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On Becoming One-Self: Reflections on the Concept of Integration as Seen Through a Case of Dissociative Identity Disorder

Debra Rothschild, Ph.D.

This paper explores the concept of “integration” as it relates to the development of self-awareness and the recognition that one exists as a self. It is argued that this awareness relies on a capacity for self-reflection which is intimately tied to the ability to locate oneself in time and in space. Through the presentation of a patient with Dissociative Identity Disorder, the author demonstrates how the development of the patient’s consciousness of self progressed through the treatment and particularly, through the relationship between analyst and patient. In the case presented, the patient began treatment unaware of her dissociative structure. She was also unaware of the continuity of time, including the concepts of past, present, and future as they related to herself, and to the fact that she existed in a body that was subject to the basic laws of physics such as being able to be in only one place at one time. Through the development of a self-reflective capacity and a growing familiarity with the various aspects of herself, the patient began to develop a sense of herself as a continuous entity physically, psychologically and spiritually.

Contemporary relational psychoanalysts have placed the concepts of self-states, dissociation, and integration at the center of theoretical and clinical discourse. (Bromberg, 1998, 2006; Davies, 1998; Stern, 2003). The very concept of “self” is understood to include multiple selves, which are experienced to varying degrees as continuous or discontinuous with “who” or what we believe we are. As Mitchell (1993) put it, “We are all composites of overlapping, multiple organizations and perspectives, and our experience is smoothed over by an illusory sense of continuity” (p. 104). This sense of continuity overlaying an actual multiplicity was also referred to by Bromberg (1998) in what he called the “illusion of unity.” He explained that this illusion develops as a result of maturation. The psyche, nonunitary in origin, develops a coherence and continuity that through healthy development becomes a cohesive sense of personal identity. When the developmental process is disrupted, as in the case of trauma, the sense of coherence is compromised and the dissociative structure becomes fixed. As Bromberg (2006) described it,

What was formerly a fluid and creative dialectic between self states ... is slowly replaced by a rigid Balkanization of the various aspects of self. The process of dissociation has now become enslaved to a dissociative *structure*. ... Self continuity is now preserved within each state, but the overarching coherence among states is sacrificed. (p. 5).

Nowhere can this rigidified, pathological dissociative structure be seen more clearly than in the most extreme condition of dissociation, Dissociative Identity Disorder (DID).

This paper presents a case of a patient with DID to demonstrate some ideas about dissociation and integration. “Integration” is often a stated or implicit aim of treating people who suffer from pathological dissociation, yet what we mean by the term “integration” is not immediately clear. It is not simply unifying dissociated parts into an undifferentiated whole. As Mitchell (1993) stated, “it seems mistaken to assume that a digestion and blending of different versions of self is preferable to the capacity to contain shifting and conflictual versions of self Discontinuities in self-organization are part of what enriches life” (p. 105). In other words, the goal is not to blend disjointed self-states into one. Rather, it is to increase awareness of the various aspects of self and to facilitate access to them at appropriate times. Bromberg (2006) said,

When we are working with dissociation, my caveat is to be wary of thinking of the therapeutic process as if it were a progressive integration of many into one. Rather, I contend that optimal mental functioning consists in our being able to access disparate self-states and that treatment ought to provide a context for facilitating internal communication between these states as a nonlinear, repetitive process. (p. 26)

The sense of continuity, that illusion of unity which allows us to “feel like one self while being many” (Bromberg, 1998) is the result of mutual recognition and internal communication among self-states. This requires the capacity to stand back and reflect on oneself. The capacity for self-reflection, in turn, depends upon the recognition that there is a self upon which to reflect. This paper explores this concept of self-knowledge and how it relates to the subjective experience of being a self located in time and place; the development over the course of treatment of a sense not only of *who* one is, but more important yet, the awareness *that* one is.

Through the presentation of a patient called Sarah, I describe the development of her awareness of self and how it progressed through our treatment and the relationship between us. Sarah came to know her various selves as I related to each of them and held and linked my relationships with them.

Clinicians who treat DID from a traumatology rather than a psychoanalytic perspective, such as Putnam (1989) and Haddock (2001), agree that the goal of treating patients with DID is to achieve a stable sense of unity. Haddock stated that the goal is never to make parts disappear, but to create more awareness and cooperation within the system. Putnam described how internal dividedness leads to a life of chaos and stated that personalities (or aspects of self) must learn to communicate and cooperate. Quoting David Caul, he said, “It seems to me that after treatment [of DID] you want to end up with a functional unit, be it a corporation, a partnership, or a one-owner business” (p. 137). When a person doesn’t know, or only “kind of knows” that he or she has various dissociated parts and is unable to communicate between those parts, life becomes chaotic and out of control. A person familiar with his or her various self-states is not surprised by her own behaviors and therefore has control over the choices he or she makes and the actions he or she takes. Knowing the multiple parts of a self allows for communication and negotiation among them.

The seeds for this paper grew from my involvement in a discussion group made up of people who had DID and professionals who treated it. Sarah, the patient presented, and I took turns attending the meetings as we were both interested but felt it would be better not to be there together. The purposes of the group were primarily support and sharing of experiences for the patients and education for the professionals. During the meetings, I was struck by how often members with

DID talked about their wish for integrated experience as one in which they would be “fully present” in a given moment. It appeared to me that something was missing from the concept as they described it. In my experience with patients with DID, it seemed that a particular aspect of self (or, in the language of trauma, an alter) was often fully present, but so fully present as to be lacking awareness of anything else. My experience of them at these times felt anything but integrated. It was as if they existed only in that moment without acknowledgment of what had come before or what was likely to come after.

“Full presence” necessitates something more than presence in the moment. To be “fully present” in relation to another, a sense of perspective is needed and that perspective can only exist in the context of having an awareness of the existence of self and access to the history of that self; it requires the capacity for self-reflection. A self-reflective capacity enables knowledge of the self existing in space and in time, with a sense of continuing from the past, through the present and into the future. In the case of Sarah I demonstrate how this self-reflective capacity developed over the course of our treatment along with a new relationship to the experience of time and space. I discuss how the relational nature of the work, the consistent presence of a caring and interested therapist and the mutual building of narrative contributed to this accomplishment. I argue that the concepts considered apply beyond the treatment of patients with actual DID, or even those for whom dissociation is the major organizing factor, but are relevant to anyone with dissociative tendencies or to aspects or moments of any treatment where dissociation comes into play. Exploring these concepts through their most clear and extreme manifestations can help us to understand and treat others as well.

A note about language seems indicated. At the time this patient began treatment, the field was in transition regarding terminology. Even the name of the disorder was changing, from the former “Multiple Personality Disorder” to the current “Dissociative Identity Disorder.” According to Chu (2005), writing for the International Society for the Study of Trauma and Dissociation Web site, Dissociative Identity Disordered patients are those who have

distinct identity or personality states, each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self. Alternate identities are dissociated parts of the mind that the patient experiences as separate from each other. (p. 1)

The patient Sarah fit this description and was accordingly diagnosed with DID. Although proper professional nomenclature for the condition was DID, the terms Multiple Personality; MPD; and the noun *multiple*, as in “being a multiple,” remained in common parlance. It is worth noting that the patient, once diagnosed, referred to herself as having MPD and being a multiple. Additionally, throughout the paper I use the terms “alters” and “personalities.” These words are commonly utilized in traumatology literature in writings about DID. They refer to what psychoanalysts would think of as unintegrated self-states or, as Chu (2005) indicated above, “dissociated parts of the mind.” In cases of the extreme form of dissociation manifested in patients with DID, however, these dissociated aspects of self, or alters, are particularly notable in that many if not most of them have names, personalities, and histories that are distinct from each other but continuous over time for that one. In this paper I alternate between the traumatology terms of *multiplicity*, *alter*, and *personality* and the psychoanalytic terms of *self-states* and *unintegrated aspects of self*. This is meant to reflect the integration of the two theoretical paradigms that underlie my work with patients who have experienced severe trauma and present with extreme dissociation. In describing

the work with the patient presented I mostly use “alter,” “personality,” and “multiple,” as those are the terms she came to use for herself.

CASE PRESENTATION

“If you smash anything hard enough enough times, it will smash into pieces. I guess that’s what happened to me.” This was Sarah’s explanation of how she had become a “multiple,” or, in diagnostic language, how she had developed DID. She said it about 1½ years into a treatment that began with Sarah having no conscious awareness of her dissociation at all. It had been after about 4 months of treatment that her diagnosis became evident. Sarah had begun therapy at the age of 43, scared to death, new to this kind of treatment, knowing that something was wrong with the way her life was going, but not able to identify exactly what was amiss. At that time she was newly (2 months) sober from alcohol, had a history of multi-substance abuse, and in sobriety had begun to recognize herself as a survivor of incest and terrible abuse. She was involved with Alcoholics Anonymous and Survivors of Incest Anonymous. Although she had never had any psychiatric treatment herself, Sarah had seen two sisters suffer through multiple hospitalizations and receive both ECT and insulin shock treatments. She had once begun a counseling/therapy relationship with a nonlicensed person who ran off with Sarah’s female lover after a few months of knowing her. Suffice it to say, Sarah began this therapy with about zero trust of anyone and less than zero for anyone who was a professional in a mental health field. Entering therapy was probably one of the most frightening and bravest things Sarah had ever done in her life.

Sarah was the second of four children born in a very rural Southern town. Her father was abusive sexually, physically, and emotionally, abusing all his children and his wife from the moment any of them entered his life. Her mother was alternately the victim of her husband and an abuser of her children, also sexually, physically, and emotionally. From Sarah’s description, her mother was most likely psychotic, or possibly dissociative herself. Some of Sarah’s earliest memories involved being wakened in the middle of the night along with her brothers and sisters to watch their father rape their mother from behind as he forced her to her knees and made her lick dirt off the floor. Sarah herself was the victim of many rapes by her father and his friends, as well as vicious beatings and gross humiliation. Sarah remembers her first awareness of dissociating in response to her father attempting to suffocate her crying baby sister with a diaper. Mother and other siblings jumped to intervene as Sarah felt herself “rise up, go out the window and observe the scene from outside.” A few days later, as her father was beating her with a belt, having come suddenly into her room with no warning, she remembered that it’s safer outside and again “went out the window” and watched the scene of the girl being beaten as she herself felt nothing.

Sarah related these and other absolutely horrifying stories over the course of our treatment in either of two ways. Mostly, she reported them in a totally affectless way, as if talking about a stranger or telling a story she’d read. I would hear the details and feel either terribly sad or overwhelmed with a mix of emotions, or, sometimes strangely devoid of feeling, finding myself wondering, “Is it true?” I knew she couldn’t make this stuff up, but it was so extreme as to seem unbelievable. I must have taken it all in however, as afterward I would find myself compelled to repeat the stories over and over to whatever supervisor or close colleague would listen. I had to process the secondary trauma of witnessing such incredible abuse. Sometimes a specific moment in a “story” would bring tears to my eyes, despite Sarah’s striking lack of emotion. For example, when

she told me about going out the window while her father beat her unfeeling body to describe how effective her newfound skill at dissociating could be, she then told me that after he left she took out her favorite doll, cut it up, destroyed it, and hid it away.

At other times, Sarah would go into a dissociative state, reliving the experience as an abreaction, screaming, crying, often banging her head on the wall behind her. At those times I would jump to action—to hold her head so she did not get hurt and to try to comfort without scaring her. I was forever afraid to get too close or too physical knowing how frightening contact could be for her, especially as she remembered intrusive, abusive experiences. I felt totally in the moment at those times, scared but not really able to think beyond the tension, to touch or not to touch—how much to touch—and how to reach through to ground her again in being present with me. Perhaps I really needed to ground us both, to bring us back to the present and the safety of knowing that the experience which seemed so immediate had really taken place in the past. I developed a pattern of witnessing the story/memory and then looking at her as intensely as I could, asking her over and over again to meet my eyes. It was usually difficult for her to focus, but once she could I would then remind her who I was, where we were, and the date and the year. We would repeat the date over and over putting the memory into a temporal perspective. This became an extremely important aspect of our work, as is elaborated later.

One of the fears that Sarah expressed early in therapy was that if she remembered too much or allowed herself to feel any of what she remembered, she would fly away and never come back, or possibly lose her mind, as her sisters had lost theirs. It was as if she knew that the dissociation was necessary to maintain her sanity, and that if she became overwhelmed she could lose her self altogether. Thus, she was aware of the potentially traumatizing nature of the therapy, but was also aware that even within her dissociated identity there was some sense of presence or selfhood that felt crucial to protect. The therapy, by challenging the dissociative structure that supported her sanity, could threaten that selfhood. In order to engage in it, Sarah had to trust that I would protect her from ultimate dissolution or psychosis. Years into therapy, Sarah told me what had allowed her to trust me enough, despite her terrible fears. During our first session, a spider came into the room. Without thinking, I picked it up and placed it outside the window. Sarah thought, “If she won’t hurt a spider, she probably won’t want to hurt me.” In that moment I had unknowingly established the environment of safety that became the foundation of our treatment together.

It was during our 4th month of work that Sarah’s DID or “multiplicity” became clear. We were talking about her suicidality, which was quite severe at the time, and she said, “Well, if it’s up to me, I won’t do it.” This was an odd statement indeed, one that sent shivers up my already tense spine. It clinched what I had strongly suspected. As I pushed Sarah to explain her statement, she became increasingly defensive and rationalized it in all sorts of ways that made little sense. Finally, she looked right at me, and with an eerie stillness in her eyes said, “There’s more than one.” At first she was terrified that she would be hospitalized or given drugs or shock treatments, but once reassured, she experienced tremendous relief from the confession. This was something she had never told anyone, nor even articulated to herself. Until that moment she had simultaneously known it and not known it, she had “sort of” known it. I think I, too, had sort of known it. There were signs, but never having seen a “true multiple” before, it seemed hard to believe. At that moment, as scary as it was to think of the implications, there was a kind of hopefulness in the confession. The secret was out. We could acknowledge what was and work from there. It felt like a new beginning for us.

Shortly after that session, Sarah reported a dream. The dream and how she told it revealed not only her awareness of multiplicity and wholeness, but also the remarkable creativity, humor, and capacity for metaphor which served her so well, and which I appreciated so much as the treatment progressed. The dream was as follows: "I was going to a committee meeting of some sort. I went into the room for the meeting and realized there were cochairs of the meeting. I walked up to the cochairs and said, 'Two chairs, you must be a couch'."

A new phase of the therapy began in which Sarah and I together were introduced to and came to know many parts of herself. As with most multiples in therapy, I often had to start over, developing a new relationship and earning new trust from different alters as they emerged. At times, she would not know where she was or who I was, and I would have to introduce myself and explain. More often, an alter personality would emerge and say, "I know you," and I would be able to ascertain that she or he had listened and been present for at least some sessions before.

It was important for Sarah to know that all of the dissociated aspects of her self (or, in traumatology parlance, all of the alter personalities in the system) would be welcome. For example, I first met a child after Sarah had called requesting an extra session. She was extremely upset because she was on a tight deadline at work and unable to do her work or to sleep. She'd spent the weekend trying to concentrate, but unable to, due to a constant clamor in her head of a child's voice saying, "Let's play, let's play." I told her that I too sometimes wished to play rather than to work; we all have that voice in some form. I explained that I believed that sometimes the child is right and we need a chance to play, that we should listen to and respect all the voices in us. Trying to shut that child up just made it scream louder in its effort to be heard. Following this session, Sarah no longer suffered from the clamor of a screaming child as she began to listen and respond to that voice in her head and soon, in the midst of a session, I saw Sarah transform into a child before my eyes. Her eyes, her voice, her demeanor became totally innocent and childlike, and we talked. Sarah's embodiment of the child state was so total that upon reflection I realized that I too had shifted without conscious decision. I automatically responded to her as I would to a young child. Eventually, this child brought toys and coloring books into my office and when she emerged during a session, she would ask to play or to color and we would get on the floor and do it together. By asking Sarah to listen to her and encouraging her to feel important and welcome, I had invited her in. Thus, Sarah and I established a relationship of openness and trust over and over again. Each of the many different aspects of her, her "personalities" or alters, was welcomed in over the course of the treatment, including some who were angry, destructive, or scary.

We had now entered what Putnam (1989) called the important phase of "development of communication and cooperation" (p. 139). This phase constituted the crux of the treatment. Sarah became interested in knowing the various parts of herself, and like with the child, she began to practice listening to the voices in her head. She learned that if she listened rather than try to shut them out, they would not have to shout so loud to be heard. The many dissociated aspects of Sarah became interested in each other and began to consider a relationship of cooperation rather than competition to be in control. Before she began treatment, whatever aspect of Sarah was present to the world and acting in any given moment was the only part of Sarah conscious at that time, and then later, in a different self-state, she would have no experiential memory or awareness of what had transpired before, and often no memory at all, even as an observer. Through this phase of the therapy Sarah increasingly developed the ability to attend to interactions and events that took place in various self-states and to hold on to them with the information shared throughout the "system"; in other words, known by various parts of herself.

This development, so obvious and crucial in the treatment of DID, is one which can be seen in more subtle forms in treatments wherever dissociation, even to lesser degrees, plays a role. It is through the relationship with the therapist that the capacity for greater self-knowledge develops. Here, with Sarah, it was so clear. As each of her “personalities” or aspects of self were revealed in the therapy, I developed a relationship with them. Over time, I became the one who knew and could hold the many facets of Sarah and literally introduce them to each other. Through sharing the important relationship with me, they came to know each other. Sarah became able to “listen” not only to the voices inside her head, but also to what was happening during sessions, between us, even when a previously silent and hidden self-state was active. This then translated to her life in the outside world. It happened less and less often that Sarah would wake to find the remnants of Chinese delivery she had no memory of ordering or eating. Similarly, in many treatments, we help our patients become aware of dissociated aspects of self and to know them simultaneously, what Bromberg (1998) described as “standing in the spaces,” the acceptance “as a valid mental state in itself, the experience of observing and reflecting upon the existence of other selves” (p. 283). Like with Sarah, the result of this expanded self-knowledge is increased control over choices and fewer experiences of surprise at “finding” oneself doing or saying something that feels like “not me.”

Mitchell (1993), Bromberg (1998, 2006), Davies (1998), and others have described the important role of the therapist in relating to each of the patient’s multiple aspects of self while holding an image of the patient as a continuous whole. Likewise, Schwartz (1994) has spoken of the importance of maintaining the tension between the opposite poles of unity and multiplicity when treating patients with DID, and reminded us that “therapeutic alliances must be cultivated simultaneously with the patient as a whole and with individual alter personalities” (p. 201). It is through these (and this) relationship(s) that the various parts can become linked and ultimately experienced by the patient as parts of a whole. Sarah understood this. She came to recognize that although the various aspects of herself may not know much about one another, I knew many, if not all, and in some sense, for a time, I could hold them together for her.

As she became increasingly interested in learning about herself and her “parts,” Sarah actively engaged my assistance by asking me to tell her about personalities or incidents of which she was not able to be aware. At times, while in one self-state, she would write me a list of questions to ask a particular other self-state (alter) when he or she emerged, so that I could communicate back. She also began a journal in which she wrote entries often as letters to and from the various parts of herself. The journal, as well as the mediated communication through me, enabled Sarah to negotiate amongst the parts of her mind. This was especially helpful when she felt physically threatened or actually hurt, as when she would wake to find herself cut or bruised in some way. For example, a protective part of Sarah slept with a knife under the bed to ward off intruders. Another self-destructive part often used the knife to cut or mutilate herself during the night. A literal negotiation session took place, with me as moderator. At the end of a tense and frightening hour and a half, the one who kept the knife agreed to be ready to scream instead of attack if an intruder came in, and the one who cut agreed not to obtain any weapons during the night. The knife was put back in the drawer and Sarah’s self-cutting was greatly reduced. I was relieved, but it had been scary indeed. I felt as if I had taken on the responsibility of managing a life-and-death hostage situation with no training in hostage negotiation and no control over the outcome. Sarah had described herself to me as sometimes running on “parallel tracks.” I believe I understood what she meant. I had moments during these negotiations of feeling simultaneously completely calm and in charge while totally panicked and over my head.

I experienced “parallel” opposing feelings at other times with her as well. One instance explicitly depicted for me the simultaneous horror and danger of what we were facing together with the underlying safety we had established. I believe it was this ability to experience both together that provided the basis for much of what we achieved in this treatment. Sarah was describing the abuse she had suffered at the hands of her mother. When she was small, Sarah’s mother would scream and beat her, yelling what a dirty, unforgivable sinner she was. As Sarah was telling me this, she suddenly switched and became her mother. Sarah was a large woman. She stood up, came over to my chair, and leaned over my body, completely surrounding me, screaming in my face in a way I had never experienced before. It was terrifying. I knew she was in a trance-like state and she could hit me at any moment. The yelling was so loud, the physical threat so imminent, I was shaking and paralyzingly frightened—and yet, at the same time I *knew* that she would not hit me. Sarah would never really physically hurt me. Somehow I knew I was safe.

As referred to above, early in this phase I was very much an intermediary amongst alters, or as Schwartz (1994) described it, I functioned as a “relational bridge over which different parts of the self [came] to learn of each other’s existence, history and functions” (p. 199). With time, Sarah learned to listen and communicate internally herself so that my mediating role was decreasingly necessary. According to Putnam (1989), and as evidenced here, the development of internal communication is a major force in the promotion of change in DID.

The development of internal communication and an increased ability to “stand in the spaces” and simultaneously know various aspects of self is closely related to the development of a sense of continuity in time. Reis (1995) stated, and I agree, that the disruption in the subjective experience of time is fundamental to the dissociative process. This is related to the distortion of time in the experience of trauma. Many people describe an accident in which they fell or were hit by an oncoming car as everything moving in slow motion. In terms of trauma and dissociation, Reis described the collapse of a temporal sense as a model of co-conscious mental operations in which a person responds simultaneously in the past and the present. An example of this is a patient with posttraumatic stress disorder who remains hypervigilant months or years after the trauma. Most clinicians who have treated traumatized patients have witnessed the confusion of time as the traumatic memory is recalled. The patient will often describe it in the present, not as an event of the past, but actively reliving the trauma before our eyes. Through treatment a sense of time perspective develops in which what occurred in the past becomes memory rather than daily experienced present, and with this development, reflection becomes possible. As described above, this happened over and over with Sarah as she relived absolute horrors that she had had no conscious memories of before therapy began and we then remembered the current date and placed those events in the past.

Siegel (2003) contrasted the notion of “autozoetic consciousness” in which the self can create the experience of mental time travel by linking past, present, and future with “noetic consciousness” in which one knows the facts but lacks a sense of the self. With this, Siegel demonstrated the integral link between knowledge of the continuity of time and the awareness of having or being a self.

One of the hallmarks of extreme dissociation is a perceived discontinuity of time. The experience of “losing time,” or suddenly finding oneself doing something or being somewhere with no recollection of what led up to it, is common. As Putnam (1989) described, most people experience occasional episodes of preoccupation or intense concentration during which they lose sense of the passage of time, however, people with dissociative disorders frequently do something while in one

state and then, while in another, have no idea what they have done or that any time has passed. This can include buying clothing, cutting one's hair, applying for or quitting a job, moving across country, or any number of events over the course of a few minutes or months

As Sarah became more aware of her alter personalities and dissociative process, she became increasingly distressed by any incident in which she lost awareness of the passage of time. Previous to treatment, "losing time" had happened routinely to her, but she had accepted it as a part of life, one which was disconcerting at times and extremely upsetting at others, but inevitable. As she began to sense the continuity of her existence and how her dissociation could disrupt her experience of it, Sarah increasingly wanted to attend to the flow of time. In reclaiming a sense of coherence related to time, one can reclaim not only a narrative history, but also a sense of continuous consciousness, or continuity of selfhood, throughout the days of one's living.

A major event in Sarah's life was the purchase of a watch, early in her 3rd year of treatment. She had never allowed herself to have one before, and any watch she had bought had been promptly broken and discarded (by a different part of herself than the one who had bought it). Now Sarah could wear a watch. She described it as follows: "It's like someone who is obsessed with diet and weight loss who can't have a scale in her home because she'll be weighing herself throughout the day, looking to see if she gained or lost half a pound." If she had worn the watch any earlier in her treatment, Sarah would have obsessively checked it to make sure she had not lost any time. What changed that allowed her to comfortably and joyfully wear a watch was the development of a capacity for self-reflection. Although still prone to dissociation, Sarah was now aware of her dissociative tendencies and therefore not as terrifyingly baffled by her lapses in awareness of the passage of time. She could think about it in terms of herself being a self which had continued to exist even if she could not remember in a given moment what she had done moments before. With this growing ability, Sarah began to develop an understanding of the continuity of time from past through present to future and with this, a sense of her own history began to evolve.

Siegel (2003), speaking from a neurobiological perspective, described how integration of brain functions allows an individual to have an internal sense of connection to the past and to anticipate a future while living fully and mindfully in the present. He described how the process of therapy which allows for the reexperiencing and communication of traumatic states in the context of a securely attached interpersonal relationship facilitates a bilateral integration of information across previously dissociated brain hemispheres and also an integration of here-and-now with past-present-future consciousness. This results in an increased coherence of autobiographical narrative.

Experientially speaking, in the process of treatment words are put to what was previously unsymbolized and dissociatively stored or enacted. A narrative is created and with internalization of "story," linear memory begins to exist in the mind of the patient. Sarah began to reclaim, symbolize, and take possession of many of the traumas of her life. At one point, she was speaking of some memories, placing them in a historical context, when what she was doing dawned on her. At that moment, she exclaimed with glee, "This is new. I could never time travel like this before." For the first time, she had become aware of herself having a past to which she had access, and in the attainment of a past she also became aware of being able to remain in the present while looking at that past and conceive of having a future which she would live through.

Time is one dimension which is disrupted by the dissociative process; space is another. Dissociated aspects of self, or alter personalities, continue to live not only at a time other than now but also in a place other than here. Alters, especially child alters, may continue to believe they exist in the place where the patient was living at the time of the trauma that that alter holds. For example,

13-year-old John locates himself in Kentucky living with Dad while adult Sarah lives in New York. Just as various aspects of self exist even when not activated, alter personalities exist when they are not “out” or present to the external world. They live in their “room” inside, or may watch what is happening from another point in space outside the body we see.

A fundamental aspect of recognizing one’s presence in space is the knowledge that one has a body and that that body has limits and obeys physical laws. With extreme dissociation, this perspective has frequently been lost or never existed. Winnicott (1949/1975) referred to the gradual process of mutual interrelation of psyche and soma as an early phase of development that eventually results in the individual’s recognition of having a body, a body with limits, an inside and an outside, which when felt by the individual forms the core for the imaginative self. According to Winnicott, when continuity of being is disturbed by an unhealthy environment, this development of psyche-soma is disrupted. Sarah suffered from such a disruption. Before entering treatment, she had no concept of having a body, of existing in space, and no experience of continuity of being. She did not recognize the limits of her body or its physical laws, such as not being able to be in two places at once. As therapy progressed, such awareness developed, and at times it was difficult. “Maria” (one of Sara’s alters) was quite distressed when she had to give up her dreams of graduate school in order for Sarah to keep working. Although it took us through a very difficult time, one of the many where Sarah (in the form of Maria this time) deeply resented the therapy, the recognition was an indication of Sarah’s growth. In earlier times, she might have “woken up” at school in another city, having lost both time and place (and income) and not knowing how she got there. The development of internal communication and a new understanding that the parts of herself make up a whole that lives in one body in one space is what prevented that from happening this time.

Recognition that all the alters share one body was central to the treatment. For Sarah, as for many patients with DID, this was a major and somewhat traumatic discovery. For example, “Andrea,” who is thin and eats healthy food, was enraged to learn that “Nancy,” “Mary,” and “Sarah” overeat and the body they share is quite overweight. The first time “Andrea” appeared in my office was a fascinating experience for me. Sarah came in and I thought, “How did I not notice she’s been losing weight all this time?” She looked so much thinner! As the session progressed, I noticed that there was something different in her inflection and affect. She sounded grounded, a bit serious, and with a resonance in her voice unlike any I had heard before. Eventually she told me that “she” was called Andrea and she talked about living in Seattle as a massage therapist several years ago (something I had known nothing about). Late in the session, it emerged that she was thin. I was flabbergasted! The thin alter actually looked thinner! Andrea came to many sessions after that and I got to know her quite well. It turned out that she had had a lesbian relationship when she lived in Seattle (she was the only alter who enjoyed being touched; the others could not tolerate it) and was quite lonely. She had not been aware of the therapy for most of the time and had some catching up to do. Many of the other alters were grappling with the issue of having one body at this point, but for “Andrea” this was a new concept. It became a major topic of conversation with her and she reacted with a mixture of sadness, disgust, and anger. Around this time, Sarah was planning a vacation to France. Finally “Andrea” admitted that she was planning to abandon her life and not return from vacation. With exploration, it was revealed that her motive was to escape the therapy. We went through some angry sessions until we got to this point, but eventually it became clear. I told her then that she did not have to leave her job, friends, and home, but that if she wished to leave therapy, she could return from France and simply leave therapy. She was amazed. It had never occurred to her that she had that kind of freedom. Of course, once she knew she could

leave if she wished, she decided to stay. We were then able to talk about how difficult the therapy was for her as it confronted her with such painful truths, like the idea that she lived in a body that was overweight, had an ulcer, and was scarred from self-cutting. She told me one day that she had “heard” other alters inside telling her that it was true that they all shared a body and encouraging her to remain present and listening more often during therapy sessions. She did, and with time, she became interested in the phenomenon and asked me often with curiosity and wonder what I saw when I looked at her.

Another, very serious concern around sharing a body concerned safety. All of Sarah’s alters had to learn that if one of them gets hurt, they all get hurt. If, for instance, alter A cuts herself or attacks alter B, the entirety of Sarah will be affected. One of the several times we faced this was with the knife under the bed incident described above. For all dissociative individuals, this issue raises obvious questions and dilemmas, such as when a male alter learns that he is in the body of a female, or when children find themselves in a body engaged in sex.

Recognizing the integrity of one’s body is a recognition of oneself occupying a particular place in space and it contributes to the recognition of oneself as an (at least physically) intact object separate from others. When it coincides with an awareness that one has memories, a past, present, and future, and therefore occupy a moment in continuous time, it is an experience of feeling like a coherent self, a knowledge that one is a “one.” For somebody who has never before had such perspective, this can be a profound awakening. Sarah had the experience for the first time at a street corner in a blizzard on her way to her therapy appointment. She suddenly looked up, saw a street sign, and thought, “I know just where I am, just where I am going, what day it is, what time it is, and why I am headed this way.” She jubilantly described it as a moment of exhilaration and great peace throughout her body. This sudden recognition of her self-coherence became an experience she frequently referred back to as deeply moving and significant.

At a certain point in the treatment, Sarah’s alters began to spontaneously unite. First, two at a time, then more. A pattern emerged in her dreams and waking life in which the children were becoming a “broth” and the adults a “cake.” She chose broth and cake because in her words, “both are substances in which although the individual ingredients lose their original distinct forms, none are lost and all contribute to the result.”

A huge fear of uniting alters is that in the unification, “someone,” that is, an alter, will die. It is not always just the patient who carries this fear or suffers grief over a lost identity. An important part of the work was the relationship I, as therapist, had with each of the personalities embodied by Sarah. It became very important to recognize my own countertransferential mourning for particular alters as they were no longer distinct presences with whom I could interact. This was especially so for a child who loved to play and a rational, helpful adult who told me what was needed when I felt stuck. Despite this, Sarah believed that I would be pleased by this development and she began reporting a rapid succession of alters becoming part of the mix. Following a minor trauma in the therapy process, many came back apart. Sarah was upset by this at first, but then realized that what she had been doing was not integration but “sticking together pieces without any core, without any *soul*” (Sarah’s words, italics mine).

As Sarah learned, integration is not simply putting pieces together so that they cohere as one. It is a process that includes some kind of center, core, or, as Sarah put it, a soul. I believe that that requires knowing that one exists. It is not about finding, or building a self, but rather developing awareness of having a self and a capacity for self meaning—a capacity that includes seeing oneself in time and in space.

Becoming an “integrated person,” therefore, can be seen as becoming aware of the continuity of one’s coherent existence across person, place and time while being cognizant of the multiple and various aspects of self. It is what Bromberg (1998) referred to when he spoke of “standing in the spaces between realities and between past, present and future, without having to lose any of them” (p. 283) and what he says self-acceptance and creativity is all about. He depicted beautifully how standing in the spaces facilitates self-awareness, creativity, and perspective. Hacking (1995), writing about multiplicity and dissociation as a philosopher, took a similar view, equating self-consciousness with having a soul. A person with self-knowledge, he said, is a person with a soul, with “what the philosophers call freedom ... our best vision of what it is to be a human being” (p. 267).

Sarah had one alter whom she called the Old Man. The Old Man knew everything (“everyone,” as in all of her parts) and saw all that she did. “He” had perspective and an awareness of consequences implicit in the recognition of time and a future. Sarah believed the Old Man protected her from harm. She did not claim that capacity as part of herself. Until Sarah could accept the Old Man into her concept of self, she did not believe in her ability to take care of herself or to know the varying parts of herself. Her capacity to stand in the spaces was split off, dissociated, and relegated to an alter personality she had named the Old Man.

As she progressed through treatment, Sarah began to claim her memories, talk about them, and remain present through painful experiences. She was increasingly able to bridge dissociative gaps by remembering the past while being consciously in the present and simultaneously aware of the varying moods and self-states she occupied throughout her day. She became able to stand back, observe, and reflect on herself. Eventually, through the process of integrating various “parts” into a whole, the Old Man became integrated as well. Sarah accepted the integrative function itself as part of herself. As B. Wolstein (personal communication, May 1, 1996) suggested, Sarah’s newfound capacity to “not feel minus a soul [may have been] the result not of internalization, but an emerged awareness of something originally there beyond awareness.”

Judy Kessler (1996), in her autobiographical description of life as a “multiple” before therapy said, “I did not know life existed. I did not know I existed.” To know one exists requires having the perspective to look at oneself, and consequently, to know something about who one is. This is what Hacking (1995) referred to as “soul.” He said, “The Delphic injunction, ‘Know thyself!’ did not refer to memory. It required that we know our character, our limits, our needs, our propensities for self-deception. It required that we know our souls” (p. 260). Is this not the aim of psychoanalysis? Regardless of the extent of dissociation we see in our patients, our goal is not to uncover memories, but through them, along with recognition of the various qualities and aspects of self, we strive to help our patients know themselves better. We facilitate awareness of being a self and knowledge of who that self is.

To know oneself requires the capacity to stand in the spaces. Perhaps what stands in those spaces is what Sarah and Hacking refer to as soul. Sarah knew this was missing when she talked about sticking her pieces together “without any core, without any soul.” As she began to recognize her existence in time and space and to know the many aspects of herself, including the Old Man, she began to reclaim her soul. Implicit in having a soul is acknowledgment of being the center of one’s own life and of having agency in it. As Sarah described it, “It used to be like I was on a people mover at the airport. I’d just get moved along and I’d close my eyes then open them and I’d be someplace else. Now it’s like I’m walking and I know I’m doing it.”

Sarah's expanded self-knowledge and internal communication led to this growth. The context of safety, consistency, and love facilitated and allowed it to happen. Toward the end of our work Sarah said, "I think the whole process here with you that I've been doing unknowingly—it just happened really—it's like a deeper sense of living in the present. Just being there. You know, you are a person who knows a lot about me and you still greet me at the door and seem happy to see me and you don't run from me like I'm an ogre and it means I don't have to switch or hide or go away. I can be myself in the world and it's acceptable. That's huge."

Sarah and I had traveled a long road together. As may be obvious, I came to care for her deeply, and Sarah knew that. In that context, she worked hard to recognize and accept all the aspects of herself and this led to the ability to be fully present, to have perspective, and to know that she exists. She knew she had a center, a soul. Sarah was able to stand in a blizzard and know not only that she was there, but where she was going, where she had come from, and why.

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