He who comforted them (and me) as they told of their hurts, and He who quelled their painful abreactions. It was Strong Man who produced and directed their integrations. And it was Strong Man who, one by one, welcomed the alters home. In the end, it was Strong Man who grieved Grace Ann's incessant determination to self-destruct.

Grace Ann enjoyed one blissful year of wholeness. A traditional/medical model psychotherapist might suggest the lack of full integration was the result of polyfragmentation, or that her seemingly insurmountable psycho-social stressors (loss of employment and home, abject poverty, unrelenting knee pain, and deaths of her long-estranged biological parents) had led to her psychological instability and final demise.

The transpersonal clinician might accept these rational interpretations to hold some level of truth, but would likely look beyond the bounded ego for a broader understanding. Grace Ann refused to integrate her internal self helper, her spiritual core. While the child alters gleefully and without reservation acknowledged the presence of the inner knower, choosing to return home to Strong Man, the egoic (based in the personal) Grace Ann remained angry and distant from her external God to the bitter end. Perhaps it was her fundamentalist faith that proved her greatest obstacle. Perhaps, as Almaas has states, Grace Ann failed to “find God independently from the opinion of others” (Almaas, 1990, p. 57).

“How could a loving God allow this to happen to little children?” she would question.

“What did I do that was so bad that He would let me live in this Hell?”

I believe that in refusing to integrate her spiritual core, Grace Ann ceaselessly spiralled, with no hope of grounding, or peace. The fear, hatred, and abandonment she felt within was, in time, projected onto me. I, as her therapist, became the target of her unhappiness, and ultimately, her vitriol.

Much reflection has gone into my analysis of why I was able to accept Strong Man Jesus’ guidance. I realize that literally a lifetime of events has prepared me for this experience. *(For a biographical account of my unfolding transpersonal awareness, see A Therapist’s Journey in Appendix B.)*

My own “understanding” had evolved from a doctrinal, historical, external context to an inner knowing, a mystical awakening to unbounded potentialities. I reluctantly concede that if I had been more experienced, or perhaps even more successful with a traditional treatment approach, I may, in all likelihood, have been disinclined to follow Strong Man’s lead. If I had not felt

bewildered and incompetent, I certainly would have been less willing to depart from my well-rehearsed psychoanalytic path. The struggle had weakened my confidence. My ego had been sorely bruised. I embraced my own inner knower out of sheer desperation, and came to rely upon my internal source of wisdom, not due to religious conviction, but because I had no other choice.

I had been officially introduced to transpersonal theory by my Advanced Theories professor, who had kindly listened to my anxious babble about this perplexing case. As I paused to take a break from my incessant dialogue, he turned, lifted a well-worn copy of Walsh & Vaughan's (1993) Paths Beyond Ego, and effortlessly located Wittine's Postulates (*refer to Chapter II*). He suggested that I purchase the text, that this might shed some light upon the circuitous (*and unusual*) path I had undertaken. I followed his advice, and when my edition arrived, I voraciously digested not only Wittine, but Wilber, Huxley, Walsh, Vaughan, Boorstein, Grof, and Ring as well. It was from this initial reading that I drew comfort. Bewilderment gave way to validation. Pathology turned to promise. Strong Man Jesus, Grace Ann's Internal Self Helper, had assumed the role of guide and director of this most unusual play because I, as therapist, had embraced the experience of unbounded awareness.

In retrospect, I now realize how closely this phase of the therapy followed the Principles of Transpersonal Practice outlined by Cortright (1997) in Psychotherapy and Spirit (pp. 229-243). Cortright's principles are as follows.

Transpersonal psychotherapy is a theoretical framework which views psychological work within a context of spiritual unfolding. Grace Ann declared, early on, that she needed to work on her spiritual journey. As I have stated, her request was discounted at the time as non-therapeutic and inconsequential. It was not until she "forced the issue" that I seriously considered

her plea. According to Cortright, early transpersonal clinicians believed (as I must have) that a client's spiritual issues could only be addressed once the psychological work was completed. However, contemporary clinicians now view "spiritual work as emerging in the psychological work rather than after it" (Cortright, p. 230). This certainly proved to be true in Grace Ann's case. She presented for therapy with a complex case that had to be addressed at all levels: the physical, psychological, and spiritual. This appears to be consistent with Cortright's viewpoint that a spiritual (not to be confused with religious) recognition can begin anytime, regardless of the ego's stage of organization, and that psychotherapy, while a facilitator of this process, is not a requirement for it. Cortright stated:

A transpersonal orientation implies an openness to transpersonal content when it arises in the course of psychotherapy. This can take many different forms, from a client's need to be seen and affirmed to his or her spiritual wholeness to the emergence of spiritual or numinous experience in a client's life all the way to more dramatic manifestations such as spiritual emergency. . . . Another part of this knowledge base consists of grounding in traditional psychotherapeutic approaches and recognizing that there are behavioral, psychodynamic, and existential points of entry into a client's experience. Exploration can stop here (as it usually does with any one of these therapies) or it can proceed to any or all of the other dimensions of depth work. The more extensive the exploration, the greater the degree of consciousness which can be liberated (p. 237).

Consciousness is central in transpersonal psychotherapy. Cortright maintained that the an intellectual understanding of transpersonal theory in itself is insufficient to effect change within the client, that "the spiritual intention and aspiration of the therapist, the presence of the therapist, and the therapist's own deepening inner exploration and consciousness work provide the guiding light for the therapeutic journey" (p. 238). My own, [A Therapist's Journey](#) (Appendix B) is certainly consistent with this principle.

Transpersonal psychotherapy is multidimensional and experiential. Cortright asserted that transpersonal psychotherapy is, at its very depths, experiential. Grace Ann and I relied heavily upon the experiential therapies, i.e., “the big, red bat,” journaling, guided imagery, and art and play therapy, for a verbal dialogue, traditional “talk” therapy as it is sometimes called, proved ineffectual in assuaging her pain. I believe we were able to enter the different dimensions of consciousness because we rarely “talked about,” but experienced, Grace Ann’s pain. Upon reflection, this aspect of the therapy was absolutely vital to introduction and healing of the altered states of consciousness.

Transpersonal psychotherapy is heart-centered. This fourth principle provided an ongoing inner turmoil for me in my work with Grace Ann. I felt if I was walking the razor’s edge between two worlds, the detached, somewhat distant stance of the psychoanalytic camp, and the empathic, unconditional positive regard of Roger’s humanistic psychology. How much support should I provide? How could I maintain therapeutic boundaries essential for meaningful work while not shutting down the process by alienating an already abandoned client. I can say that the only peace I had about this was when I quieted my own churning mind, accessed my own inner knower, and addressed Grace Ann’s needs with a “compassionate energy” (p. 240) that seemed, at least to me, to hold all the answers.

Transpersonal psychotherapy is profoundly optimistic and hope-centered. There is no debate as the value of optimism when working with dissociative symptomatology (Cohen, Giller, & Lynn W. (1991). By depathologizing her anguish, couching her pain in a different light, we were able to rise above the trauma of the moment. As Cortright has so eloquently stated:

This means that the therapist continually views the experience of the client as meaningful, no matter how bleak, painful, or apparently random and meaningless it may appear on the surface. It is hard to capture, but the transpersonal perspective brings into view the person's psychological process as a spiritual journey, a more exciting, inspiring view of psychotherapy being sacred work, and a deeper, more profound trust in the process.

This demands faith--faith in the unfolding process, faith that a larger story will reveal itself, faith that a deeper significance will be discovered. This allows a therapist to be with a client's tragedy and pain in a more accepting, spacious way, not just caught up in outrage or sadness or personal reactions on the one hand and not in a closed, hardened, or defensively withdrawn posture on the other hand, but openly and tenderly, holding the client's pain in his or her heart in a way that facilitates the client's being able to be with his pain more fully. A transpersonal therapist has an unshakable belief in the client's movement toward a higher self or greater spirit, and all the wounds, suffering, and stumblings along the way have their contribution to make toward the birth of this emergent being (p. 241).

The transpersonal view of psycho-spiritual transformation extends far beyond the healing and growth of the self. It is my belief, based upon my subjective observations, work with 'Strong Man Jesus,' and unfolding awareness of the transpersonal realms of consciousness, that Grace Ann's incomplete integration was based upon her refusal to accept guidance from her Inner Knower. She was not ready, for whatever reason, to incorporate Strong Man Jesus, choosing instead to isolate her Source and continue in her perhaps, overly comfortable world of pain. I believe this refusal prevented even greater change from taking hold, in essence leaving her beside a half-opened gate which she was too angry, or afraid, to pass through.

Phase Four: Termination and Referral

A Tremendous Breakthrough

It was so rewarding seeing Grace Ann, yes, Grace Ann, enjoy the holiday season so. Ever determined, she had been successful in ferreting out long-lost relatives, and had wrangled herself an invitation to spend the Holiday season with Mommy and Daddy's (*the good Mommy and Daddy*) granddaughter. Not only was she returning home healthy and whole, she would be spending Christmas as a part of a family. She was "beside herself" with happiness! Thrilled to "be normal" as she put it, she invested her long-denied energy and enthusiasm into baking her famous pound cakes and altruistically wrapping cross-stitch presents for friends she has not yet met. Several therapy sessions were scheduled only to be canceled, as she "just [did] not have time." It was a very happy time, and I must admit, I was feeling quite smug . . .

Aftermath

In three short months, everything had changed. The calls returned with a vengeance. Sensing Grace Ann was in need of help, but reluctant to begin this process again, I began searching for appropriate local support groups. She either refused to attend, or attended one session, then called the office in an accusatory manner. Stressors mounted. The health care facility where she had worked for most of her professional career was closing, and even if she could work, she would have no job. Her orthopedic surgeon, a thoughtful and supportive fellow medical professional, had taken ill, and was forced to resign his position. Grace Ann again attempted to develop a relationship with her now elderly parents. Once again she failed. She learned of her father's death, then, shortly thereafter, was fully rejected, one more time by her now elderly mother.

“I don’t have no children. Don’t call here again!” appeared to have been the crowning blow.

It was incomprehensible to me that this process could be starting over. The more I sought external support for Grace Ann and consistently enforced boundaries, the more out of control Grace Ann became. Countertransference, previously a subtle concern, now took center stage. I just could not continue the odyssey. I was, quite simply, burnt out. (For a thorough description of the countertransference of this period and its toll on the therapist, see Chapter IV.)

Termination and Referral

The work had become merciless. There was no one willing to help. In sheer desperation, an emergency custody order was issued, expecting, if she were hospitalized even for a few days, to have some respite from this case. Little did I know that less than twenty-four hours after her detention, I would be called before a judge to plead *my* case. It had never occurred to me that she would not be admitted, or that I would become a villain in not only her eyes, but in the eyes of those in my professional circle.

As has been stated previously, had I been a more seasoned counselor, perhaps I would have established ironclad boundaries in the early days of our work. Conversely, the point should be made, that if I been a more seasoned counselor, I would more than likely *not* have taken her case in the first place. I am not certain why all this happened. I am certain, however, that the circuitous, gut-wrenching, rewarding, exhilarating path I found myself on changed Grace Ann’s, and my life, forever.

The Conclusions: A Feasible Alternative

A Transpersonal Approach in a Case of Dissociative Identity Disorder has offered transpersonal psychotherapy as a feasible alternative to traditional/medical model psychotherapy in the treatment of Dissociative Identity Disorder.

Previously assumed to be most suitable for use with relatively healthy, growth-oriented clients, the emerging paradigm's broader scope encompasses, then enlarges the parameters of traditional psychotherapy, thus offering a new perspective in the treatment of the disorder. This fourth force approach has neither minimized nor negated the vast contributions of psychology's preeminent theorists/clinicians (Cortright, 1997). This is perhaps what has made it such an appropriate compliment to its predecessors. (In fact, its broader scope allowed the clinician to blend traditional therapeutic techniques into those of the transpersonal.) Its unitive orientation transcends the boundaried ego, and in so doing, offers a means of understanding the psyche that is affirming and harmonious, respectful of all cultures and spiritual traditions. The theoretical conceptualizations posited by this early research are in need of further study and empirical validation.

Chapter Six

An Introduction

Chapter VI is comprised of two parts. Chapter VI, Part I, presents an external analysis by Dr. Jenny Wade, a transpersonal psychotherapist, author of Changes of Mind: A Holonomic Theory of the Evolution of Consciousness (1996), and Doctoral Chairperson, the Institute of Transpersonal Psychology, Palo Alto, California. Dr. Wade was recommended to the researcher by Dr. Frances Vaughan, author and psychotherapist in the field of transpersonal psychology. Part I concludes with the researcher's reply to Dr. Wade's external analysis. Part II addresses recommendations for (a) utilizing a transpersonal approach in the treatment of Dissociative Identity Disorder, (b) clinician training, and (c) implications for further research. This chapter allows us to interpret, or the draw conclusions from, Chapter V's chronological clinical analysis.

An External Analysis



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September 4, 1998

Ms. Deborah Berkley-Carter
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Dear Ms. Berkley-Carter:

I've just completed reading the draft of your dissertation, *A Transpersonal Approach in a Case of Dissociative Identity Disorder*. Since you did not ask for a general critique of your work but only an evaluation of its use of transpersonal theory and application, I will confine my remarks accordingly.

I understand the work is retrospective, and in that context, the decisions you made regarding your therapeutic approach, your ultimate evaluation of it as transpersonal, and your conclusions about how to work with this kind of case in future all seem very congruent with transpersonal models (especially in contrast to the first three "waves" of psychological theory, as you observe). On the whole, the stand you have taken seems very appropriate and productive, especially in view of the extreme difficulty of this (first!) case, and your placing it within the transpersonal model is insightful and fitting.

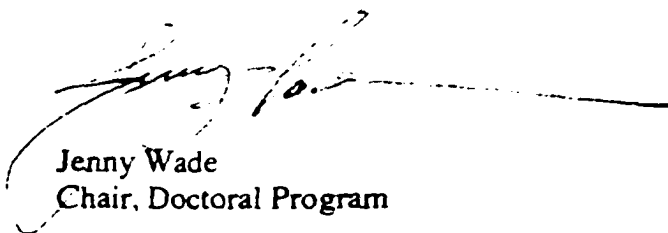
I must, however, admit to some concerns about your literature review, and therefore, the outgrowths in application to your case. Although you have obviously done extensive reading to study all facets related to this case, the transpersonal section seemed overly reliant on a few authors: Boorstein, Walsh and Vaughan, and Cortwright. I would have expected citations from Scotton, Chinen & Battista's *Textbook of Transpersonal Psychiatry and Psychology* and more recent definitions of transpersonal psychology and citations from related case work in the *Journal of Transpersonal Psychology*, for instance. I make all allowance for the immaturity of the field and the lack of both systematic and critical research in transpersonal psychology—and am glad you were critical of the field in your dissertation—but I found it quite surprising that C. G. Jung was virtually overlooked as a resource, especially since his work is prominently used by transpersonal therapists and since it would seem to have a very direct bearing on the archetypal nature of the alters/personalities in DID.

One of the reasons this omission seems so surprising to me is that an archetypal interpretation of alters/personalities seems to be at least as valid as, if not superior to, their interpretation as "altered states." While it is indeed possible to view alters/personalities as altered states, such an interpretation suggests that any personality is a discrete state, which invites many problems for which there is currently no good theoretical basis (so which are "altered?" what does this mean about personality theory). The connection between personality theory and noetics is not at all clear, at present, nor do ~~your~~ your text make this relationship clear. I am not disputing that alters/personalities display distinctly different forms of awareness, but whether these are consonant with what we understand to be personality is a question I do not believe psychology has answered. (In this regard, you might be interested in my book, *Changes of Mind*, which treats developmental stages as discrete states of consciousness. There is a good case for this, I believe, and one that might have direct relevance to some of the pre-, egoic, and trans- alters you were encountering in this case.) It may very well have been more useful to have understood these entities in just the terms you (and the literature) employed: archetypal ones, which would permit an entirely different kind of interpretation and basis for therapeutic approach. John Perry, for instance, used a Jungian approach for some fairly effective therapy with severely disturbed people (schizophrenics, I think; he developed a technique with an unusual name, which I'm forgetting). By and large, transpersonal psychology has not tended to address severe mental disorders, but the therapists I know who are treating people who are severely disturbed seem to use more Jungian than other approaches.

This is not to suggest that you need to rethink your dissertation, but I would recommend including the Jungian literature in your review and I would also recommend it to you in future, if your practice is likely to utilize a transpersonal approach. You might also want to look at the literature on prenatal psychology, which has considerable transpersonal implications and conventional ones (like the formation of defense structures from intentional and unintentional abuse in the womb). This 20-year-old literature and its relationship to transpersonal psychology is summed up in a chapter in my book but can also be found in the *Journal for Pre- and Perinatal Psychology and Health*. It is quite different from the Grof theory and from the usual neurological developmental psychology of early life.

I hope this has been helpful. Good luck with your research and your practice.

Sincerely,



Jenny Wade
Chair, Doctoral Program

**Researcher's Reply
to
Dr. Wade's External Analysis**

**Deborah Berkley-Carter, Ed.S.
The Madeline Center
18697 Forest Road
Lynchburg, Virginia 24502
Phone (804) 239-0003**

October 15, 1998

Dr. Jenny Wade
Chair, Doctoral Committee
Institute of Transpersonal Psychology
744 San Antonio Road,
Palo Alto, California 94303

Dear Dr. Wade:

I wish to begin by thanking you for the time and careful attention you invested in critiquing my work. I am more grateful than you will ever know, and, if possible, would very much like to make your acquaintance. I hope to visit Palo Alto in the near future, as I have a son who is quite interested in ITP's Program of Studies.

Since receipt of your comments, I have purchased Scotton, Chinen & Battista's Textbook of Transpersonal Psychiatry and Psychology (1996), your text, Changes of Mind: A Holonomic Theory of the Evolution of Consciousness (1996), as well each issue of the Journal of Transpersonal Psychology from 1969 to the present. I have spent several months reading these volumes, and have cited them throughout my revised Review of the Literature. Your point was well taken, and I feel the work has been strengthened by your observations.

You expressed concern that Jung's work, "prominently used by transpersonal therapists," was "virtually overlooked as a resource." I would like to address this point. While I wholeheartedly agree that Jung's work set the stage for Fourth Force Psychology, I, at the time of this case, had only a cursory knowledge of his theory and was operating from within my own therapeutic, albeit admittedly naive, comfort zone. However, in retrospect, the circuitous path undertaken, while lengthy, stressful, and certainly inefficient, has only validated my quest. As I stated early on in the work, I was able to arrive at a transpersonal point of reckoning not because of my scholarship, but in spite of it. I am currently pursuing my fourth graduate degree, and have found "answers" in Academia for many years. I feel certain that if I could have "thought" my way out of this dilemma,

I would have. It was only in utter frustration that I was able to “see.” I simply had to find my own way.

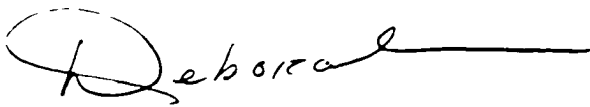
In addition, Jung’s contributions may have been diminished for pragmatic reasons. Initially, the unwieldy Review of the Literature included research in the areas of Ritual Abuse, False Memory Syndrome, Purposeful Dissociation, standard treatment for DID, Adlerian, Object Relations, and Psychosynthesis, as well as the emerging field of Transpersonal Psychology. My committee (very appropriately) chose to limit the areas to be included in The Review. Perhaps Jung’s donations were inadvertently minimized in our attempt to create a workable document. In any event, your comments have been noted and a brief section on Jung as a precursor to the transpersonal field has been included.

In regards to the archetypal vs. the “personalities” or altered states of consciousness debate, I too feel psychology’s historical reference to “personalities” has been an unfortunate misnomer, for it has served to minimize credibility within the field of dissociative research. Chapter V, which I believe was quite sketchy upon your reading, now addresses alternative hypotheses, i.e., organicity, standard trauma theory, as well as the activation of the Central Archetype.

I am fiercely aware that therapists treating the severely disturbed, in particular, Dissociative Identity Disorder, have not utilized a transpersonal approach. However, I am finding that the cases I have seen since Grace Ann have greatly benefited, both in duration of therapy and decreased levels of pathology during treatment (less debilitating symptomology) when I have sought out and relied upon direction from the client’s Inner Knower. I have found this to be rewarding work, and feel that we, as a profession, are on the cusp of an exhilarating, non-medical model approach to understanding this most challenging therapeutic population.

Again, I can not thank you enough for your insightful guidance. Please accept this small token of my deep appreciation. I remain

Respectfully yours,

A handwritten signature in cursive script that reads "Deborah". The signature is written in black ink and is followed by a long horizontal line that extends to the right.

Deborah Berkley-Carter

DBC/jo

Recommendations

Utilizing A Transpersonal Approach in the Treatment of Dissociative Identity Disorder

A Transpersonal Approach in a Case of Dissociative Identity Disorder has presented transpersonal psychology as an appropriate modality in the treatment of Dissociative Identity Disorder, arguably the most therapy-resistant of the DSM-IV classifications (Kluft, 1985; Putnam, 1989; Ross, 1989). The approach has encompassed multiple planes of consciousness (Wilber, 1977, 1979, 1986, 1995; Washburn, 1994, 1995; Wade, 1996), and thereby has provided a multi-leveled developmental/therapeutic framework for the treatment of the disorder.

Transpersonal psychology has offered a non-pathological perspective on dissociative dis-ease (Walsh & Vaughan, 1993; Nelson, 1994; Boorstein, 1996; Scotton, Chinen, & Battista, 1996). In affirming some degree of psychological health, the therapeutic viewpoint serves to validate and hearten the despairing client, who, more often than not, has been immersed within the mental health system, been the recipient of numerous ineffectual diagnoses, and, upon presentation, is likely to be even more impaired than when treatment was first begun (Ross, 1989; 1995)

The transpersonal paradigm has removed Dissociative Identity Disorder's etiology from the treatment process. In this case, the approach has enabled the unequipped and overwhelmed psychotherapist, as I have been, to validate the fear and anguish of the alleged satanic ritual abuse victim without having to become embroiled in the interminable, frequently antagonistic debate (Ross, 1989; 1995)

The dissociative individual has frequently reported the presence of spiritual helpers/guides within the fractured system. The transpersonal paradigm's psycho-spiritual orientation has

provided a means to demystify these oftentimes confusing and frightening experiences. The approach has granted the client permission to incorporate this higher awareness into the healing process, rather than accept this 'knowledge' as 'evidence' of mental derangement or psychosis (Wilber, 1977; 1979; 1980; 1995; Washburn, 1994; 1995).

From a pragmatic perspective, the treatment of Dissociative Identity Disorder utilizing a transpersonal approach may prove to be relatively cost effective. The paradigm teaches healing has begun once the client has learned to accept, rather than rail against, the guidance of the inner knower. Once a transpersonal 'understanding' has occurred, the degree of debilitating symptomatology will likely be lessened, and consequently, the length (and cost) of both inpatient and outpatient treatment may be reduced.

Clinician Training

The transpersonal clinician working with the dissociative individual should assume a broad work view, one which is likely to encompass global psychologies, philosophies, and religions. This multi perspective, relational, multilevel, awareness should allow the therapist to recognize the healing potential in transpersonal experiences. It should provide a means to differentiate between the pathology of psychosis and the transcendence of mysticism, with an altered state of consciousness (ASC) viewed as potentially positive rather than invariably negative in orientation.

Those practitioners trained within this framework (academic, professional, and personal) should be more fully prepared to recognize the relationship between spirituality and the addictive process, an understanding of immense proportions since many dissociative individuals present with substance abuse, eating disorders, workaholism, and/or excessive dependency needs.

Perhaps most importantly, the transpersonal psychotherapist working with dissociative clients

should be more likely to recognize that he, too, is the by-product of a fractured society. Therefore, he may invest in an intense program of personal inner work and spiritual practice (bioenergetics, biofeedback, guided imagery, holotropic breath work, contemplative thinking, meditation, etc), may focus upon ethical training, and may place high value upon service to others.

Graduate Programs in Transpersonal Psychology

Fortunately, we do not need to speculate about how a clinician training program would look.

Two programs within the United States currently offer graduate programs in transpersonal psychology

The Institute of Transpersonal Psychology

The Institute of Transpersonal Psychology offers a Doctoral Program in transpersonal psychology. The goals of the program, as outlined in the 1996-1998 Academic Program of Studies, are to provide (a) academic expertise in transpersonal principles and practice, (b) professional preparation, which includes traditional course work in research, counseling, education, and religious studies, and (c) personal development/experiential training.

The California Institute of Integral Studies

The California Institute of Integral Studies (CIIS) currently offers a Psychology Doctoral (Psy.D.) degree. The Institute's mission is to produce well-rounded practitioners whose professional practice "is rooted in depth of self-knowledge, breadth of world views, and an abiding commitment to honoring and exploring the diverse dimensions of human experience" (Academic Catalog, 1996-1998, p. 65). Both programs of study include, but are not limited to, course work in (a) world religions and philosophies, (b) cognitive therapy and Asian psychology, (c) Taoist and existential psychology, (d) Akido, (e) spirituality, and (e) Eastern approaches to

self, world, and enlightenment. Both programs place emphasis upon the transpersonal student's inner journey.

Personal Reflection

Had I attended either The Institute of Transpersonal Psychology or The California Institute of Integral Studies, I am certain my route to an understanding of transpersonal awareness and practice would not have been as circuitous, or at times, confusing. My academic training had been based primarily in the personal/egoic. My own transpersonal growth was the result of frustration, discouragement, and despair. This period of questioning led me on a haphazard search, and encompassed the likes of Almaas' (1990) The Pearl Without Price, Bucke's (1901) Cosmic Consciousness, Flinders' (1994) Enduring Grace: Living Portraits of Seven Women Mystics, Maslow's Religions, Values, and Peak Experiences (1964), and The Farther Reaches of Human Nature (1972), Nelson's (1994) Healing the Split, Russell's (1966) Love, Scheffer's (1984) Bach Flower Therapy, and Shield & Carlson's (1990) For the Love of God. In addition, I began practicing meditation, researched world religions (with particular emphasis upon the Asian traditions), and was credentialed as a Reiki practitioner.

Had I formally studied this approach, I feel I would have surely done a better job at establishing therapeutic boundaries, the absence of which undoubtedly played a role in Grace Ann's decompensation. As has been stated previously, I unwittingly undermined the long-term effectiveness of the treatment because I gave her a false message. Safety and trust were provided within the treatment setting, but she also got the message that if her maladaptive behavior was persistent enough, she could breach the normal avenues of access to me. Unfortunately, during her decompensation, she played this trump card again. It didn't work, this time wiser and more

realistic. I realized that without professional or community support I could not go through another round with her.

Implications for Further Research and Conclusions

Dissociative Identity Disorder represents but one facet of a larger, societal problem (Ross, 1994). Walsh & Vaughan (1993) suggested that we have collectively dissociated from ourselves, sought outside for answers that can only be found by turning within, denied the mind's many units of consciousness, rejected all that cannot be scientifically proved, and turned our backs on the divine. Ross (1994, p. xii) believed continued dissociative research might provide greater insight into the realm of psychological trauma. He stated:

I believe MPD to be the key diagnosis in an impending paradigm shift in psychiatry, because MPD best illustrates the characteristic response of the human organism to severe psychosocial trauma, and because trauma is the major cause of mental illness from a public health point of view. Trauma, I believe is a major underlying theme in much mental illness including eating disorders, depression, personality disorders, substance abuse, psychosomatic illness, and all forms of self-abuse and violence. Biological psychiatry might obtain more clinically meaningful results if it focused on the psychobiology of trauma and abandoned the search for causality in genes and endogenous chemical derangements.

Nelson (p. 334) offered:

As yet there is no way to conclusively prove the superiority of the open model of the psyche over the closed, or vice versa. Perhaps there never will be. But the stubbornly demonstrable facts of telepathy and other paranormal events, bolstered by the age-old phenomena of channeling and MPD, strongly suggest that human minds are relatively open systems, some more so than others. They also suggest that consciousness is far more than a passive by-product of the brain, and is more complex and universal than any of us can know. The challenge is to come up with new theories that fit *all* the data, rather than ignoring important aspects of human experience simply because they don't fit in.

Cortright (1997) referenced the “marked paucity of research” within the transpersonal community, suggesting the model’s theoretical constructs, while intriguing, currently lack empirical grounding. In addition, research into the treatment of Dissociative Identity Disorder, utilizing a transpersonal approach, has remained sparse to non-existent. This study was undertaken to begin the process of empirical study of a transpersonal approach to dissociative identity disorder. It is this researcher’s conclusion that a transpersonal approach in the case of Grace Ann greatly enhanced the effect of the standard treatment approaches also used. However, much research still needs to be done in this area. The field is in need of a micro-analysis, a deeper level of sophistication in teasing-out how the transpersonal therapist’s approach is different from that of the traditional, medical model practitioner, much like sophisticated research has ferreted-out Rogerian techniques. Three areas of future research are suggested by this study.

First, research should address Wade’s question,

“Is an alter an archetype or an altered state of consciousness?”

A second suggestion would be to examine the level of distrust that serves to alienate clients such as Grace Ann from themselves. Grace Ann was so wounded by her perceptions of the traditional church that she was unable to integrate her own Internal Self Helper. Further research should examine if this was idiosyncratic to her case, or can be found in others. If it is discovered that this phenomenon has presented in other cases, then Transpersonal Psychology would be applicable, as research in the field has already addressed the area of religiously based trauma.

Thirdly, a more systematic comparison of the Internal Self Helper is needed. A possible research questions could be:

“What are the effects of identifying the Internal Self Helper and following its guidance?”

“What are the effects of identifying the Internal Self Helper and rejecting, or minimizing, its guidance?”

“What are the effects of not identifying the Internal Self Helper?”

The Conclusions

In conclusion, Chapter VI, Part I, has provided an external analysis of the research, as well as the researcher’s reply. Part II has offered recommendations for (a) utilizing a transpersonal approach in the treatment of Dissociative Identity Disorder, (b) clinician training, and (c) implications for further research.

Epilogue

My Friend

I have a special friend who
 lives right next door.
 When I cry 'cause its dark in here
 she says I hug you dear.
 I don't get lonely 'cause I can see
 the light.
 Its like daytime, even in the night.

(over, I run out of room)

When I have a bad dream
 and start to scream.
 She be my mommy it seem.
 She not a person like you see
 She is an angel for Katie and me.

She is God's half kinda to live
 with me,
 So they are safe and [so is] me.
 She say, don't worry little ones
 I not far away,
 Even when you grow big and strong.
 I am always next door to stay.

She my friend.
 little kay
(I sleepy now)

Within a year of Grace Ann's untimely termination, a second Dissociative Identity Disorder referral wound its way to The Madeline Center. The afternoon caller was none other than Dr. Sullivan, Grace Ann's psychiatrist. I held my breath and gripped the receiver in revulsion as the respected physician shared a now hauntingly familiar story. Clearly frustrated, he offered an overview of a complex and perplexing case. I nodded with sickening awareness as I heard of

multiple therapists, resistant depressions, debilitating panic attacks, recurring headaches, self-mutilating behaviors, suicidal ideation, repeated hospitalizations, and not surprisingly, the presence of vague, seemingly overlapping dissociative states.

Perhaps Dr. Sullivan sensed my silent reluctance, for he quickly assured me of this patient's relative mental stability, anxiously offering that this individual was not nearly so fragmented and boundarilessness as Grace Ann. He assured me the individual had health insurance coverage, then artfully delivered the blow. Would I be willing to accept this referral? Struggling with the rising nausea, yet strangely exhilarated, I heard my own disembodied voice agree to provide, not therapy services, but a single consultation.

The single consultation has turned into eighteen months of treatment. I reflect upon my hesitation at accepting this second dissociative client as I nervously pace the reception area. The hour of the National Public Radio Broadcast (June 9, 1998; 7:00 p.m.) is rapidly approaching, and I find myself, once again, attempting to quell the rising tide of nausea. *My consultation turned client*, now fully integrated, has been invited to discuss her diagnosis and healing, as well as her recently completed manuscript, When I Was Five: A Personal Story Written and Illustrated by A Survivor of MPD. A bare three minutes into the broadcast, my labored breathing ceases! Fear subsides, pride emerges, and an unsuspecting tear wells as her strong and articulate voice permeates the empty room. *She's obviously not nervous, why should I be?*

I listen with excited anticipation as she matter-of-factly addresses the issue of child abuse, acknowledges this as a factor in her own DID, then firmly closes the door to the non-productive line of questioning. Reframing the process, she shares her gratitude (*yes gratitude*), toward the dissociative process. She is appreciative for her former internal family, and describes joy with life

beyond recovery. Caller after caller congratulates her on her courage, desire to leave the past behind, and willingness to forgive.

Kay's presentation had been similar to Grace Ann's. Little Kay and Katie Did were the system's children. The adolescent (*and persecutor*) alter, originally known as The Bad One, was renamed (*in a stroke of genius*) "Sweetheart" by the client's husband. The Internal Self Helper was called Guide. Having learned my lessons well, I did not balk, but simply followed the procedure painstakingly hammered out in my previous, marginally successful case. Once the Inner Knower was identified, she (*yes, she*) directed the process. Not only did Guide facilitate the ego's integration, she introduced me to the world of automatic writing and past-life regression.

I am no longer amazed, but have come to expect the appearance of a spiritual center in DID clients and non-DID clients alike.

Appendix A

Delores Berkley-Carter L.P.C.
 2486 Riverview Ave. Suite 203
 Lynchburg, Va 24503
 -804-847-7440

To Delores Berkley-Carter L.P.C.
 I give her permission to use any documents, oral and/or
 taped conversations, any photographs, newspaper articles
 reading materials, any audio or video tapes, medical records, &
 files on myself or records I have received regarding my biological
 parents and/or other family members. Letters from the Courtland
 on going just recently, received. Any records, letters I have
 could instructing me not to have any contact with my
 mother.

-Delores give Delores Berkley-Carter L.P.C. permission to include in
 such information received from friends, acquaintances and
 members. Especially the taped messages from the
 people, with their permission on tape.

Getting Better: Graduating from therapy. Some of the
 people I have met in group, have stop going to
 individual therapy or graduated from one on one therapy
 group. I am presently in individual therapy as well as
 going to group therapy. I have been in therapy since
 1992. When I began therapy I had no idea what I was
 facing ahead of me. I have been in very intense therapy
 my multiple personalities. I still see one day when I
 graduate yet it scares me to death. How and when will I
 hit a time?

I am presently having lots of flashbacks and crises. I
 have also become more aware of going to my safe place. I
 sometimes know what triggers them and in
 memory of what has triggered a part
 back to Berkley journaling so I can dis
 therapy. I have found when I
 free the painful things.
 painful things and process.

A. 1. Permission to release confidential clinical data.

②

The painful things will bring me closer to my most feared day, when I have to break off with my current therapist. I have a great deal of respect for her. The most important is, it took me so long to trust her. I now trust well as my inside family now trust her because they are all working together to help me deal with it and graduate! As long as I have been seen as a therapist, a long-term trust relationship that I hurt to lose. I have a fond of trust and love, my goal is to get well. I WANT TO GET WELL.
Dedicated to get Well.

I don't honestly know when I am ready to "graduate". I feel like I have a clock that tells me & my helpers when to take the next step - another topic to be discussed with each step we take, we are growing (and coming up to a new day). I have to think of no more therapy. I know in my heart God's love will eventually turn I believe God is everyone of my therapy. I know life flows and time passes. I have many sessions to go, but today we will fly from nest and try to make it on my own. I know my heart that once I "graduate" and I have a different time adjusting to next therapist. She will be there for me to face all in God's love and guidance.

When "graduation day" comes, I want to hope that perhaps I have survived any form of verbal, physical, spiritual, sexual and ritual abuse. I never want anyone to hurt until they are 43 years old to feel of I.F.C. I never want anyone to waste half their life not being able to feel anything. I still have a lot of work to do, yet I thank God Deborah Berkeley-Later T.P.C. for knowing my good and spiritual, I want to thank her for allowing the privilege of trusting her. I even want to thank her for pushing me when at times when I was of it and I want. I am ever so thankful to her.
 A. I. 2.

I put her through some very difficult, hard
 frustrating and testing times. For the first
 in my life I feel I could trust someone
 feel they present thing I can do for myself
 for my therapist, Donald Babby, Laker of P.O. has
 accomplished my pain healing. In her EYE
 have seen Jesus' love, care & compassion
 I feel she has my total and complete healing -
 I am no longer a victim. I will be
SURVIVOR. Upon my recovery I plan to do
 my training skills in the direction of dealing
 with numerous facets of child/adolescent abuse
 intend to educate doctors, nurses, lay people &
 their families that the diagnosis of Multiple Per-
 sonality does not mean one is "crazy".
 helped me to survive and that's the idea
 I am ALIVE today. I am a Survivor, not
 a victim

With Deepest & Sincere Thanks
 for never giving up on me. To God be the
 and praise for your perseverance with all of

Dorothy Barker, Lita, Esq.
6 Ruevenant Ave.
Blacksburg, Va.

Dear Dr. Barker,

When I first met you...
I could not believe...
time that you...
me to a program...
my idea...

We have done...
years of therapy...
taking...
traced...
what you...

We have...
your help...
almost three years...

I live in the past...
for now and what God has in store for
me in the future. I am a SURVIVOR and

now I write that (or sh
nat) You will be aware of
about. Since I feel we
Good work together

...ethically, morally and legally
who could meet my needs at this

...intensive work almost three
until now... I realize yet
stared up anger at you who
of recovery... I am ever so

...well together... thank you
assignments and guidance over the

...I do not wa
I want to
in store for
SURVIVOR and

...I feel we
Good work together

20, 1992

A. 2. Permission to release confidential clinical data.

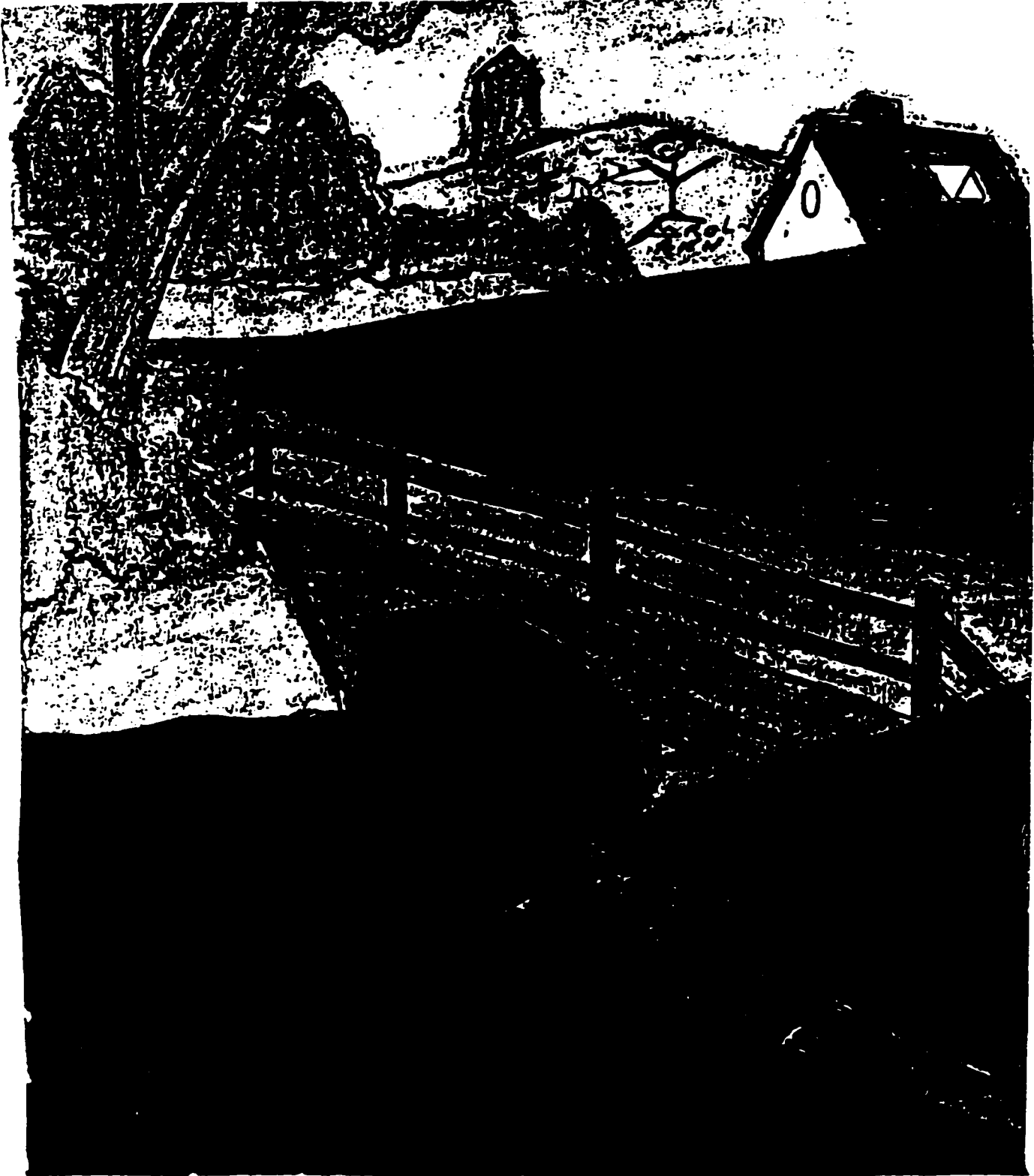
② I give you full permission to use any and all notes, journals, cards, letters, drawings, audio and video tapes for anything at all, with or without any payment or remuneration whatsoever. I help you to work with people who have been emotionally and spiritually abused. You so please to even write a book in the future, you also have my permission for as long as you change the name we have my blipst permission to use whatever you need to pursue your work.

The two greatest things, when actually the three greatest things I have learned are

① The Greatest Gift a client can give their therapist is their own healing

② "Because I believe Jesus Christ brought me through today, when others died, I have learned that greater is He Jesus than can be seen that is in the world"

A. 2. 2.



A. 3. Grace Ann's "Safe Place."

Justin and Gabriel were friends. They played together almost every day. One day Gabriel got mad at Justin. He said, "Justin, you are a pig-faced punk."

Justin didn't know what to say. He walked away from Gabriel and went into his own house. He was hurt. The Hurt was like a big round stone, all cold and hard. It seemed he could hold it in his hand and feel the hardness. Justin didn't tell anybody how he felt. He took the Hurt into his room.

"Gabriel isn't my friend anymore," he thought.

The Hurt grew bigger.

"I'll never talk to him again," he thought.

"I'll just stay here in my own room by myself."

The Hurt grew even bigger.

Justin heard Daddy call him. He was happy that Daddy was home. He ran out to see him.

Daddy said,

"Justin, I'm very disappointed in you. You tracked mud into the house. Just look at the floor."

Justin went back to his room.

"Daddy didn't even notice that I put away my hat," he thought.

"Daddy only notices the bad things I do."

The Hurt was huge now. It was bigger than Justin.

Each day after that, Justin saved up all his bad feelings and gave them to the Hurt. The Hurt grew bigger and bigger. Justin didn't really like the Hurt. It wasn't as much fun as Gabriel. But the Hurt was dependable. Justin didn't have to worry that it would be nice one day and mean the next. It was always the same, only bigger. . . That night as Justin slept, he felt the hard cold Hurt pushing against him. When he awoke, he said,

"My bed isn't snug anymore. That Hurt is ruining everything. Pretty soon it will be so big that there won't be room for me in here."

"Then there won't be room for me in the house."

"Then there won't be room for me in the world. The Hurt will take up all the space."

Justin got scared.

"Daddy," Justin said. Daddy was making breakfast in the kitchen.

"Daddy, a big Hurt came to live in my room, and it's taking up all the space."

"Where did it come from?" Daddy asked.

"It came from Gabriel calling me a bad name."

"What name?" asked Daddy.

"A pig-faced punk," said Justin. Saying the bad name out loud made him feel better.

"I understand why you were hurt," said Daddy.

"Did you tell Gabriel how you felt?"

"No," said Justin.

"I just came home."

Daddy sat down, and Justin climbed into his lap.

"Sometimes our friends make us feel very bad," said Daddy.

"And other times they make us feel good."

Gabriel made me feel good when I had chicken pox," said Justin.

"He drew me a funny picture that made me laugh."

"Friends are good to have," said Daddy.

A. 4. Doleski, T. (1983). The Hurt.

"But what will I do with the Hurt?" asked Justin.

"You'll have to let it go," Daddy said.

"It's too big to get out of my room now," said Justin.

"When you're ready to let it go, it will be small enough."

When Justin went back to his room, the Hurt was a little smaller.

"I don't want you here anymore, Hurt," Justin said.

"You don't make a very good friend."

The Hurt grew even smaller.

Justin went outside to help Daddy wash the car. He said,

"Daddy, it hurt my feelings when you saw the mud I tracked in but you didn't see the hat I put away."

"I'm sorry," said Daddy.

"You are very responsible about putting your things away. Sometimes I forget to tell you I'm proud of you. You're a fine little boy, and I'm glad you're my son."

Justin felt all sunshiny inside. He wanted to make that car glisten. Working with Daddy was fun. That night at bedtime, Justin opened his window. He pushed the Hurt to the window and left it there. Then he went to bed. The bed felt warm and cozy. In the morning the Hurt was gone. Justin closed the window.

That day Justin went to Gabriel's house.

"Do you want to play?" he asked.

"Ok," said Gabriel.

From then on, they played together almost every day. If Gabriel got mad and called Justin a pig-faced punk, Justin called Gabriel a crooked-eyed creep. Then they both laughed and went back to their playing.

Or sometimes, Justin would say,

"Gabriel, I don't like it when you call me names."

Gabriel would say, "I'm sorry."

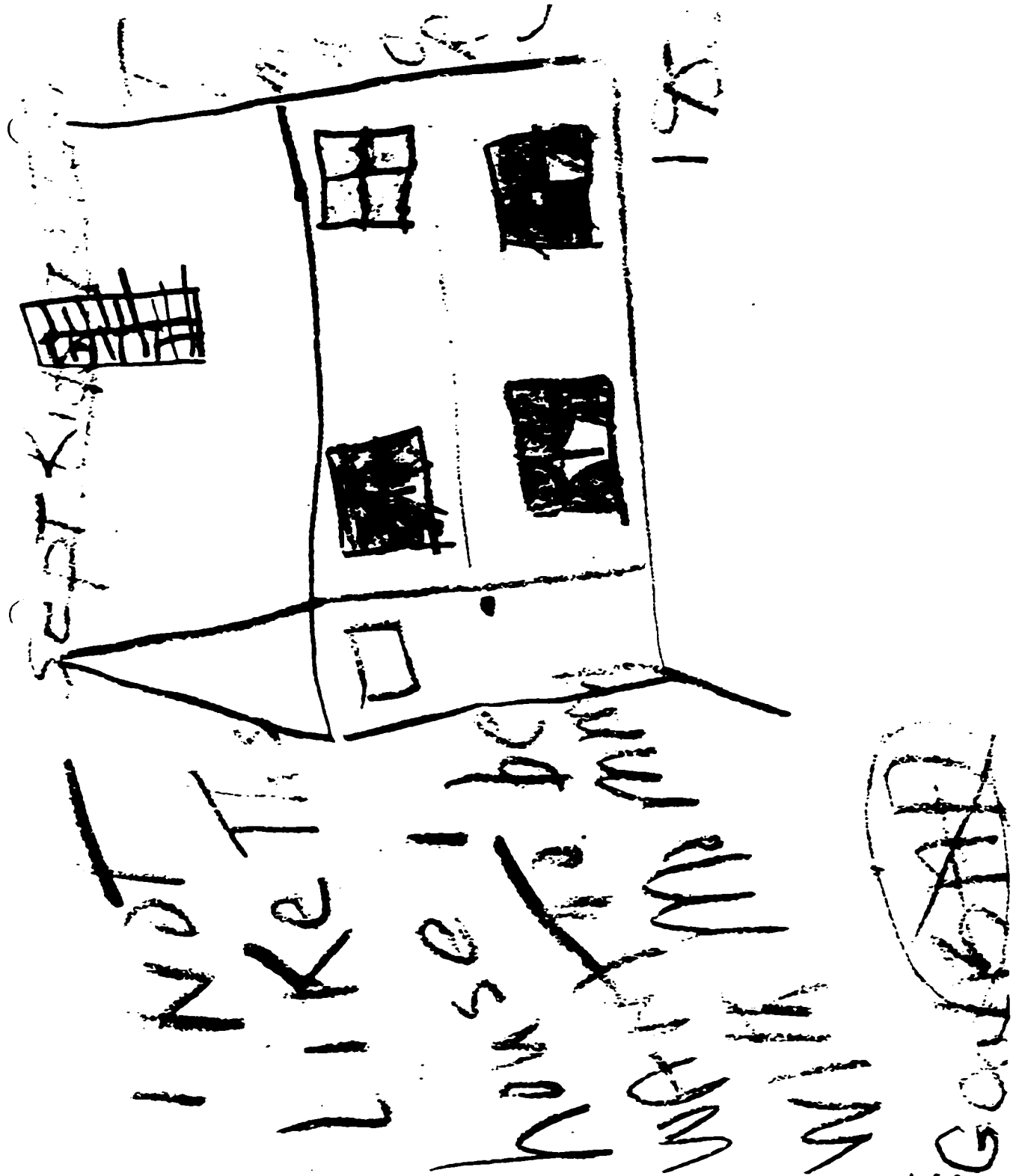
And Justin would say, "I forgive you."

Then they would play some more.

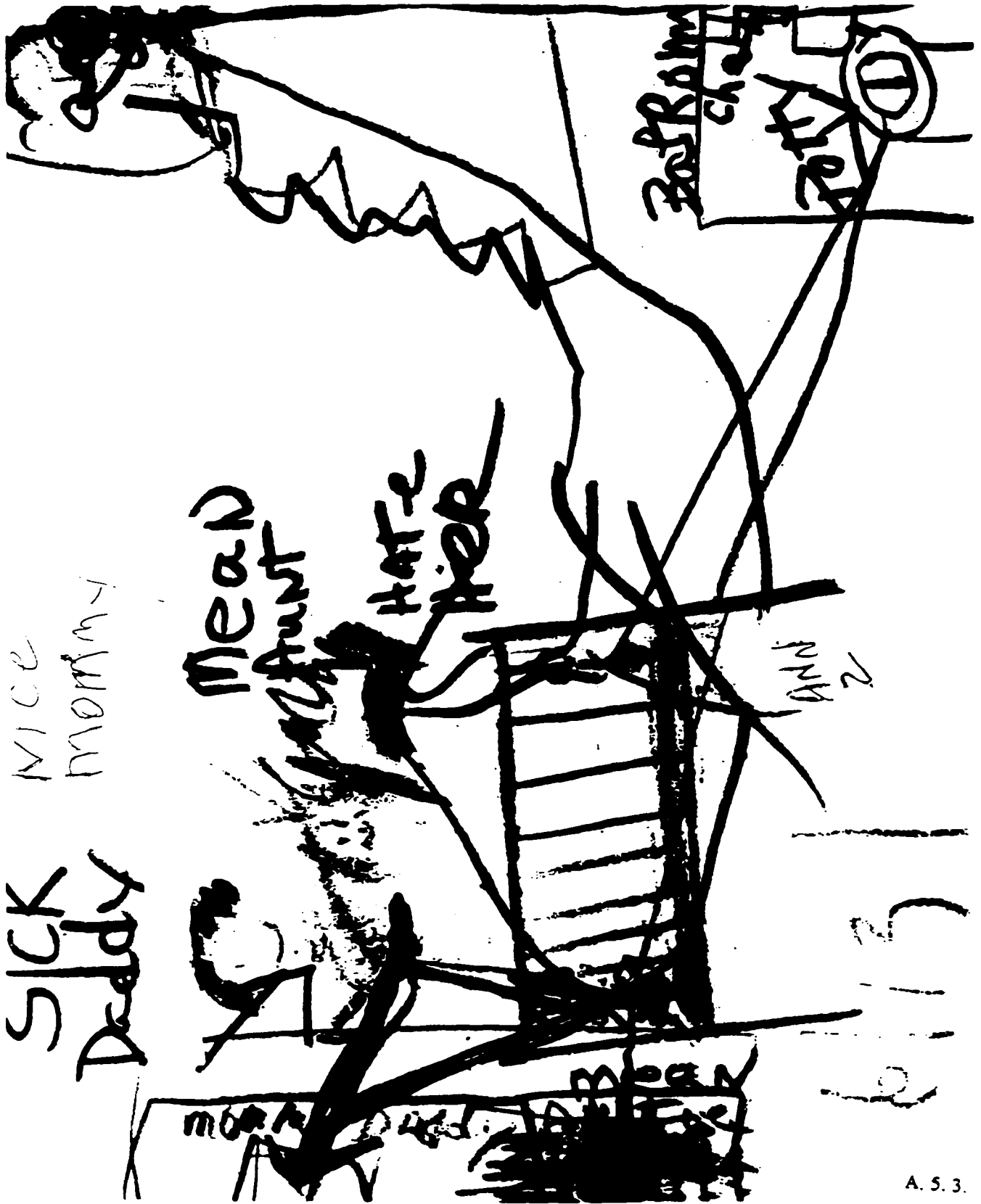
There were times when something bad would happen, and the Hurt would come back. But Justin didn't hide it. And he always let it go before it got too big.



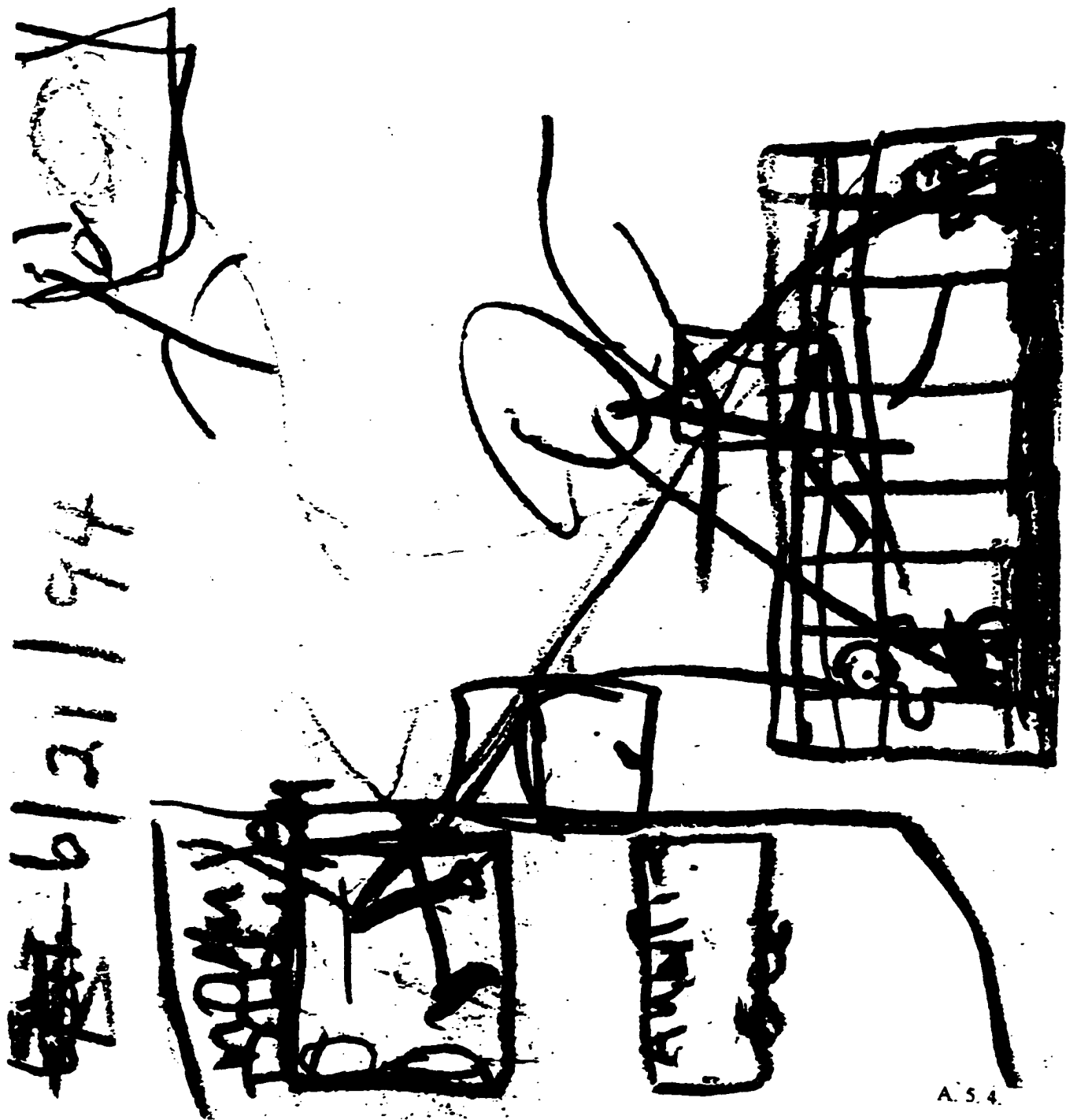
A. 5. Memories Frozen in Time.



A. S. 2.



A. S. 3.



A.S.4.



A. S. S.

Monday Nov. 29, 1993 3:20 p.m.

Little ANN, you

Should not have told

Dr. Debbie. Now the

People will come
and get you and they
will KILL you

DEAD Forever. You

were told to Never

Never Tell. Judith

A. 6. "Never, Never, Never, Tell!"



November 29, 1993 3:20pm

Jessica you
ARE N'T ALLOWED
TO CALL DR. Debbi
EVER AGAIN. If you
keep telling Dr Debbie
Things we will all
be KILLED.

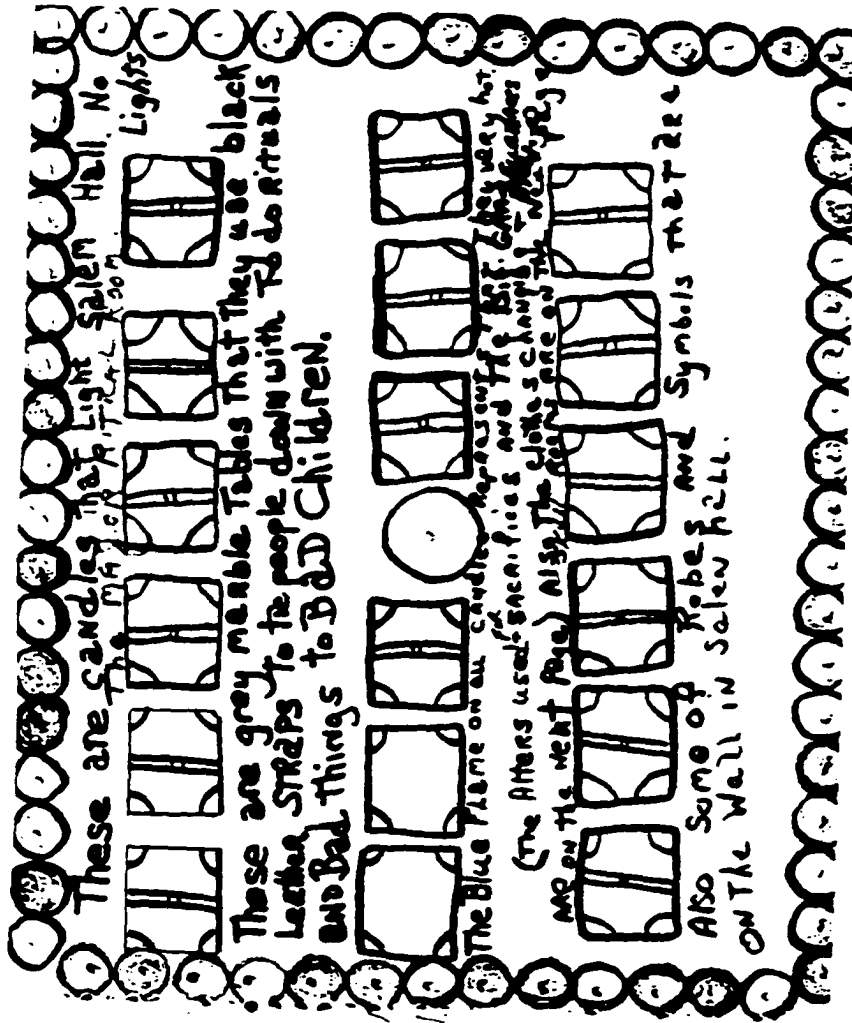
~~Julia~~ 

I do not trust Dr. Debbie
And NONE of you should
either. How do you
know she won't hurt us?

A. 7.



A. 8. Allegations of Satanic Ritual Abuse



A. 8. 2.



Tonight They come
and get you curious
you should have
never, never Told
you can cover your
eyes and face but
they will find us.

Judith
Nov. 29, 1973



They might cut your heart
out for telling Dr. Debbie

A. 8. 3.

Oct 18, 1963

Dear Dr. Debra -

Today is my healing day. It is also my 15th birthday.

Strong Man Jesus said I had to remember to tell you what the $\frac{1}{2}$ meant. They always told us "we would remain $\frac{1}{2}$ until we said yes to joining the house of seven gables." Said yes, "to becoming the bride of Satan" said yes to becoming a princess

A. 9. The Healing Day

and yes to being a
~~breeder~~ breeder for Satan."
 They also told us only
 'when we said yes
 then we would
 become whole,
 otherwise we would
 always remain 1/2."
 However, Strong
 Man Jesus says
 today Judith you
 become healthy
 all hurts told,

have much work for
 Dr Debbie and
 to accomplish in
 helping the millions
 today who are in
 cults. Dr. Debbie,

Keep close to
 me. I am greater
in you than he (satan)
 is in the world.

Happy 15th Birthday,
 Judith Work hard

so you can help me,
Dr. Debbie and
with the task ahead.
Dr. Debbie,

I Am With You
always.

Strong Man Jesus

10/18/94

Deborah Berkley-Carter, Ed.S.
Licensed Professional Counselor
The Madeline Center
18697 Forest Road
Lynchburg, Virginia 24502
(804) 239-0003

September 15, 1998

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Most sincerely,



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DBC/jrb

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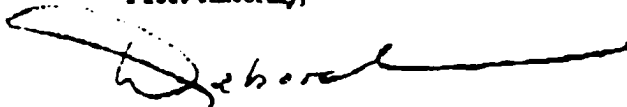
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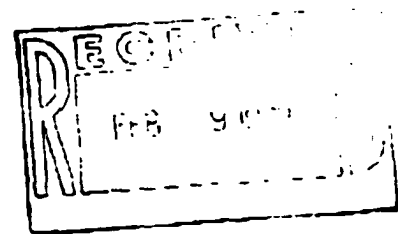
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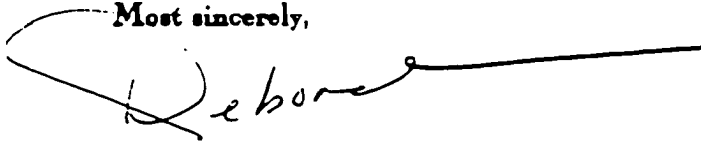
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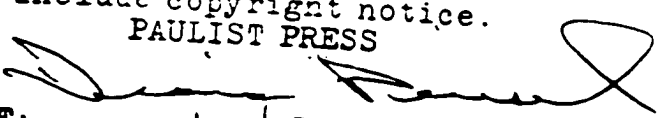
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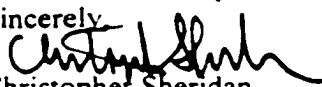
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March 23, 1999

Deborah Berkley-Carter, Ed.S.
The Madeline Center
18697 Forest Road
Lynchburg, VA 24502

Dear Ms. Berkley-Carter:

Thanks very much for your kind acknowledgment of my services for your dissertation (and the remuneration). I'm glad you found my comments helpful, and I'm pleased that you seemed to find value in some of the additional references I suggested. You evidently pursued them with great zeal--even I haven't read all the JTPs since 1969!

I'm particularly delighted that through the course of your working with the case material you reported on you've been able to find a transpersonal methodology that works well with severely disturbed people, a population I believe is usually underserved by transpersonal therapists. We need people like you who are willing to find creative approaches to honor the Spirit in even the most disturbed clients and enlist that ever-present Presence to facilitate healing. Your tenacity and dedication to Grace Ann, as reported in your paper, were inspirational.

I hope you will feel free to call on me when you are in the Palo Alto area; it would be a pleasure to meet you.

Sincerely,

Jenny Wade
Chair, Doctoral Program

Deborah Berkley-Carter, Ed.S.
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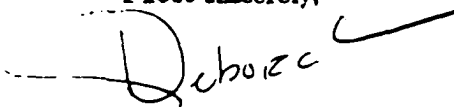
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Appendix B

A Therapist's Journey

Wasted Time

Who, or what, is this Inner Knower, this purveyor of veiled wisdom? In referencing the case of Anna O. (Bertha Pappenheim), Breuer and Freud (1895/1986) portrayed the entity as “a clear-sighted and calm observer [who sat], as she put it, in a corner of her brain [looking] on at all the mad business” (p. 101). Allison (1978) alluded to the mystical quality of the inner self helper in,

“There is no human to human relationship with which to compare this partnership. It is so unique a relationship it has to be experienced to be believed” (p. 12).

Comstock (1987) attributed “the center”(ISH) with an exceptional spiritual intelligence, while Ross (1989) suggested the inner knower manifests both transcendental capability and a capacity to heal. Putnam acknowledged the divergence among clinicians regarding the significance of the enigmatic helper. While he conceded the scarcity of literature on the subject, he alleged that, at least in private, therapists have reported “significant success in incorporating an ISH into the therapy” (p. 202).

I find myself mulling-over the concept of the illusive self helper as I embark upon my now daily walk, for I am learning to take walks, lots of walks. Our tiny office is located on “The Boulevard,” a majestic sweep of pavement meandering through the heart of the city’s mimosa-lined historic district. A visitor strolling through the idyllic setting is greeted with vistas of wide-verandas on turn-of-the-century homes, verdant lawns, and tranquil ‘hidden’ gardens. Early morning strolls are the best, for, refreshed and somewhat clear-headed, these undisturbed, as yet uncluttered early hours serve to ‘ground’ the troubled thinker. It is on days such as these that I struggle to find a semblance of order in this most ‘unordered’ chain of events. Psychology tells

me that, as individuals, we seek to categorize our experiences in an effort to give them meaning. Well, this 'experience' has no meaning. How can this be? I have an alter, a gentle, welcoming soul, guiding the therapy. When I am willing to step aside, to suspend my well, perhaps overly-developed ego, I can 'hear' his wisdom and 'know' his peace. On the other hand, when I plow ahead, certain that I know what is in Grace Ann's best interest, I fall, most unceremoniously, fully upon my face. I am not scolded, but softly chided, that if I would only listen, only trust, discernment would be mine.

My rational mind will simply not support this mystical encounter. I have no category for a Strong Man Jesus. It just does not fit. I reluctantly acknowledge that I am faced with a challenge far greater than any I have ever known. I can't 'think' my way out of this one, heaven only knows, I've tried. I have no choice but to turn within, no choice but to surrender, to, as Justin says, let go . . .

All paths lead to a deeper, more profound center. The contemplative walks are soon to be augmented with a long overdue return to the daily practice of meditation. As I gaze inward, the world takes on a sublime value, an unlikely hue. The scarlet-throated daffodil, the blazing sunset, and even the subtle wind whispering through the delicate branches of the weeping cherry tree are somehow brighter, more radiant, more alive. An ethereal glow, for I do not know how else to describe it, surrounds the strangers I meet. I 'experience' Strong Man's "peace that passeth all understanding," recollect similar instances of this 'celestial' comprehension, and reflect upon my own circuitous spiritual journey.

In my mind's eye. I 'see' myself in the white clapboard church of my youth, sparring with my junior high teacher (who just happens to be my Uncle Harris), over the New Testament's

relevance within the chaos of a 1960's world. I like going to church, because I like to debate. I almost always win. (*Upon reflection, I wonder if I really do win, or if Uncle Harris just lets me think I do so I will keep coming back.*) I, like the others, partake in the sacrament of Christian baptism. I, like the others, receive a leather Bible (mine red), which upon high school graduation, I promptly shelve away.

As the inner journey continues, I discover that not all awareness is bliss. I am, in 'the eye of my understanding,' now a young mother, torn between the love of a child and a world who tells me I'm wasting my time, that I should return to the fast track, the world of achievement and success that has been my refuge. My 'celestial comprehension' takes on a decidedly hellish chill, as I am unwillingly drawn back to my own 'period of unabashed despair,' a time, long-ago, when I, as Grace Ann, know endless days of darkness. I 'feel' those days of hopelessness, days when I seek solace in the teachings of my childhood, the only certainty, or Truth I have known.

I search for my now decrepit Bible, for in the dusty cobwebs of my mind, I recall that during that life-altering depression, I had, in a dire attempt to retain my own sanity, scribbled within its pages what were to become well-worn affirmations of encouragement and faith. In fading, age-splotched ink, I find testaments to my own fear and discouragement, and feel as if I am returning to the embrace of a long neglected friend. Once again, I find peace in Barklay's,

When Christ is there, the storm becomes a calm, the tumult becomes a peace, what cannot be done, is done, the unbearable becomes bearable, and men and women pass the breaking point and do not break. . . To walk with Christ will be for us also the conquest of the storm.

Comforting from the tattered front page, I find,

Have no anxiety about anything, but in everything by prayer and supplication with thanksgiving let your requests be known to God. . . And the peace of God which passes all understanding will keep your hearts and mind in Christ. **Philippians 4: 6-8.**

An excerpt from the Gospel of Luke offers,

Ask and it will be given to you, seek, and you will find, knock, and it will be opened to you. For everyone who asks, receives, and he who seeks, finds, and to him who knocks it will be opened.

And, written in a bold, determined script, as if intending to burn itself into my memory, I read, from John.

... and you will know the Truth, and the Truth will set you free.

The back cover of this now pitiful volume is attached by a thread of twine-like binding. Once positioned, so that it is upright if not intact, I discover a fragment from the Confessions of St. Augustine, and 'feel' the mystic's presence as once again I devour,

What is man?
Can any praise be worthy of the Lord's majesty? How magnificent is His strength! How inscutable His wisdom! Man is one of your creatures, Lord, and his instinct is to praise you. He bears about him the mark of death, the sign of his own sin, to remind him that you thwart the proud. But still, he is part of your creation, he wishes to praise you. The thought of You stirs him so deeply that he cannot be content unless he praises you, because you made us or Yourself and our hearts find no peace until they rest in You.

Etched along the margin, an unlikely Tolstoy offers,

"Where love is. . . God is," and from Dante comes,

"His will is our peace."

I realize the words that sustain me come not from my ego, but from a source far greater than I, for like Barclay, Luke, John, St. Augustine, Tolstoy, Dante, and countless others before me, I,

too, struggle with the appropriateness of my path. It is only in surrender that my answers come, never from an intellectual knowing, but from an other-worldly, an as yet undiscovered realm. I have no choice but to relinquish the illusion of control, no choice but to 'get out of my own way. . .'

Continuing my reluctant mission, I search through yellowed boxes, testaments to an earlier life. My memory is 'jogged' as I unearth early literary attempts--autobiographical pieces, poetry, and children's stories, some published, some not, most from this 'era of darkness' I have chosen not to remember. Tears stream down my cheeks as I read from my first printed article, entitled, "Neither Forsaken Nor Forgotten," when, in the utter depths of despair, I question, as Grace Ann must, how I have so lost my way.

I peruse a second magazine, only to uncover a poem, additional evidence of my 'search' for Truth.

Wasted Time?

The world tells me I'm wasting my time,
 watching these children grow.
But anyone who has ever
 tied a shoe,
 or wiped a tear,
or shared the wonder of nature with a child
 knows,
in a way the world can never comprehend
That this
 "wasted time,"
These days of self-discovery,
Are the very foundation upon which all future
 accomplishments draw- - -
 for
 strength,
 direction,
 and purpose.

Deborah Berkley

And finally, in an apparent tribute to both a young son and my hard fought understanding,

I find the words,

O Child of Mine

O child of mine,
If only I could stop your pain
The pain of insecurity,
 awkwardness,
 inferiority. . .
The pain of forever measuring your worth,
 your abilities
 through someone else's eyes. . .

O child of mine,
Let me let me tell you of God and His love.
You will never conquer your fears, but
 His love in you can--will.

O child of mine,
 Live for God, not for man.
Then, only then, will your accomplishments,
 whatever they might be,
 be worthy of you and your potential. . .

Only then will you find peace. . .
O child of mine.

Deborah Berkley

The meditations continue. Along the path of my inner wanderings, I encounter an immense silver cord, an ambiguous thread whose singular purpose seems, at least in my mind's eye, to link one very own life event to another. At various points along the free-floating cord, I am rewarded with fleeting snapshots of past moments, which, upon review, I 'understand' categorize my life in such a way that I am afforded a clarity of spirit. I recall 'a mother's intuition,' the inner instinct

we women have to 'know' when our child is approaching danger or is in need of our nurturing care. I reflect upon all those times I have said,

"I don't know how I know, I just know."

I remember instances of a long-distance awareness, someone in pain, a loss, a death, a 'feeling' of dread that something, somewhere, is not as it should be. I shake my head as I recall 'seeing' one of my young sons lose his wallet while on an elementary field trip, some two hundred miles from home. I meet the tired youngster at day's end, and, without a second thought, inquire if he made it o. k. without money. Tilting his head in a show of exasperation, he exclaims,

"Who told you? It wasn't my fault, Mom!"

I 'observe' that I seem able to wordlessly intuit others, often 'knowing' the issue at hand prior to entering the therapy room.

I reflect upon a time of dis-ease, a time when, guilt-plagued over a life choice I had unwisely made. I suffer from debilitating migraines. Desperate to find relief (for I can no longer subsist on a diet of Fiorinal with Codeine), I seek out our area's only alternative healer, a Buddhist Chiropractor. While I relish the stress-relieving manipulations, the real blessing comes in his teaching, for during our short time together, I am introduced to both the healing art of Reiki, and the world of Edward Bach.

I recall driving the forty-five minutes to his office, my head pounding so badly my vision is distorted and nausea threatens to turn me back. Sensing my unrelenting pain, he closes the blinds as I struggle to lie down, now dizzy and disoriented by the throbbing anguish. Silently, he cradles my head in the palm of his hands, while, in the stillness of the room, he bows his head and waits, simply waits. . . In a matter of minutes I am pain-free, and feel as if I am blissfully suspended in

mid-air as I experience a healing warmth embracing my neck and head. It is much later before I am to understand his position as a Reiki Master, that he has directed the healing energy of the universe through his hands and into my pain.

At the conclusion of my 'anonymous' Reiki treatment, a chiropractic assistant enters the tranquil room and proceeds to, matter-of-factly, "do a Bach reading." I watch with skepticism as I am 'prescribed' four of the thirty-eight 'remedies.' As I examine the small brown apothecary bottle. I notice the handwritten label reads, 'Centaury, Gentian, Oak, and Walnut.' I am advised to place three to four drops of this 'personalized prescription' under my tongue at six hour intervals. The 'assistant' also hands me a list of affirmations, which I am instructed to repeat throughout the day. The 'homework' consists of:

"My task is only to be found within myself."

"I believe in an ultimate success."

"Everything has a deeper meaning."

"Joy will yield strength," and,

"I am only following my own inner guidance."

As strange as this all seems, I still have no pain. On the way out of the office, I notice Scheffer's (1988) Bach Flower Therapy--Theory and Practice, and purchase a copy for no other reason than to soothe my burgeoning curiosity.

As I settle-in with a mug of hot chocolate, I learn of Dr. Bach. As an English physician, Bach presides over a lucrative medical practice. Disenchanted, he, at the age of forty-three, leaves the world of traditional medicine to explore of the relationship of spirituality and disease. Believing divine healing to be a birthright of us all, Bach writes.

Disease is solely and purely corrective; it is neither vindictive nor cruel, but is the means adopted by our own souls to point-out to us our faults, to prevent our making greater errors, to hinder us from doing more harm, and to bring us back to the path of Truth and Light from which we should never have strayed (Scheffer, p. 9).

Dis-ease, in Bach's view, is the consequence of disharmony. Healing occurs, not through external applications, but rather through reversing internal energy blockages. Therefore, Bach practitioners do not diagnose on the basis of physical symptoms, but on the state of the disharmony in the patient's soul. I find this an utter foreign concept, the antithesis of all I have been taught. Confused, I forge ahead, and am consoled to read that I am not alone in my disbelief, for to date, no one knows how the Bach Flower Therapies work. I discover it is 'accepted' that the remedies (the distilled essences of flowers) increase the subtle energy vibrations and open the individual to his own, ever present but unrecognized, spiritual self. I am told the essences address the negative soul states which, if not treated, will result in physical illness. (In my case we appear to be too late!). In referencing the essences, Bach writes,

They are able, like beautiful music or any glorious uplifting thing which gives us inspiration, to raise our very natures, and bring us nearer to our souls and by that very act to bring us peace and relieve our sufferings (Scheffer, p. 13).

I search Scheffer's text for information on the essences 'prescribed' earlier in the day. Centaury has been incorporated to strengthen my will, to lesson my overreaction to the wishes of others. Gentian is related to faith, and is offered because I am "unconsciously refusing to be guided by [my] Higher Self and to see [myself] as part of a greater whole" (Scheffer, p. 86). I am taken back as I read that Oak, too, is related to an individual's refusal to be led by a Higher Power, that the 'Oak Person' is lost in a world of achievement and winning. (This sounds

hauntingly familiar!) Walnut is 'prescribed' for those persons who are immersed in the uncertainty of life changes, for those who, "have decided to take a great step forward in life, to break old conventions, to leave old limits and restrictions, and start on a new way" (p. 175).

Several months have passed. I still do not understand the logic behind someone holding my head while I sip a tincture of distilled flower essences. How could these 'alternative healing practices' possibly be beneficial? I do, however, remain pain-free, so I decide not to protest too loudly. I continue with Bach's program throughout the following year.

Cosmic Consciousness

As I continue my trek along the silver cord, I find myself once again pouring over Bucke's (1901) Cosmic Consciousness, in which the lives of 'enlightened' men, i.e., Buddha, Jesus, Paul, Mohammed, St. John of the Cross, Pushkin, Emerson, Thoreau, and the like, are examined. Written as a tribute to his deceased son, I am struck that he, as does Bach, references a higher form of consciousness, a state of 'illumination.' Bucke describes this higher plane of existence as an eternal understanding, a joyful and morally-stimulating awareness which can only be 'learned' through experience. Believing cosmic consciousness to be the inevitable legacy of the modern man, he predicts,

In contact with the flux of cosmic consciousness all religions known and named to-day will be melted down. The human soul will be revolutionized. Religion will absolutely dominate the race. It will not on tradition. It will not be believed and disbelieved It will not be a part of life, belonging to certain hours, times, occasions. It will not be in sacred books nor in the mouths of priests. It will not dwell in churches and meetings and forms and days. Its life will not be in prayers, hymns nor discourses. It will not depend on special revelations, on the words of gods who came down to teach, nor on any Bible or Bibles. It will have no mission to save men from their sins or

to secure them entrance to heaven.

It will not teach a future immortality nor future glories, for immortality and all glory will exist in the here and now. The evidence of immortality will live in every heart as sight in every eye. Doubt of God and of eternal life will be as impossible as is now doubt of existence; the evidence of each will be the same. Churches, priests, forms, creeds, prayers, all agents, all intermediaries between the individual man and God will be permanently replaced by direct unmistakable intercourse. . . Each soul will feel and know itself to be immortal, will feel and know that the entire universe with all its good and with all its beauty is for it and belongs to it forever (p. 5)

Bucke speaks of his own 'cosmic understanding,' of a glorious Spring evening spent with friends reading Wordsworth, Shelley, Keats, and Browning, an evening when he,

All at once, without warning of any kind, he found himself wrapped around as it were by a flame-colored cloud. For an instant he thought of fire, some sudden conflagration in the great city; the next, he knew that the light was within himself. Directly afterwards came upon him a sense of exultation, of immense joyousness accompanied or immediately followed by an intellectual illumination quite impossible to describe. Into his brain streamed one momentary lightning-flash of the Brahmic Splendor which has ever since lightened his life; upon his heart fell one drop of Brahmic Bliss, leaving thence-forward for always an aftertaste of heaven (p. 10).

My mind races forward, as I recall, years later, my 'aftertaste of heaven,' when, in the midst of a weekly trek to graduate school, I, most uncharacteristically, depart from the 'beaten path' to explore a place called 'Swannanoa.' I question the wisdom of my impulsive act, as I attempt to dodge the potholes of an unkept mountain road. Upon reaching my destination, I sit in awe of the majestic Italian Renaissance dwelling, and am bathed in an aura of astonishing serenity. I wonder about this 'wasted time,' but choose, again uncharacteristically, to throw logic to the wind.

Upon entering the towering carved door, I discover that 'Swannanoa' is the home of Walter

and Lao Russell's "University of Science and Philosophy," a foundation dedicated to "self-transcendancy." (*I do not know the meaning of the phrase, "self-transcendancy."*) My few moments 'in the light' impress me greatly, for when called upon to engage a speaker for the Advanced Counseling Theories class, I immediately turn to Swannanoa. I write the gentleman who had, during my brief visit, introduced me to the Russell's teachings, and receive the following correspondence in return.

Dear Deborah,

Hi! I was pleased to make your acquaintance and to meet a soul who resonates to the ideas of Oneness and Wholeness expressed in the Russell's teachings. I have been mulling over the questions you posed and the intent you have to incorporate these teachings/philosophies into your counseling and psychotherapy. (*I have no memory of discussing this concept with him, or with myself, for that matter!*)

I believe the root word 'psyche' means spirit or soul which give an excellent lead-in to the Russell's perspective on who we are and what is real.

First, I would emphasize communication through meditation with the Divine presence within. In the Stillness within is the source of all knowledge, power, presence and healing. . . . By bringing your desire for healing into the Stillness the process is energized with Divine force, guidance, and action. Constantly seeking communion with the Divine presence within will gradually activate the true nature and character of the soul into the personality/ego/sensed environment. I would add here, Deborah, there is an abundance of research literature available on the benefits and effects of meditation to support this idea.

In conjunction with meditation or if necessary apart from using it, I direct you to the universal truths espoused in Lao's Code of Ethics. Practice of these simple principles of behavior will gradually reap the bounty of so-called "fruits love," or any quality of character a person may want to have can only come from within them, they will learn to take responsibility for their feelings and thoughts. The experience of giving first and opening up to the reception of what was given, without attachment to the source of return, produces inner acknowledgment of both the truth and the person's true, sterling, soul nature.

When I give love, love fills my life; when I give recognition of worth I receive it; and as an extension as I give time, money, feelings, things, so I receive them.

The truth here is a two edged sword, when I give judgement, I receive it; when I give anger, hurt, jealousy, disdain, hate, etc., I will receive like back. I have found my own inner sense of love and self-esteem to be ever increasing. The fears, dysfunction, uncertainties, guilt and sense of separation gradually melt away as I continue to go within and express my desire for wholeness (mental, emotional, and physical health) to the inner point of Light or Stillness which I am. Slowly a sense of well-being, trust in life, and connection to my Creator and creation evolve. . .

In service and Light, God Bless You,

Jim

One lesson flows into another, as I 'recall' a long-forgotten poem, presented to me in lieu of payment, by a horribly neglected and abused client.

The Child

There was A child,
 huddled, alone
 afraid
 abandoned.
The child needs love.

There is A child
 who wanted love. . .
 waited for love. . .
There was nothing lovable about the child
 it was not beautiful
 it was not smart
 it was not talented.

The child had hoped. . .
 It waited. . .
 But no one offered attention
 no one recognized the need
 no one offered love.

The child lost hope
 It waited
 It wanted to welcome death
 but even death didn't care--
 wouldn't embrace the child.

The child despaired. . .
If life offered no warmth or love. . .
If death offered no warm embrace
What did it matter
What did anything matter
Without love there was nothing
In life
Or death.

The child heard A voice
it was strong
it was warm
it was loving
The voice demanded nothing
if offered everything

The voice spoke of children
warmth and love radiated
and invited.

Let the children come unto me,
of such is the kingdom of God made.
All children are made in His image,
each is special to Him.
Even He came as A child,
just A poor child
with nothing special to recommend Him.

The announcement of love
given of His arrival
was greeted with FEAR
REJECTION
and DEATH.

Only
those who trusted as A child
CAME
Only those who came as A child
RECEIVED

Only

Those who receive and accept like A child
The love of God
Have the peace of God.

A Former Client
(who prefers to remain anonymous)

Journal Entry

Overwhelmed with questions regarding Catholicism, Satanism, the seemingly purposeful disappearance of a supposedly loving God, ultimately, the purpose of life itself, I [am] embroiled in a quagmire of existential yearnings. What do I do with this case? Where am I supposed to place my recent discoveries regarding the nature of abuse? Am I to place [them] on a shelf, pretending I have no knowledge at all, indeed, that no knowledge exists? Am I to incorporate [them] into the therapy itself? What therapy? All I am doing is white-knuckling an oversized arm-chair while the client recounts, weaves, or both, a nightmarish tale of abandonment and despair. How do I go on? I dread checking the voice mail! I search for her car as I pull into my parking space, praying for a few precious moments of respite before the bombardment begins! The secretary, an elderly woman of impeccable qualifications, has just informed me,

"I don't think I'm the person for this job."

"Hell, I don't think I am either, but it doesn't seem that anyone is listening."

In sheer desperation, I seek out my long-time refuge, the musty, family-owned bookstore of whose blessings I, too frequently, partake. Even if I fail to find the "gem of the day," just being in this holy place [makes] me feel better. I suppose I have always felt that if I allow myself to be surrounded by the knowledge of the ages, some of it will, in due time, rub off on me.

Who knows, but on [this] particular springtime day, a day only to be fully [appreciated] by

those fortunate few who count themselves among the resident's of the [Southern] Blue Ridge, I find, unearth, am led to, I don't know, a book that [is] to give direction to both my work and my life. I see (again?) with 'the eye of my understanding,' and, as Rogers said we must, once again become genuine and authentic. My work takes on a spiritual path. Who I am and what I do [are] no longer at odds. It [is] as if I [have] been a great Vidalia onion, whose layers, once peeled away (they rarely peel without splintering), reveal an unbelievably sweet core which [feeds] the bulb throughout its lifetime without its even knowing. There [is] no more work and me. There [is] just me. I am, [once again] transported back in time to my youth, and [am], once again, sitting in my Uncle Harris' Sunday School class. [No longer debating.] I am [instead] listening, and at last, his words have meaning. My newfound knowledge [has] led me to the most remarkable place--home.

The Women Mystics

I have heard of Carol Lee Flinders. Her vegetarian cookbook, Laurel's Kitchen has been lauded as a "classic" throughout the years. I do not, however, know this Flinders, professor of Religious and Women's Studies at U.C. Berkley, and now author of a no less than inspiring publication entitled, Enduring Grace--Living Portraits of Seven Women Mystics. (I am soon to purchase the audiotape as well, and judge the words to be fine company during the seemingly endless treks to graduate school). Flinders admits finding herself immersed in early feminist writings, when, as a doctoral student, she chooses to compare the earlier [short form] "showings"(visions) of the fourteenth century recluse, Julian of Norwich, with the "long form" drafted by the Anchorite during the later years of her life.

Sifting through the patriarchal language of medieval Europe's "chaotic, holistic.

multidimensional world” (Flinders’s, audiotape), Flinders becomes convinced the voices of the women mystics have become “marginalized” due to the canonization process, i.e., the Catholic Church’s elevation of an individual to the sainthood. This “kiss of death,” as she terms it, has resulted in history’s recollection of these women as pious, unapproachable, clerical beings, entrenched in the church of the day and thereby void of all humanity. Flinders feels their misrepresentation, and ultimately their absence, has left “a deep hunger that [has been] felt across the whole imbalanced [Western] culture. . . [that]. . . every human relationship finds its perfect fulfillment in the mystical experience” (Flinders, p. 98). The author points to the unique spiritual perspective offered by these women, for they speak of transcendence while fully grounded (immanent) in the reality of their medieval world, or, as Flinders states,

“The God that [is] encountered in isolation must also be encountered in the world”
(audiotape).

Flinders mission is to “paint a living, hands-on portrait of these women”(audiotape), vividly detailing their imperfect stories, their wanderings towards Christianity’s Council of Perfection, their horrible suffering and ultimate joy. She portrays each as the mortal, infallible creature she is, diverse in perspective and voice, oftentimes responding “willy-nilly”to her call, but united by a “genuineness for inwardness. . .[a] seeking [of] her own deepest self”(audiotape).

I understand “willy-nilly,” for I, too, have followed a circuitous route to an awakening.

I listen with reverence of Saint Clair of Assisi and her “pure, spotless, gleaming, radiant, path”(audiotape). As a member of the austere Franciscan Order, Claire refuses the traditional (often lavish) convent holdings of the day, insisting, instead, that she and her sisters subsist only upon whatever God provides. Flinders suggests Claire’s vow of outward poverty leads to a holy

trust, an abandonment of all worldly attachments, a forsaking of self-serving behaviors, and ultimately, to an inner letting go.

How many times during my work with Grace Ann has she referred to 'trust?'

"Dr. Debbie, how do we know we can trust you?"

"Strong Man Jesus says we have to trust you," and

"Dr. Debbie, you have safe eyes. . ."

It is only after trust is established that she is willing to suspend her fractured ego, to let go. . .

Two hundred years have passed. Upon finding herself betrothed to an "unseemly" man, Catherine of Genoa, overcome with despair, prays for three months of just enough sickness to confine her to her room. According to Flinders, Catherine's intuitive self ("just enough sickness") senses an inner movement towards a spiritual awakening, for her biographers write she emerges from this purgative experience with "her mind. . . clear and free, and so filled with God that nothing else ever entered into it" (Life 39, p. 143). Catherine provides an opposing view of the sainthood, for unlike the serenity of a Claire, she turns her back on convention, leaves her life of privilege among the wealthy Genoese society, and, of all things, establishes a hospital for the disenfranchised-- lepers, plague sufferers, and the like.

With the exception of the "life of privilege" piece, this portrait of Catherine could easily describe Grace Ann. Her "sickness" has led to a spiritual awakening! She, too, has worked among the disenfranchised, the profoundly disabled, the poorest of the poor.

Flinders' work leads me to Catherine of Sienna, the "high-visibility, charismatic, spirit-filled" saint who, while "barely in the body at all" (audiotape), heals plague victims and is known to perform exorcisms. (*Where is she when I need her?*) While her historical claim to fame has been

her uncanny ability to influence a pope (she does, after all, persuade him to return the Papal Court of Rome), her biographer, Raymond of Capua, suggests her true gift to be the capacity to construct within her being an “invisible cell of self-knowledge” (p. 109). This “secret cell. . . inner cell which no one could take away from her” (Life 43, p. 109) provides Catherine with a marvelous inner awareness, a continuous, intimate dialogue with Christ.

Of Catherine, Flinders writes,

“Everyone [is] astonished at the quality of her listening. . . [she can] see the beauty of the soul despite the wretchedness of the container. . .” (audiotape).

Once again, I am reminded of the inner goodness of Grace Ann.

Flinders’s attributes to Teresa of Avila a “dazzling intelligence [and] genius for mental prayer” (audiotape). Of her literary skill, Flinders offers,

“She begins writing in a marvelously colloquial way. . . to disarm the more learned serious academic critics” (audiotape). (*O.K., I admit it, I’m guilty!!*)

Though her adult life is filled with sickness, (“twenty years of the pain of continuous vacillation”) (audiotape), Teresa is eventually, through what she terms “raptures” (p. 172), to experience “delights and favors from God” (audiotape). It is these “raptures” that allow her to see the beauty of God, satiating her hunger and instilling within her the gift of detachment.

Flinders writes,

She . . . moves beyond the need for raptures, but she remain(s) grateful always for having had them because they [have] given her the detachment that her work would require--detachment from all things, including the admiration and affection of others she [has] always needed so desperately. She would never again look outside herself for joy or security because she [has] found the source of all joy and security within (p. 172)

I question if the experience of “raptures” (defined by Webster, not by Jessica, as “extreme joy, ecstasy, bliss, [and] exultation”) would constitute pathology in today’s, medical model society? What would be the treatment of choice, brief therapy? What anti-psychotic medication would most likely be prescribed?

On a more serious note, I wonder if, in cases of dissociation, a rapture could be synonymous with the internal self helper!

Teresa craves a mentor. She fully acknowledges the church’s discouragement of mental prayer (The Inquisition is in full swing), and is indignant that no one is there to direct, what seems to her, to be a wholly unconventional journey from awareness to understanding. (*I understand this “wholly unconventional journey from awareness to understanding.”*) Chafing at the perceived dearth of direction (John of the Cross is later to become her Confessor), she couches her pilgrimage in the only way she knows how.

I, too, write only of my own experiences!

In her Autobiography, Teresa outlines her ascending levels of mental prayer by likening them to a garden, insisting, “the soul [is] a garden [that] we must cultivate” (audiotape). Gardening is hard work. The physical body becomes fatigued, and we are to only succeed if we remain resolved. Flinders writes,

The garden of the human soul, she explains, is on barren soil and full of weeds, but ‘His Majesty’ pulls up the weeds and plants good seed. God plants the seeds, she emphasizes; it falls to us to water the plants. . . (p. 178).

Likewise, the beginning stages of mental prayer require from the petitioner a determination of

will. and an acknowledgment of the potential weariness of the intellect. Initially, mental prayer, like gardening, is simply hard work.

Teresa's next stage, the "Prayer of Quiet" (p. 178), is compared to turning the crank of a cistern. While continuing to require a physical investment, the work itself is less laborious and increasingly effective. With the rising water (one is "nearer the light" (p. 178), comes intellectual clarity. Teresa writes that, although she does not know Latin, she is now able to "penetrate the meaning of Latin prayers" (p. 178).

In her third stage (later to be known as the "Prayer of Contemplation"), the nurturing life force flows, instinctively, into the garden through a river or spring. The gardener's only job is to direct the flow, and in so doing, he will receive the joy of the fruits of the garden. In Teresa's contemplative prayer, the will and intellect slumber, thereby inviting the tremendous bliss of a soul giving itself over to God. Teresa describes this level of mental prayer as "a delightful disquiet" (p. 178).

The remaining level, Teresa's "Prayer of Union" (p. 179), is categorized by the rainfall. As the heavenly water saturates the garden, the soul too, becomes immersed, free to become increasingly "courageous" (p. 179) in its quest for the ultimate freedom.

Teresa writes her The Way of Perfection to provide instruction for mental prayer to her fellow Reformed Carmelites. She points to the need to live as a community, recognizing that "how we live with other people determines the depth of our spiritual attainment. . . [our] detachment, humility, and love for one another"(audiotape). The Interior Castle, written at the age of sixty-two, references ascending levels of consciousness (the stages of mental prayer, outlined previously in her Autobiography) as well as her experiences at the "center of the labyrinth"

(audiotape), her experiences of the inner world she has known while fully human. (She offers an apology to the readers for failing to describe this earlier, but declares she could not write of that which she did not know.) *I 'know' what she means!*

Teresa's Interior Castle is comprised of seven "dwelling places" (p. 186), representing her [now] seven stages of prayer. Of these "dwelling places," she writes,

"Consider our soul to be like a castle made entirely out of a diamond or of very clear crystal in which there are many rooms" (Interior Castle 1.1.1, p. 186).

The first three levels are initiative, requiring a settling down to mental prayer. The "Prayer of Quiet," the fourth level, outlines the transition between the natural and the supernatural realm, with the fifth level, the "Prayer of Union," portraying a spiritual transformation, a death to the ego. The traveler remains in the sixth room (likened to purgatory) for a long while, and is filled with spiritual torment, purification, and preparation.

I have certainly been here!

Teresa's seventh, and innermost chamber represents freedom and truth, and is known as "The Center of the Labyrinth" (p. 188). It is in this "dwelling place" that Teresa eloquently describes her vision of the Trinity, viewing the union of Father, Son, and Holy Ghost in "the extreme interior" of herself. Of this visitation, Flinders writes,

"And it seemed to her, despite the trials she under[goes] and the business affairs she [has] to attend to, that the essential part of her soul never move[s] from that room" (Interior Castle 7, 1.10, p. 188).

I am becoming aware of this "essential part. . . the extreme interior" of my life as well!!

It is Teresa who insists that young women be granted, as Julian so eloquently states, "a room

of [their] own with a door [they] can close" (audiotape). She wishes to spare them the frustrations of her lifetime, and seeks to provide the guidance and support she at times found so lacking. In what later is to known as "The Bookmark Prayer" of Saint Teresa of Avila, Teresa encourages her fellow travelers to:

Let nothing upset you,
Let nothing frighten you.
Everything is changing.
God alone is changeless.

Patience attains the goal.
Who has God lacks nothing
God alone fills all her needs.

I marvel at how closely this "benchmark prayer" resembles "O Child of Mine," my own admonition to a hurting son.

In A Book of Showings to the Anchorite Julian of Norwich, the author writes of her "showings," or visionary experiences, while enclosed as an Anchorite. Contemporary scholars are often thrown off guard with the concept of visions. Flinders, attempting to diffuse the controversy, refers to the mystics' visions as "her own deepest self. . . from the very depths of consciousness this sacred text is delivered up to her," as well as "deep down truths that she can feel in her bones" (audiotape). According to Flinders, the male clerics of the day believe women to be more receptive to God's truths, for cloistered, women are afforded the gift of contemplation. (The male clerics, on the other hand, are required to instruct the masses, and have had their minds cluttered with a university education) (audiotape).

Julian dialogues with God, asking Him the questions that have burdened her heart. As she talks with Him. God not only accepts, but encourages her questions, a concept foreign to the woman of

medieval Europe. She brings to Him her conflicted self, the church teaching her of a wrathful God, her “showings” revealing yet another. Perplexed, she states,

“For I saw not wrath except on man’s side, and He forgives this in us” (audiotape).

Julian inquires as to the nature of evil, asking how it is that the “great prescient wisdom of God” has not prevented sin? (p. 89). Curious, she wonders aloud if God is not only omnipotent, but omniscient as well.

A respectful God replies that sin has no ultimate reality, for it simply represents “all which is not good” (audiotape). Ever the teacher, He shares with his willing student that man falls into sin, not because of his wicked nature, but out of ignorance and naivete. He suggests that sin is in fact necessary, for it is instructive rather than punitive, leading one to a self-knowledge and a humble seeking of God. God shares, with Julian, the words that have become immortalized by the poet, T.S. Elliott.

All will be well,
And all will be well.
And every kind of thing
Will be well. . .

Julian writes that it is our separation from God, not our shortcomings, that create our pain and suffering.

The lord sits in state, in rest and in peace. The servant stands before his Lord, respectfully, ready to do his lord’s will. The lord looks on his servant very lovingly and sweetly and mildly. He sends him to a certain place to do His will. No only does the servant go, but he dashes off and runs at great speed, loving to do his lord’s will. And soon he falls into a dell and is greatly injured, and then he groans and moans and tosses about and writhes, but he cannot rise of help himself in any way. And of all this, the greatest hurt which I was in him was lack of consolation, for he could not turn his face to look on his loving lord (Long Text 51, p. 92).

I bolt upright as I read of Julian's encounter with a "fiend," much like my friend Judas. She writes,

And as soon as I fell asleep, it seemed to me that the devil set himself at my throat, thrusting his face, like that of a young man, long and strangely lean, close to mine. I never saw anything like him; his color was red, like a newly baked tile, with back spots like freckles, uglier than tile. His hair was red as rust, not cut short in front, with side-locks hanging at his temples. He grinned at me with a vicious look, showing me white teeth so big that it all seemed the uglier to me. His body and hands were misshapen, but he held me by the throat with his paws, and wanted to stop my breath and kill me, but he could not (Long Text 67. p. 93).

She faced the fiend, awakening "more dead than alive" (p. 99), understanding that even though he sought to kill her,

"He could not. . . my heart began to gain strength. . . and immediately everything vanished and I was brought to great rest and peace" (p. 99).

God speaks,

"Know it well, it [is] no hallucination which you saw today, but accept and believe it and hold firmly to it. . . and you will not be overcome" (p.100).

Grace Ann has questioned, as I have, where a loving God is hiding when a mother leaves, or dies, or is simply unable to care for her children.

Julian is "shown,"

" . . . as truly as God is our Father, so truly is God our Mother" (Long Text 59, p. 96).

She attributes to God the love of a mother for a child, calling this ever present love "one-ing."

Julian is "shown" that our love of God brings us to that "natural place, in which we were created

by the motherhood of love, a mother's love which never leaves us" (Long Text 60, p. 96), and is assured.

"No one ever might or could perform this office fully except only Him" (Long Text 60), which Flinders so beautifully translates as, "the mother we long for, and the mother we long to be, is with each of us. We can meet her there" (p. 98)

Julian reminds us that she does not ask for these "showings," for she has no natural desire to understand the great mysteries of life. Flinders offers,

Not intellectual curiosity, but desire, was her starting point. . . . withdrawn from ordinary objects and focused intensely, her desire to grow closer to God has finally pierced the veil between this world and the other (p. 100).

Julian concludes with,

And from the time that it was revealed, I desired many times to know in what was our Lord's meaning. And fifteen years after and more. . . . it was said: What, do you wish to know your Lord's meaning in this thing? Know it well, love was his meaning. Who reveals it to you? Love. What did he reveal to you? Love. Why does he reveal it to you? For love (Long Text 77, p. 101).

Julian's writings may have been suppressed, due to the vast difference between what she has been taught by the hierarchy of the Catholic Church and her "showings," that which she has come to understand "the eye of my understanding." She comes to 'know' that nothing stands in the way of healing more than an individual perceiving the judgement of a wrathful God, and, because of fear or anger, willfully separating himself from his Creator. Julian tells us, our healing, and ultimately, our freedom, lies in our trust of His abiding love.

I sigh as I, too, 'understand,' that I can neither change Grace Ann's past nor her perception

of her past, that her healing lies, not in my hands, but in a union with a God she is convinced has forsaken her.

The Adlerian work that we have done has helped with the discouragement and maladaptive behavior. The object relations therapy has assisted with "the relationship within the room." I however, humbly recognize that I am merely a vessel, a conduit really, nothing more—that my 'understanding' of a loving God, the God of,

*All will be well,
And all will be well,
And every kind of thing
Will be well. . .*

is all I have to see me through. . .

Of the seven lives portrayed in Enduring Grace, Mechtild of Magdeburg touches me most deeply with her honesty and humanity:

Mechtild is never even considered for the sainthood. She has never received the accolades and reverence of the others. It is only through her "jottings," a mere writer's notebook, that we come to know of the "humanity" of the mystical experience..

Mechtild is brutally honest, for while she freely admits she has never regretted her union with the Divine, she

. . . never pretended it was easy. . . Thanks to her we know that mystics do not always live happily ever after and that human frailty does not vanish just because one has experienced the true greeting from God (p. 75). . . Mechtild takes us inside untive consciousness--the state of being where all divisions are healed and all dualities transcended--and lets us glimpse its terrors as well as its consolations. . . (p. 44).

Mechtild is perhaps more of an everyday mystic. She writes in a "different voice. . .

[characterized by] informality, earthiness, warmth of feeling, a preference for open-ended literary

form--these qualities hav[ing] traditionally baffled and disconcerted men of letters” (p. 46).

Mechtild possesses none of the serenity of a Claire, or a Julian or even a Teresa for that matter! She is forced to leave her home, then exiled from her newly-discovered adopted family. She is betrayed by trusted spiritual companions and is barred from the rite of Holy Communion (*In the church's defense, this refusal is likely the result of Mechtild's reference to the cathedral clergy as "stinking goats" (p. 51).*

When, in despair, she seeks out the convent life, she is refused acceptance due to her insufficient social stature and absence of dowry. With nowhere else to go, Mechtild joins a Beguine community, a women's movement right in the middle of medieval Europe. While the Beguines lead Christlike lives, they take no vows, are not cloistered, wear no uniforms, and, not surprisingly, are neither authorized nor acknowledged by Rome (audiotape).

Mechtild does not assemble her "jottings" until the age of sixty-three. She writes of flow--of wine, mother's milk, honey, tears, "love flows from God to man without effort, as a bird glides through the air without moving its wings" (2.3, p. 53). She speaks of an everlasting connectiveness, a "deep reciprocity" (audiotape), a sense that "God is as hungry for union with the soul the soul is for God" (audiotape). Of this hunger, she writes,

Before the world I longed for thee.
I longed for thee and thou for me.
When two burning desires come together.
Then is love perfected.

Mechtild counsels that we must be receptive if we are to receive God's grace. She describes God's love as only flowing into "the low places" (audiotape), flooding our souls when we empty

ourselves of pride and anger and arrogance and become, as do the women mystics, “poor and naked”(p. 59). She sighs,

“Ah Lord, even in the depth of unmixed humility I cannot sink utterly away from thee. . . in pride I so easily lost thee, but now the more deeply I sink, the more sweetly I drink of thee”
(audiotape)

Mechtild writes of dualities, of light and dark, grief and joy, separation and union, and courageously addresses both sides of the mystical journey. She writes of a transcendent God while purposefully addressing His immanence. She speaks of humility, not of guilt and self-deprecation. Mechtild acknowledges that is our “desire,” and our desire alone, that leads us toward God. In.

“Wouldst thou come with me to the wine cellar? That would cost thee much,” (p. 59) she describes the tremendous price one pays when one seeks union with God. She writes,

Ever longing in the soul,
Ever suffering in the body,
Ever pain in the senses. . .
Those who have given themselves utterly to God
Know well what I mean (audiotape).

In what is to later be known as The Flowing Light of Godhead, Mechtild enters a flirtatious sparring match with God. Employing the medieval love tradition, God, as courtier, teases,

Look how she, who has wounded me has risen!
She comes. . . racing like A hunted deer
to the spring which is Myself.
She comes soaring like an eagle
Swinging herself from the depths
Up into the heights.

Mechtild enters the banter with.

Lord, I bring thee my treasure
It is greater than the mountains,
Wider than the world
Deeper than the sea
Higher than the clouds,
More glorious than the sun,
More manifold than the stars.
It outweighs the whole earth!

Curious as to her illusive meaning, God inquires,

O thou, image of my Divine Godhead
Ennobled by My humanity
Adorned by My Holy Spirit
What is they treasure called?

Mechtild, as a young maid, professes her devotion to her suitor.

Lord! It is called my hearts desire!
I have withdrawn from the world
Denied it to myself and all creatures
Now I can bear it no longer,
Where, O Lord, shall I lay it?

To which an ever present, loving God replies,

Thy heart`s desire shalt thou lay nowhere
but in mine own Divine heart
And on my human breast
There alone wilt thou find comfort
And be embraced by my Spirit. (1.43, pp. 55-57)

Mechtild understands that before she will be able to enter “God’s embrace,” she must overcome the pitfalls of worldliness, temptation, and pride, and submit to “the annihilation of self, which drags so many souls back that they never come to know real love” (p. 57).

The height of the soul is reached in love. . . therefore, those who would storm the heights by fierce, inhuman effort deceive themselves sorely and bear within themselves grim hearts, for they know not the virtue of holy humanity which along can lead the soul to God (p. 57).

Once again, Mechtild emphasizes that union with god is the result of “flow,” not of “force,” and cautions the reader, not to over intellectualize his spirituality. After all, if faith is a gift from God, it must be accepted as such. On a similar note, Flinders observes. . . “remarkably, the very disciplines we undertake as spiritual aspirants can themselves become obstructions in the latter stages of spiritual development” (p. 57)

The coquettish discourse continues. When her illusive companions anxiously suggest a union with the Divine is simply too “fiery and hot” (p. 58), Mechtild unexpectedly counters with what Flinders suggests would be a great line for a Billie Holliday song. . .

Fish cannot drown in water,
Birds cannot sink in the air.
Gold cannot perish in the refiner’s fire.
This has God given to all creatures.
To foster and seek their own nature.
How then can I withstand mine? (p. 58).

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