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MULTIPLE PERSONALITY DISORDER
Two Cases in Progress

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> ...My sisters will never know
> that I fall out of myself and
> pretend that Allah will not
> see how I hold my daddy
> like an old stone tree.
>
> Anne Sexton *The Moss of His Skin*

After five years of bioenergetic therapy R began to remember a horrendous history of sexual abuse. For the next 18 months she relived one abuse trauma after another. These gruelling abreactions did not, however, lead to the positive results that I had expected. There were only brief periods of relief from chronic insomnia and somatic ailments. Then R started to redo catharses of traumatic material that I thought had been thoroughly processed. Quite perplexed, I consulted a colleague, Robin Scherm, who is an expert in the area of sexual abuse and multiple personality disorder (MPD). Robin helped bring R's dissociative behavior into focus. As I continued working with R,
I soon realized I had mistaken her switching to alter personalities for ordinary regression. I had also misread her flashbacks and night terrors as fantasies, dreams and nightmares. R strongly opposed my suggestion that we explore the possibility of MPD. Nevertheless, in the very next session, in the throes of reliving a familiar incident of abuse, two of her alter personalities came out and identified themselves. Attending to the amnesia that kept the alters incommunicado brought about dramatic changes. The reabreactions stopped and, despite a temporary rise in anxiety, her psychosomatic symptoms lessened considerably.

The contrast between R's and J's therapy is striking. I had become more thorough in recording patient's histories and more attuned to dissociative elements in the behaviors and bodies of

incest victims. Certain features in J's body were similar to R's, and the large gaps in her memory pointed to significant amnesia. Using the breathing stool made J feel "spacey," that is, not cogent in her thinking and uncoordinated in physical movement. Kicking on the bed or hitting with the tennis racket quickly dissociated her. Her throat went into spasms as soon as she would begin to release crying or rage. Although I could help her discharge by loosening the jaw and throat manually, her eyes became so cloudy that she could not maintain contact with me, nor could she connect to her feelings. I had learned from my previous treatment of R that continuing with highly dissociated chaotic abreac- tions made for a prolonged and painful therapy. Especially with MPD patients there is so much amnesia within the personality system that they cannot integrate the material produced by these kinds of catharses.

A change of pace and direction was therefore indicated. We continued with the physical work in a moderated fashion that seldom triggered full scale abreactions, and I found ways to bring out some of her alter personalities (alters for short). Sufficient contact with these alters confirmed her diagnosis as MPD. The next step in the treatment of MPD is establishing a cooperative co-consciousness in the personality system. There is no skipping this step in which the major resistances to therapy will inevitably emerge. Depending upon the makeup of the personality system of a given MPD patient, abreactive work can be resumed once enough of the alters are co-conscious and agree at least not to undermine the therapy.

R's therapy might well have been shortened had I recognized the degree of dissociation in her body, in her abreactions, and in her memory. R was, I must say, extremely clever in covering up switches and time losses not only from me but from herself. Once R accepted that she had several alter personalities and that she needed to bring them to co-consciousness, her therapy got back on track. I feel quite fortunate that we are well along the road to completing the work that we started seven years ago.

Due to growing support in the therapeutic community, including official recognition of the disorder (DSM-III-R, 1987), an increasing number of MPD patients are appearing in treatment. Diagnosis is a major problem. A recent National Institute for

Mental Health study found that 6.8 years on average passed from initial assessment to a correct diagnosis for MPD patients (Putnam, 1989). Many misdiagnosed MPD patients are now being discovered inpsychiatric hospitals, and the proportion of male MPD patients in prisons is thought to be high. Schetky (Kluft, ed., 1990) estimates that 20-40 percent of childhood abuse victims suffer from MPD. Identifying MPD is not a simple matter. Patients and their alters seldom reveal themselves as Eve Black did to Thigpen and Cleckley (1957), or as the alters of Sybill did to Wilbur (Streiber, 1973). Neither of these women, like so many abused victims, had conscious knowledge of her abuse backgrounds. Also, a diagnosis of MPD is not always welcomed by patients and may be avoided by therapists.

Pioneering studies of MPD were conducted a century ago by Pierre Janet, who coined the phrase "Successive existences." In the United States, Janet's work was followed up by several investigators, including William James and Morton Prince (El- lenberger, 1970). In the case of Miss Beauchamp, Prince delineated the amnestic barriers existing among four alter personalities. His therapeutic solution was to hypnotize the most pathological one out of existence and fuse the remaining three (Prince, 1975). Prince's maneuver runs contrary to contemporary practice. Hypnotically dissolved alters do not necessarily stay dormant, and the patient is deprived of the lost alter's experience and energy (Bearhs, 1982).

The ascension of psychoanalysis, and particularly Frued's refutation of the seduction theory, plus the increasing suspicion of the negative iatrogenic effects of hypnosis, brought about a decline of interest in dissociative models and MPD. Ironcially, the seminal case of Anna O., which Freud's early collaborator Breuer claims to have successfully concluded, is clearly one of MPD (Ellenberger, 1970 and Lowenstein in Kluft, ed., 1990). Hysteria, a much more inclusive concept for decades, and schizophrenia replaced MPD as acceptable diagnoses. A modern example of confusing MPD and hysteria is portrayed in the biography of Pulitzer Prize poet Anne Sexton (Middlebrook, 1991). Sexton's analyst, Martin Orne, taped her sessions and insisted that she take notes from the tapes since Sexton often recalled little or nothing of their dialogues. He also refused to relate to Sexton

when she referred to herself as Elizabeth for fear that she would develop MPD. Orne had been convinced by his own research that hypnotic suggestion could be used to create multiple personalities (Ellenberger, 1970). Coons, in his review of attempts to induce multiplicity via hypnosis, shows that only a similacrum of quasi alters is temporarily produced in trance (Braun, 1986). The flaw in Orne's well-intentioned approach was his misconception that MPD could develop in an adult in the same manner that hysterical symptoms, rooted in infantile trauma, often manifest much later in life. There is now conclusive evidence that MPD can develop only in severely traumatized children, and that the multiplicity manifests immediately.

Social concerns about child abuse, knowledge gained in treating Vietnam veterans for long-term effects of post traumatic stress disorder, and renewed respect for properly conducted hypnotherapy have resulted in a more receptive attitude toward dissociative models of psychopathology. MPD is, in fact, a severe manifestation of post traumatic stress. Amnesia, flashbacks, identity confusion, night terrors, and a host of somatic symptoms, many of which may become chronic, occur in traumatized adults and children, but only the child's resilient and developing organism can create multiplicity. In one current formulation, dissociation is conceived of as a continuum from supernormal and normal states of consciousness to pathological ones that include schizophrenia, post traumatic stress disorder and, at the extreme, MPD. Bearhs (1982), Watkins (1978) and Erickson (1989) write about transforming pathological dissociation into positive skills. Sexton composed most of her poetry in trance and J honed her skills in self hypnosis to delineate an anatomical map of her alter system. Both R and J evolved dissociative techniques to tune into their child alters to provide necessary self-nurturing.

Dissociative models of personality and psychopathology are welcome additions to psychoanalytic theory and bioenergetics. An energetic formulation of dissociation is needed, and one specific to MPD will be presented in the final section on MPD and the body.

Severe and repeated child abuse is the primary cause of MPD, and this abuse includes rape, beatings, torture (both physical and psychological), and neglect. The result of trauma can be seen in

the various kinds of dissociation that ensue: complete or partial out of body experiences; anesthesia of all or part of the body; splitting of the personality into alters, one of which remembers the abuse and one or more who do not, and often others who have one or more functions in the abuse and post abuse scenarios. One of R's alters was known as the Sex Child. Her function was to beg for sexual contact at her father's behest. She was detested by most of the rest of the alters because of her adaptation. She had never been out of doors and when she first came out in my office, she reveled in the forrest scenery outside the windows. R's Guardian, who kept watch at night in anticipation of a potential attack, is a good example of a fragment.

The second etiological factor is incongruent parenting. There must be some positive nurturing experience to give the child something to attach part of herself to. R's father tenderly sang his baby girl songs from the old country, but R created an alter to cope with the father's insistence that she take part in masturbating him.

There is a difference of opinion regarding the third possible causative factor. Putnam (1989), Braun (1986) and Bliss (in Braun, ed., 1986) contend that multiples have a constitutional tendency to dissociate. Bliss notes that multiples can slip in and out of "the dream world of hypnosis" without distinguishing dream from walking reality. During abreactions, I have witnessed my multiple patients experience such a slippage, but emotionally relived memory was the main component that alternated with present reality. In light of one of J's traumas in which she was imprisoned in a wooden crate for many hours and seems to have fallen into a twilight state of mixed dreams and threatening reality, Bliss' point is understandable. Nevertheless, I am inclined to agree with Ross (1989) that there is a tautological error in assuming a constitutional propensity to dissociation. Repetitive traumas create dissociation to the extreme in children, and hypnoid states are part and parcel of the dissociative experience.

Bliss' description of the switching phenomenon, however, is quite succinct and useful. I have observed countless times a "rapid and spontaneous self induction" to the succeeding alter. He points out that the trance may be quite brief, but in the interlude between alters, an amnestic screen can be created. The succeed

ing alter usually does not remain in trance and the observer, without familiarity with the person, may not notice any distinct change. The presenting or host personality is usually unaware of any alters (unidirectional barrier), but some alters may know the host and his or her activities well.

There is a knack to relating to MPD patients that requires an adjustment in the therapist's point of view. Each alter has a *raison d'etre* of its own. Body sensations, time/space orientation, handedness, susceptibility to allergens, reactions to drugs and medications and even serious medical conditions such as diabetes may vary from one to another alter (Ross, 1989; Putnam, 1989; Kluft, 1985). J's alter, Four, is fond of petting my cat who often stations herself outside the waiting room. When Karen comes out after Four has played with the cat, her eyes redden and tear, and her nose begins to run. Karen is the only alter with this allergy. Braun (1989) contends that the therapist is actually conducting group therapy with a single body. The therapist's task is to act as a conduit through the amnestic barriers. Intrapsychic conflict emerges once contact is made with several alters. Some vie for attention, some wait in the wings and, occasionally some are forced out. R's Mother Person did just that with Esther, a young girl frozen in a time warp that had lasted 35 years. When she first appeared, she huddled against the wall with her arm wrapped tightly around her knees and a wide-eyed look of terror on her mask-like face. She did not respond to any remarks or questions. Eventually, I determined that she was able to blink her eyes, and by doing so, she agreed to allow me to pry her arms apart. Several appearances were required before she gained the use of speech and several more before she was able to stand and walk on her own. We then focused on her part of the abuse traumas without having to reabreact them in their entirety.

Even after contact is made with several alters, MPD patients are usually ambivalent about the diagnosis. They are afraid having alter personalities means they are crazy or that they will be found out and ostracized. At the same time, having a rational explanation for time loss and confusing behavior is a great relief. Both patients also feared losing control over child and acting out alters once these personalities began expressing their needs and feelings in therapy. When J took a new position teaching in an

elementary school, two of her alters became highly stimulated. J's Judy was a young adult who had few opportunities to be executive for several years except when J was alone. Judy excelled in domestic work and child care but she was socially awkward and ingratiating. She was snubbed by other teachers and J., now co-conscious of her behavior, was quite embarrassed. Four, also lonely for companions her age, became attached to one of J's students. The best that J cold allow her was to play in the kindergarten classroom when no one else was present.

Bidirectional barriers are those in which there is no awareness and memory between the host and the alter. The traffic in a multiple personality system is not fixed. Mapping the system is a necessary mnemonic aid for the therapist, especially in more complex systems. There can be other complications in making contact with alters. R's Sex Child, later renamed Samantha, can only become executive by succeeding the alter known as Bertha, to whom she is closely related and from whom she originally split off. A multiple personality system can be used as a tricky form of resistance. One of the last of R's 16 identified alters calls herself No One. Addressing this alter as such was a simple matter, but if the therapist thinks that the name means this is a non-personality state, there can be confusion. The alters and amnestic barriers separating them may be fascinating, but it should be kept in mind that psychologically this is, so long as no further abuse exists, the multiple's outmoded defense. The job to be done in therapy is dismantling it.

Ross (1989) uses the metaphor of a corporate business structure to describe the process of establishing co-consciousness. Bearhs (1982) speaks of symphony orchestra in which the conductor rather than the CEO must insure cooperation and communication within the organization. My multiple patients have referred to their personality systems more often as families. In any case, contact with alters must be made and obstacles such as amnesia, antagonisms, and conflicting needs and interests must be defined. Putnam (1989) and Ross(1989) prefer to write out contracts but, so far, I have found verbal agreements with alters sufficient.

Fusion of all alters and fragments into a single functioning personality occurs in the majority of the cases followed up by

Kluft (in Braun, ed., 1986). Some of J's alters have fused in response to energetic work. Hypnosis is often used to promote fusion. Mayer (1988) recounts the turmoil that erupted following the fusions accomplished in trance of his first MPD patient's personalities. Some patients break off therapy before fusion is complete and many relapse into a lesser degree of multiplicity (Kluft, 1985; Putnam, 1989). Bearhs (1982), Watkins (1979) and Erickson (1986) contend that total fusion is not necessarily the only, or in some cases, the preferred goal of therapy. However, if multiplicity continues to mask unabreacted trauma and amnesia still is used defensively, I question its desirability. It is quite possible, as Bearhs contends, that complete fusion is "more of a by-product than a goal of successful treatment." He points out that in non-amnestic co-consciousness, alters become so alike one another in shared goals and content that absolute fusion is more of a philosophical than a therapeutic issue. These two schools of thought do agree on the importance of the final stage of therapy, integration. Anxiety, depression and lesser degrees of dissociation are commonly experienced by MPD patients after fusion (Ross, 1989). Serious relapses do occur. In an epidemiological study, Kluft found that more than 20 percent of patients tracked up to 27 months after termination had one or more relapses (Kluft in Braun, ed., 1986). In general, the more alter personalities there are the more likely relapses are to occur. Length of treatment similarly correlates to the number of alters involved. Further victimization, the existence of undetected alters, inadequate abreactive work, and the death of a loved one or former abuser are the major causes of relapses.

The Case of R

Many MPD patients appear to be quite normal people with intact ego functions. When I first interviewed R, she impressed me as being a devoted and overworked physician and a caring but anxious wife and mother. The second of three siblings, she claimed to be her father's favorite. Both parents were deceased. She felt more nurtured by her father, whom she remembered as being somewhat tyrannical, than her mother who was weakened by tuberculosis and had a tendency to depression. She was not

aware of any abuse. R enumerated several problems, the worst of which were anxiety and fatigue that made concentration difficult, chronic insomnia and severe head and neck aches for which she reluctantly medicated herself. A physician with psychiatric training, she felt certain that her problems were psychogenic. What she feared most, however, was making a medical mistake and disappointing her family. So long as her family was reasonably content and her patients received quality care, she could put up with the pain and the fatigue. With the support of her previous analyst and her fiance, she had managed to complete medical school despite her unrelenting distress.

R's rounded upper back and shoulders, and the compression of her torso, along with her resignation to suffering, seemed basically masochistic in character. She took to the physical work diligently and pushed herself to the limits of her endurance, whereupon she would either collapse or be ashamed of her weakness, or in a playful way tease me about the tortures of therapy. Little did I realize then that I was interacting with a succession of amnestically separated alters. Mother, Critical and Control Person's names are basically self explanatory. As a group they all suffered from the same somatic problems and anxiety. R's Jennifer, however, was symptom free. She could be playful because she took everything, including therapy, lightly. Furthermore, she was void of any knowledge about medicine. Control Person lacked the endurance to control the body for long periods of time except in emergencies, such as studying for exams and taking tests. She had nearly photographic memory as well as a highly developed analytic intelligence. Mother and Critical Persons managed the rest of R's serious affairs, and Jennifer was allowed out for socializing. Seven years later it is not easy to reconstruct exactly how R's personality system operated in therapy. No doubt some intrapsychic amnesia was lifted by the hosting alters' relating to me and the therapy.

The body work alleviated R's headaches, at least during sessions. Pounding the bed with her fists along with pressure I applied to the occiput and masseter muscles helped her express hateful feelings. Her voice during these discharges was often peculiarly guttural. She would switch to a male alter, Bobby, to vent her aggression, while I assumed that her deep voice was due

to constriction of the larynx. There was no improvement of her insomnia. Her anxiety level dropped for a day or two after her sessions only to return to its former peak. Also, there was no shaking her out of character stasis that compelled her to work long hours in an inefficient and fatigued state. Working provided her with a haven from the intolerable anxiety that accosted her when she had leisure moments. By building more charge in her legs and having her improve her grounding, I did help her withstand some of her fears long enough to begin to articulate them.

R had very confused sexual impulses. On an ego level, her intent was to please her husband, but she had to fight off dread and revulsion before she could engage him sexually. While we sorted out the factors involved, she recalled recurrent feuds and power struggles she had had with her father during her last years at home. Her father would refuse to talk to her for days until she would apologize for some petty slight that he had provoked. R's mother and siblings would then pressure her to capitulate in order to relieve the oppressive atmosphere that gripped the family. She continued to unleash rage toward her father whose tyrannical control over his family became increasingly evident. R also made attempts to limit her compulsive work habits, but she continued to spend an excessive amount of time with patients in her office, at the hospitals and at home on the telephone. Without awareness of the interplay between her alter personalities, there was no way for either of us to understand her conflicting motivations.

A year before the breakthrough of the abuse memories R began to sense the presence of three phantom figures. They first appeared during a session in which she was discharging a great deal of rage by slamming a tennis racket onto the bed. Abruptly she stopped and turned pale. Glancing over her shoulder and saying that she knew somebody else was in the room, she described three menacing figures, a woman and two men. Reluctantly, she turned to face them, but they would disappear. The phantoms continued to haunt her whenever she was at leisure, which was not often, in sessions whenever she became forceful or insightful, and at night before she went to sleep. They continually mocked her futile efforts to dispel them. For weeks at a time they did not

appear in therapy sessions until R started making headway with the energetic work. I had her dialogue with them and used several means to elicit her associations to them, all to no avail. What finally dispelled the phantoms was a self induced trance. R had been kicking and breathing on the bed, and I was sitting behind her intentionally occupying the phantoms' favorite position. She suddenly became quite still, her eyes rolled about in a strange way, and her body gave a few subtle shivers. Then, practically before I realized it, she half jumped, half crawled onto my lap. R could not help but register my surprise, nor could I not be aware that she looked amazingly like an infant, an utterly silent one. I told myself that this was a somewhat unusual regression and that it was important for her to play it out. She ran her fingertips all around my eyes and ears and felt the facial bones, etc. I had no idea at the time that this was my introduction to R's Very Little Person.

Suddenly, R came back to herself, and fortunately, she did remember most of the experience. In a strangely calm voice, she spoke about her first 18 months of infancy spent in an improvised nursery separated from the rest of the living room by a glass partition to protect her from her mother's tuberculosis. I had, in effect, become her six month infant's maternal object. Perhaps Very Little Person is R's original personality. Be that as it may, she connected with me on a level that apparently preceded significant abuse. The phantom figures represented three abusers: the maid, her step-sister's father, and the father himself. They were no longer phantoms but historical people whose abuse she soon went on to relive.

When these abuse memories surfaced, R went through a period in which she felt unreal. Her sense of disbelief was certainly aggravated by the fact that we were unaware of her multiplicity. Several alters were involved in the abreactions but none of the child alters except Bertha shared memories with the host. After she began repeating the same abreactions, I insisted that she summarize her experience. Then I realized that there were significant parts that she did not recall. One can understand why some MPD therapists record sessions and insist that the patients listen to the tapes. R would shake her head when I filled in what she left out. Only when I had made contact with those alters who

recalled the missing parts of the abuse did these reabreactions come to an end. As more alters emerged, the ground rules for co-consciousness and cooperation were set. I also suggested that she might be angry and mistrusting of me for being ignorant for so long of her diagnosis. R insisted that she was upset by the diagnosis, period. She had read how common it was for MPD cases to go undetected for an average of seven years, and we were actually ahead of schedule. Nonetheless, I believe that R to some degree rationalized her anger to protect me.

During the hiatus of reliving traumas, I tried several times without much success to have R fill in the family dynamics. R described her older brother as an emotionally flat workaholic who is married with two children. Apparently, he was a thoroughly intimidated child. When he took sick the day of his Bar Mitzvah, his enraged father beat him in retaliation. R's step-sister was adopted by the family when R was ten years old. The step-sister's father lived with the family for a year and some months before he died of a heart attack. R recalled him coming into her bedroom after having drinks with her father. He masturbated while fondling her and would force his semen-covered fingers into her mouth. During the first of these repeated incidents, R saw her father watching from the doorway. R's step-sister has become an obese woman who dislikes being touched. She, too, is married with two children. Although R keeps in regular contact with her siblings, the taboo of secrecy surrounding the incest remains in force.

R's mother, a frail women from childhood, could not have been ignorant of the abuse, although R maintained this fiction until memories relating to her emerged. Just before her step-sister's father came to live with them, she confronted her father in her mother's presence. Her father punched her and demanded that she recant. Her mother stood by without intervening. The day of her first menstruation R's mother accompanied her into the bathroom and ritually slapped her. She also falsely raised R's hopes that her father would now stop abusing her sexually. R does remember one time that her mother saved her from serious harm. It appeared in her mid-teens at a point that a male alter, furious as always with the father, began threatening to kill him or herself. While R's father was kicking and pummeling her, her

mother charged into the bedroom and screamed at the top of her lungs, “Stop! You are going to kill her!”

When R returned to the abreactive work, she picked up right where she had left off reliving variations of the abuse scenario that took place once or twice a week until she was seventeen. However, there were few gaps in her immediate recall, and I could converse with the newly discovered alters during the abreaction. Inadvertently, I discovered a suggestive technique that worked like the pause button on VCR. Most of the time R would abruptly stop the abreactions to answer a question or two and then, on cue, resume them. Most often R would be dragged by her hair into her father’s bedroom, at which time she would switch from the obedient and cheerful Bertha who could not recall being bound hand and foot. Her father gagged and choked her to prevent her crying out. Intermittently, Bobby, the boy alter who railed and later threatened to kill the father, and Esther, the alter who took the brunt of the abuse, would come out. She would plead to be spared the torture of having pins inserted into her nipples and various objects that caused great pain pushed into her pelvic orifices. Before menarche, R was usually vaginally raped; once pregnancy was possible, oral, and anal rape, and masturbation took place. The father demanded that she beg for a climax often and tortured her until she acceded. Samantha, the sex child, performed this function.

As R explains the situation, torture alone could not control her because as Shadow Person, she could leave her body. But from the time she was an infant, her father had conditioned Samantha with genital stimulation to remain present. Once she, as Samantha, began to respond with feigned pleasure, her father would mock her, call her a slut, and blame her for his hideous actions. Sometimes R would plead to go to the toilet. Refused as a matter of course, she sometimes lost control of her bladder, whereupon her father would literally kick her out of bed and order her to take away the soiled sheets and wash them immediately. Once, unable to walk, she crawled into the hall where she got a glimpse of her mother peering at her from the kitchen. In the laundry closet she stowed the sheets in the machine and turned it on. Collapsing in the corner of the closet, Esther remained there until the next trauma reactivated her.

At this point, three alters remain to be brought into conscious participation. Shadow Person, who is emerging out of a twilight awareness, is morbidly preoccupied with dying. During her 6th year, R's father escalated the torture. When she began abreacting the trauma that kept Shadow Person in shock for more then three decades, I could sense that the session would go into overtime. For close to 50 minutes R relived, step by gruesome step, the familiar abuse scenario. Only this was the first time that she spoke of being penetrated vaginally and anally with kitchen utensils. Shadow Person decided it was better to die after her father repeatedly thrust a knife at her just short of puncturing her skin. During the ensuing rape she vomited, defecated and urinated. Then her father left her to clean up. A few months later, hospitalized for a ruptured appendix, R struggled mightily with the fear of living and wished to die. Her father kept vigil at her bedside, encouraging her to hang onto life, reminding her how much her sickly mother needed her at home. She resolved the incongruities by splitting off Control Person, whom Shadow Person has haunted ever since. When R returned home, her father began tutoring her in religious studies and demanded that she excel in school. Already an insomniac, R spent many sleepless nights studying at the kitchen table. She went on to gain many academic honors and awards for musicianship.

An alter, who calls herself No One, is a child trickster whose role in the personality system is as yet undetermined. A nonspeaking fragment called Guardian has widened eyes and pulled back ears. She keeps watch at night and may be responsible for some of R's insomnia. If no more alters emerge, this phase of the therapy ought to be concluded soon.

While most MPD patients are known to complicate therapy with boundary issues and frequent crises, R has been scrupulous to a fault in not imposing on my time. Her willingness to pursue the physical work and her perseverance in driving over an hour to and from her sessions without ever missing one is remarkable.

The Case of J

J had been disappointed with the result of three previous therapies. Having read some of Alexander Lowen's books, how

ever, inspired her to seek a bioenergetic therapist. She responded positively to the physical work, but releasing rage caused her to dissociate. Her eyes would roll upward and cloud over, and she slurred her words to an unintelligible degree. Reorienting her took several minutes, accessing what had occurred during her dissociated state proved confusing. Her normal versus her dissociated states were so discontinuous that she could only say that she had been "some place else."

J then began reporting night terrors and flashbacks. She agreed to make pictures of the frightening images: a monstrous furnace in a dark basement and a car, the grill and headlights of which made a sinister face. Focusing on these pictures I thought would help her make insightful associations. Instead, J went into trance and began reliving incidents of sexual abuse inflicted upon her by her father and maternal grandfather. She trembled and writhed as I strained to make out a few phrases. I was wary of uncovering more material prematurely, that is, before co-consciousness was established, as had happened with R. By the time J came back to her usual self, she had only partial recollection of the material. She shook her head in disbelief when I gave her feedback. Instead of going on with the physical work and the time-consuming abreactions to which she could barely connect, it was time to shift gears.

Systematically, I sought to make contact with all of J's alters. Keeping a journal helped J reveal those who refused to come out during our sessions. Each alter had a specific point of view, and most of them had serious gripes about some of the others. The process of abreacting traumas slowed down considerably for some months while I negotiated agreements between the various alters. J agreed to buy Four a teddy bear in return for Four's assurance that she would not come out at school to play with J's students. Amanda went along with being co-conscious so long as I respected her refusal to come out when J was menstrual. Judy was allowed to buy some romance novels as a reward for not flirting with J's male colleagues. In the meantime, those alters involved in the initial abuse memories shared their experiences with each other and with me, and J's adult alters began to soothe and comfort the child alters who were reliving the abuse.

Her furnace image had come from flashbacks to incidents of

abuse that had taken place in her father's basement workshop. There he had taunted her with snippers that could cut off fingers, and demonstrated how the vise could crush her arm before he tied her to a hook on the wall and raped her. There had also been ongoing abuse from her mother who once beat the child's bare bottom with a hairbrush for being late in getting to the potty. The injury was so severe that J's father rushed her to a doctor when he returned from work. The car with the raging face flashed J back to the year she lived in a children's home. Her mother had been placed in a psychiatric hospital and her unemployed father was recovering from surgery to repair an abdominal hernia. Some weekends he drove her home for an overnight visit. J recalled waking in the middle of the night gaging on his penis. Like R's Bertha, J's Four (four years old when her sister was born) remained amnestic of the trauma and attached to positive parenting by splitting off two more alters: Angela, who was flown up to heaven to play on the clouds with the angels, and Sarah, who awoke the next morning with a bruised face and stomach cramps.

J's fugue states had sometimes been dangerous. She claimed to experience only mini fugues since she began therapy. Her Amanda once took over while J was driving to a workshop in a rural area and headed for the nearest city. J somehow regained control before Amanda reached her destination, but she was hours late for her appointment. Amanda is a street-wide urchin. During J's youth, she was occasionally caught stealing from department stores but, as she said in her sullen way, "I never stayed around to take the rap." Instead Karen, the host during J's pubescence, loot in hand, would find herself professing her innocence. Not only was Karen amnestic of the theft and travel to the store, but she disliked Amanda's taste in clothing and sweets. Karen, Amanda, and Becky form an age-related cluster of alters as do Four, Sarah, and Angela. Karen's cluster replaced Four's around puberty in reaction to further traumatization and the demands of an inner city environment. Becky's seduction behavior was partially responsible for sexual attacks from an older brother and abuse from a neighbor. J had found a substitute mother who baked cookies with her after school and sewed her a costume for a school play. The husband, however, seduced the child and bribed her with money. Becky became an eroticized alter with a

desire, as she put it when she reluctantly came out in session, "for the finer things that money can buy." Once she got over her fear of my disapproval, she saucily recounted her sexual escapades. Flirtation, seduction, foreplay, and oral sex excited her, but she had a phobia about vaginal penetration which she would avoid by switching if necessary. J feels comfortable with Karen and Four, but has good reasons to keep a tight reign on Amanda and Becky despite the agreements she has reached with them.

After 13 months of twice weekly therapy, J had anchored most of her alters in sustained co-consciousness. A few alters preferred not to take an active part in the therapy sessions but allowed others to act as spokespersons. In contrast to R's therapy, there was almost no reabreaction of traumatic material. Contracting agreements between alters and myself, and cathartic work went hand in hand. In one session 1 read Four a children's story from a book that she had brought with her. She had curled up with a blanket and her teddy bear. My intention was not so much to reparent as to win the child alter's cooperation. I also had her relive in trance some harsh events from childhood with imagined good parents.

Amanda once filched $20 from her father's wallet and took herself and two other alters on a shopping spree. J's father had been promising her an allowance for doing extra chores for weeks without ever paying her. When he discovered the theft, he pulled his nine-year-old daughter's panties down and severely spanked her in front of her mother and siblings. No discussion before or after the beating took place, and J had to work off the debt. Retelling the story with a father who could understand the child's feelings, admit his unfairness in not paying the promised allowance, and encourage communication instead of theft made a profound impression on J's child alters, including her 10-year- old Mother Person. With co-consciousness, the latter could now observe J's interaction with her own children.

To assist her therapy J created an alter she called Reppi, a diminutive for Reporter. Reppi's function is to keep tabs on each member of the intra-psychic system. She explained to me Amanda's resentment of doctors and therapists. After two years of hospitalization, J's mother returned home in a more remote, drugged state than before. Eventually, she died from overdosing

on her medication and alcohol. Besides blaming the doctors for her mother's absence and death, she resented the money and time that J continued to spend on therapy. Amanda exacted some revenge on J and myself by "doctoring" J's checkbook. To her chagrin, J bounced three checks to me in a row. Reppi's briefings had prepared me to deal with Amanda. Gingerly I coaxed her to come out, whereupon I expressed my admiration for her math skills and fighting spirit. As Amanda, J's prowess in performing mental calculations is exceptional.

After much deliberation, I proposed a trade to J for research purposes. There was general agreement among her alters. The trade would defray the cost of therapy and give J the opportunity to explore her psyche in more depth. The therapy sessions directly followed the hour spent investigating the relationship of the alters to the body. After a dozen research sessions, J showed signs of being overwhelmed with the copiously emerging information, so I suggested to her that we stop or postpone the trade. Initially she agreed, but soon after I received a letter, authored by Rebecca, who spoke for the "little one" feelings of rejection and of her anger that I underestimated her. She also stated, "Personality is not who we are. It is something the core of the self uses like a hand or a tongue to function in the world." For Rebecca and the child alters, the research and therapy provided a positive sense of the body and the motivation to unify the split core. However, the intrapsychic conflict could not be ignored. The other alters found the increased activity of the "little ones" beyond their tolerance. We resumed for two more sessions to clarify the issue of privacy and agreed to postpone the research indefinitely.

Following a year of intense co-conscious abreactions some fusion of alters had begun. Preceding a session spent largely on grounding and sustaining eye contact, J spoke of feeling that she was dying. She was more sad than scared of the prospect. While developing a charge in her legs, the vocal and facial distinctions between herself and Judy began to blur, or perhaps it would be better said that their combined range of expression from J's seriousness to Judy's insouciance was expanding. Soon part ofj's third adult alter, Rebecca, entered into the fusion. The remaining part of Rebecca contains a mix of unresolved sexual longings,

and a passion for metaphysics and meditation. J spent two years in residence at a Zen monastery where the rigorous practices were not easily harmonized with the demands of mothering. Her priorities have since changed to meeting the family's needs, developing a social network and continuing therapy.

In general, the physical work with J has, from the inception of her therapy, been the easiest part of treatment for me. Three related problems repeatedly arose, but with patience and persistence they steadily improved. When J dissociated to the point of going out of contact, it was imperative to stop any abreaction by calming her down. Inevitably, a child alter would come out, and communicating with the alter would establish a context for future discharge. Except for periods of time spent gagging and choking, the speech of the child alters during ensuing abreactions then became clearer.

The second problem had to do with spasms, cramps and other somatic reactions to the energetic work. Manual pressure on the mental muscles under the chin helped relieve these spasms which were frequently reactions to oral rapes. Painful spasms in the upper back and lower ribs would plague J for weeks, and although she gained some release in sessions, the tensions often returned with the same force. J regularly did bioenergetic and other exercises at home, but she had to be careful not to trigger an abreaction which she could not handle on her own. Only recently has she mastered the dissociative defense so that she can now discharge rage effectively by hitting and kicking in full voice. Convulsive sobbing remains blocked due to a combination of tensions in the pelvis and waist area. Nevertheless, she is crying more fully with increasing satisfaction. J has hinted that giving in fully to crying might loosen her control over sexual feelings, which at this juncture she is not prepared to risk.

The case histories of the two MPD patients, R and J, bear out the importance of identifying the degree and effects of dissociation, memory lapses, hypnoid states and inexplicable changes of mood, behavior and expression, all of which may indicate amnesia and switching. Although highly functioning professional women, both suffered from anxiety, depression and somatic ailments. Neither was aware of sexual abuse or multiplicity at the start of treatment.

In order for therapy to be successful, the MPD must be diagnosed and the alter personalities must be brought into treatment. Co-conscious cooperation, once secured, lifts the amnestic barriers and enables the abreaction of traumatic material to proceed in an integrated, non-chaotic fashion. The physical work in bioenergetic therapy with MPD patients has several advantages, such as revealing dissociation, promoting catharses, and integrating the alters into the body.

Multiple Personality and the Body

There is a common denominator in the bodies of the three MPD patients that I have had the opportunity to observe closely. All of them have unusually compressed torsos, the segments of which give the impression of a stack of boxes. The pelvic segments of many sexually abused women that I have treated have this squared off or rectangular shape, which I attribute to a combination of stimulation and numbing constriction. Shame, hatred, disgust, and terror are the emotions that come to the surface as the numbness recedes. In the bodies of these MPD patients all the segments have this boxy shape without transitional areas between the segments.

In order to stimulate the feel of this peculiar compression, I had to squeeze the segments of my trunk in three opposing directions simultaneously. Such pressure along the vertical axis forces the segments into closer proximity. Opposing pressure from front to back and side to side flattens and shortens each segment and the torso as a whole becomes corseted. It would be surprising if repeatedly abused children did not resort to some degree of defensive masochism. The structure that I have just described might at first appear to be an elaboration of that kind. Yet in these patients I have noted little passive aggressive behavior, or whining, and with the exception of R's rounded upper back and shoulders, no tucked in tailbones, curled under toes and other physical features of a masochistic structure.

Apart from the boxy torsos, the bodies of these women are quite different. Although R and J have shortened necks, J's shoulders are broad and closely held. R's lower legs and feet are thin while J's legs are evenly proportioned. C's limbs and neck are elongated

and thus the short and compressed torso is accentuated. Hers is an organism which grew up too quickly with too little nurturing to gain mature independence. Before I explain how these patients' multiplicity ties in with their character structures, I want to stress a fundamental point: MPD patients, in contrast to schizoid characters, are not "frozen in the core area " (Lowen, 1975). On the contrary, the core of the multiple is a hyperactive one in its shifting from one reality to another with its diversely split personalities.

In the bow position, for example, they maintain the alignment of the head, torso, pelvis and legs. The body does not fragment into non-integrated sections in the zig-zag schizoid manner. The psychological correlate that distinguishes the kind of splitting in multiples, versus the schizoid type, is that of incongruent parenting in the former as opposed to being consistently "met with hate" (Halfaer, 1991).

Another consequence of this distinction has to do with treatment. The schizoid's fragmentation at the beginning of treatment is hidden in the core and must be exposed before treatment has much of a chance. (There are multiples who are of the more dysfunctional and highly fragmented type with up to a hundred alters, and these may be partially frozen in schizoid manner and partially hyperactive. Not having had direct exposure to these kinds of multiples, I would assume there to be schizoid elements present.) In other words, what is referred to as the integration phase of treatment, might well be, from a bioenergetic point of view, the beginning of character analytic work. Healing J's multiplicity to the point of fusion, quite a therapeutic accomplishment in itself, leaves her with a narcissistic character defense. R's masochistic upper body and the orality of her legs will require a good deal of post-fusion energetic work to get her feet firmly on the ground and increase her capacity for pleasure. Whether or not, and for how long they choose to pursue the next level of treatment is a separate matter from the clinical issue of what remains after fusion. Although in the integration stage of treatment the writers already cited speak of accustoming the patient to cope without recourse to dissociation, the implication is that maintaining fusion is sufficient therapy. What the cure means to the fused multiple in terms of sexual functioning in particular

has not, to my knowledge, been discussed in the literature. Since modern MPD psychotherapy has until quite recently been limited to its few pioneering practitioners, post fusion sexual functioning and some other clinical issues may yet emerge.

To return to the energetic dynamics of MPD, consider the following metaphor. Twisting or smashing a sapling can rend its fibrous core into separate strands. The tree loses structural strength to keep itself erect as well as the vitality transmitted through its sap. Horizontal bands of tape may be wrapped around the pliant stalk to bind the split fibers, and perhaps, to save the saplings life. But its energetic capacity will be reduced for as many seasons as it takes for the rent fibers to readhere. Similarly, the repeatedly traumatized child constricts its musculature time and again to bind the vertical splitting in the core. The binding both separates the segments and compresses them, so that the inner vertical splits are horizontally compartmented. Due to the protean psyche and the immature musculature, there is a vulnerability in the infant's and child's organism that allows love and cruelty to go right to the quick. There is also a youthful resiliency that enables the child to adapt to incongruent parenting. R maintained the reality of a loving father via the alter Bertha. In separate identities, coincident to corresponding and discrete patterns of core excitation, she formed separate realities.

The research with J's alters illustrates the latter point. None of the alters fully inhabits either the depths or surface of the body. In executive control each alter is more right or left sided, which accords with the physiological investigations that point to a lack of integration between cerebral hemispheres (Putnam and Brene in Braun, ed., 1984). When not physically active, her alters reside in specific anatomical areas, and each of them has a different route through the body that brings them into and out of executive control. Painful cramps under the lower left ribs, for example, regardless of the current executor, always had something significant to do with her alter Four, and often provided me with a valuable clue to the underlying conflicts. J imaged the core of her body in the form of a dwelling that mostly resembled a house. Upstairs in the chest the three adult alters share a central room with separate private enclosures. J, Judy and Rebecca were reluctant to delineate the stairs that connected their quarters to

the hall and playroom for fear that they would be intruded upon by needy children downstairs. The floor plan helped me follow J's energetic process and gave me verbal cues to use suggestively.

The playroom is an open space below the sternum where J's 10-year-old Mother Person stays. Sometimes other child alters join her there to play chase and read children's stories. They have, since co-consciousness, found a window under J's left breast to look out upon the outside world. J's Karen has a quiet mossy cave off the hall where she often hears or feels rumblings that are probably the sound of intestinal activity. Below the umbilicus the hallway loses definition and becomes increasingly dark and foggy. J's Amanda brings her own light down to the left thigh where she is safely removed from any turmoil that may be going on above. There have been intimations that other alters may be hidden in the dark below.

Except for the areas specific to each, the alters had only a vague notion of the details of the system's topography. Nor were any of them originally aware of the routes the others took through the body to assume and relinquish executive control. Each alter is uniquely identified with a vertical passage through the core and a different partial awareness of the rest of the body. Four's path from the playroom bypasses the stairs as she floats up to the left side of the head and face. She is left-handed and awareness of the right side of the body is dim. Judy comes up from the right side of the chest and neck, whereupon she has a heightened awareness of her face, right arm and hand. She senses a steady current of excitation from the right index finger, arm and neck to her eyes, which coincides curiously enough with the large intestine main meridian in traditional Chinese medicine (Mann, 1964).

I could cite several more examples, all of which further the idea of vertical splitting of the core into distinct routes of excitation, each one of which is associated with a discrete personality. Somewhat exceptional is J's Reppi, who takes over the body with a "whooshing" wave or breeze that starts in the feet and rushes to the head. She gathers, as it were, the information cognitively available to the system as a whole and synthesizes it. It is an exhausting endeavor that limits executive control to less than five minutes.

In sum, the likelihood of finding more MPD patients in bioenergetic therapy behooves us to be prepared for the particular clinical challenges that they present. Recognizing the dissociative behavior which includes hypnoid states, fugues, amnestic defenses, and switching to alter personalities is a skill that experienced therapists ought to be able to catch on to without difficulty so long as there is not a bias against multiplicity. There is a need for caution. Chaotic abreactions that cannot be integrated must be halted. Instead, contact with alter personalities, removal of amnestic barriers, and establishing cooperative coconsciousness is required so that subsequent abreactive work maybe fruitful. Ambivalence about the diagnosis, flights into health and various forms of dissociative behavior continue as defenses right up to fusion. The character structure, although apparent in the MPD patient's body all along, comes to the fore as the major therapeutic issue once dissociative defenses have been largely eliminated.

MPD patients from early childhood have suffered from severe abuse and neglect, yet received some positive nurturing. They may be highly functioning individuals and certainly they are quite clever in covering up time losses and in rationalizing unaccountable behavior. The energetic work is not generally resisted but may easily overwhelm their defenses. Once co-consciousness is secured, emotionally reliving a great amount of traumatic material is to be expected. Hypnotic techniques can be quite useful in several ways and can readily be combined with the exercises in grounding, releasing emotions, and sustaining contact.

In MPD the core of the organism is split into vertical pathways which are identified with specific alter personalities. The physical unification of the excitational pathways is psychologically manifest in fusion of alter personalities. Once the splitting of the core is healed, character issues and corresponding energetic blocks to grounding, sexual functioning, and pleasure can be tackled as is usual in bioenergetic analysis.

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