

ABSTRACT

AN ALTERNATIVE LENS FOR A CASE OF DISSOCIATIVE IDENTITY DISORDER: EXPERIENTIAL PERSONAL CONSTRUCT PSYCHOLOGY

By Carol Lee Humphreys

As a child, Kristen constructed a complex, imaginal world. As an adult, she continued to struggle with a fragmented sense of self and was diagnosed with Dissociative Identity Disorder (DID). Although written about extensively, our understandings of DID have been limited by a lack of theoretically diverse conceptualizations. In this paper, in addition to a discussion of the DID diagnosis, the therapist's theoretical influences, and the clinical case study, Kristen's dissociative experiences will be used to elaborate one non-reductionistic understanding of DID, Experiential Personal Construct Psychology (EPCP). Kristen's results on the Dissociative Experiences Scale (DES), Sentence Completion, House Tree Person, Robert's Apperception Test for Children, sand tray work, and the Minnesota Multiphasic Personality Inventory-Adolescence (MMPI-A) will be discussed. An elicitation of construct pictures and the Diagnostic Axes of Human Meaning Making will also be presented in support of EPCP as an alternative lens for viewing dissociative experiences.

AN ALTERNATIVE LENS FOR A CASE OF
DISSOCIATIVE IDENTITY DISORDER:
EXPERIENTIAL PERSONAL CONSTRUCT PSYCHOLOGY

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DEDICATION

I would like to dedicate this paper to Kristen, a courageous young woman, whose determination to understand her experiences of dissociation has both informed me and inspired me. In our therapeutic journey each week, we have collaborated in the identification of that which led to her fragmented sense of self and worked to restory her life narrative. Her dedication to making change in her life has compelled me to learn all I can about internal multiplicity and Dissociative Identity Disorder. Kristen's willingness to share her story with others has, in so many ways, allowed me the privilege of growing as a therapist, a researcher, and a human being.

I am forever grateful.

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"I am large, I contain multitudes"

Walt Whitman

Introduction

Apart from the confusing search for identity that many of us experience during our normal development, personal meaning making becomes especially difficult for those who struggle with extreme experiences of internal multiplicity. Living in a Western World that traditionally values the idea of an individualistic or unitary self often exacerbates this struggle. Despite the fact that many of us regularly enact disparate roles throughout the day (e.g., that of empathic mother, fun-loving friend, hard-working employee, authoritative manager), multiplicity of self often is pathologized, particularly for those who report more extreme forms of internal multiplicity (e.g., dissociative experiences). In reality, many of us experience mild forms of dissociation such as zoning out during college classes or while driving a familiar road to work each day. However, in cases of severe dissociation, some parts of the self maintain amnesic barriers from other parts of the self. Since the 1970's, the Western Psychiatry has diagnosed this experience as Dissociative Identity Disorder (DID).

Although DID has been written about extensively, our understandings have been limited by a lack of theoretically diverse conceptualizations of the phenomena. In particular, the writings on DID have focused predominately on cognitive behavioral and psychoanalytic conceptualizations, primarily as a response to trauma. Alternative theories have different assumptions about human experience and, particularly, the nature of health, pathology, and treatment than cognitive-behavioral and psychoanalytic ones. These alternative theoretical lenses may help clinicians understand DID in new ways—ways that present new options for being with their clients.

This thesis will elaborate on the first several months of therapy for Kristen, a client, who as a child, constructed a complex, imaginal world, and who as an adult continues to struggle with a fragmented sense of self. As my work with Kristen involved years of psychotherapy, it is inevitable that I will share some examples from our time together beyond those initial few months. However, in this paper I shall focus primarily on the early experience in therapy of Kristen's internal voices emerging. Her experience of internal multiplicity and dissociation then will be used to elaborate one non-reductionistic understanding of DID, provided by Experiential

Personal Construct psychology. In elaborating the ways this theory accounts for the experience of dissociation and internal multiplicity, it is my hope that our understandings of the experience of dissociation may be enriched.

After providing a background and history of dissociation and internal multiplicity, I will present briefly three theoretical frameworks that informed my work with Kristen as her therapist. I will present what is known about Kristen's childhood history, results from a previous psychological assessment, and her experiences of dissociation from two perspectives. I will first present Kristen's diagnosis of DID as defined by the DSM and the medical model viewpoint. To support this traditional, Western conceptualization of extreme dissociation, I shall present Kristen's results on a number of personality measures and projective tests: Dissociative Experiences Scale (DES), Sentence Completion, House Tree Person, Robert's Apperception Test for Children, sand tray work, and the Minnesota Multiphasic Personality Inventory-Adolescence. These measures will be discussed as they are often facilitative in diagnosing DID within the medical model. I then will discuss Kristen's experiences of dissociation as seen through the lens of EPCP by presenting an elicitation of construct pictures and the Diagnostic Axes of Human Meaning Making (Leitner, Faidley, & Celentana, 2000).

Dissociative Experiences

Webster's Dictionary (1989) defines the word dissociate as the process of "keeping apart in one's mind, separate." The word suggests a severing or cutting off from another, either physically or mentally. In psychology, the act of dissociating can be viewed as "alternations in consciousness that appear to involve a variety of individual memory processes" (Kihlstrom et al., 1994, Ray, 1996). It includes three common aspects: amnesia, absorption, and depersonalization.

Some evidence of amnesia or an inability to recall personal events unlike that of ordinary forgetting over time is considered to be a component of dissociative experiences. It can be as simple as driving in a semiautomatic way, arriving at work, and realizing that you remember few details as to how you got there. Another common dissociative occurrence might include performing repetitive tasks, such as assembly line work, without concentrating and with no memory of the work that was completed. It also can manifest itself in a more extreme form where a person loses days at a time and has no recollection of what has occurred during that period.

A mild dissociative experience that is thought to be a common phenomenon is absorption in movies, television shows, or books (Ross, 1989). The inability to hear the call to dinner or see the people walking near us while we read or watch a movie is a dissociative state experienced by many. Deeper absorption includes believing to some degree that you are living the life of the character in the book you are reading or the television show you are watching. As you become more absorbed, you might even experience the fear of a victim being stalked in a crime show or the pain of a husband who has lost his wife to cancer in a love story.

Depersonalization can be described as experiencing events in your life as if you were the observer rather than the actual participant. It is the experience of standing outside your body or floating above it, all the while observing your actions as if you were watching another person talk and move. It is this disconnection from your body or feelings that most often occurs during episodes of depersonalization.

At first glance, dissociative experiences may seem unusual. However, the general population has reported everyday occurrences of experiencing mild amnesia, absorption and depersonalization as ways of psychologically separating one's self from uncomfortable, recurring, traumatic, emotionally intense, or boring situations (Ray, 1996). Zoning out during dull math lessons or losing track of one's self in a love story is a universal experience that removes us from otherwise uncomfortable situations. For the most part, these common episodes of dissociation are not perceived as distressful to the person experiencing them, whereas, some forms of dissociation can be quite painful.

It has been suggested that, for a certain population of individuals, there is a predisposition or enhanced capacity to dissociate. Some theorists suggest it is equivalent to a person's receptiveness to hypnosis (Midgley, 2002, Ross, 1989). Various studies suggest that the person who can be easily hypnotized to lose weight or act like a duck on stage is a person who also might dissociate effortlessly (Breuer & Freud 1895, Spiegel, 1988).

Ross (1985) described dissociative experiences as lying on a "continuum of increasing complexity, chronicity, and severity." One side of the continuum focuses on mild dissociative experiences or altered states of consciousness (ASCs) (Beahrs, 1982). These ASCs include everyday daydreaming experiences, drunken or drugged states, and hypnotic states. Next to ASCs lie moods or states of mind that come and go with some degree of unpredictability. Soon after are subpersonalities, defined by John Rowan (1999) as "semi-permanent and semi-

autonomous regions of the personality capable of acting as a person”(p. 1). Other theorists (Stiles, 2002, Watkins & Watkins, 1996) have labeled these aspects of the self as ego states, subelves, identity states, or voices. Still further on the continuum lies the experience of being voluntarily or involuntarily possessed. Finally, multiple personality or DID is considered the most extreme form of psychological separation on the continuum of dissociation and involves fugue and amnesic states (Putnam, 1989, Rowan, 1990).

Dissociative Identity Disorder

Those who struggle with severe dissociation, and the professionals who treat them, often have a difficult time succinctly understanding or even identifying the experience. In many cases, both clinicians and clients struggle over a period of time to properly describe, understand, and name the experience. Despite its complexity, and perhaps because of it, therapeutic inquiry and psychotherapy research continue to focus on the ways in which dissociative experiences originate, develop, and present themselves. The psychological community has previously labeled severe cases of internal multiplicity and dissociation as Multiple Personality Disorder (MPD) and more recently, Dissociative Identity Disorder (Sinason, 2002). DID is defined by the American Psychiatric Association in the DSM-IV (APA, 2000) through four criteria. The first specification, Criterion A, is that there must be "a presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self)." Criterion B requires that "at least two of these identities or personality states recurrently take control of the person's behavior." An inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness is listed as Criterion C. The fourth criterion (D) assists in ruling out other diagnoses. It states, "The disturbance is not due to the direct physiological effects of a substance (e.g. blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g. complex partial seizures). In children, the symptoms are not attributable to imaginary playmates or other fantasy play."

The DSM's description is one view of the experience. However, there are alternative conceptualizations of dissociation or internal fragmentation. In *Divided Minds and Successive Selves*, Jennifer Radden (1996) lists four loose conditions that formulate an alternative criterion for internal multiplicity. Radden's first condition, separate-agency, is described as separate selves having and maintaining separate agendas. Her second condition is labeled separate-

personality and is defined as those times when a client's separate selves exhibit distinct, non-agential personality traits singly or jointly. The third condition, continuity, describes when the separate selves persist through time. Radden's fourth condition is referred to as disordered-awareness. She explains it as at least one of the selves experiencing a disordered awareness resulting in a disordered memory in excess of that found in normal people. Radden links these conditions of severe multiplicity to the imagination.

Richard Kluft (1984) proposed a four-factor theory of Multiple Personality Disorder. He suggests that 1) those with MPD have a propensity or vulnerability to dissociation; 2) they have often used dissociation to cope with severe childhood trauma; 3) MPD looks different according to each individual's temperament and non-abuse experience; 4) the abuse continued over time and the victim did not receive enough consistent love to heal long-standing wounds.

Still others assert that, but for a weak ego, there might not be DID. Ray (1996) argues that a lack of a strong or coherent personality system predisposes one to DID. DID is often described as a switch from one identity, personality, or sense of self to another. The switch in executive control is concurrent with amnesia.

Perhaps what is agreed upon is the general consensus among practitioners that clients who experience DID often present to therapy with a set of shared complaints. They describe blackouts, fugue states, time lapses, headaches, finding items in their possession that don't belong to them, being called names that they don't recognize, meeting new people who insist that they have met previously, and regularly experiencing a number of similarly inexplicable things. Rowan (1990) describes the difference between regularly experienced dissociation and DID as "a qualitative divide which is evidenced in that fact that multiple personality is a much more serious disturbance of the person, and classifiable in psychiatric terms" (p.13).

Conceptualizations of Dissociation and DID

As a Resource in the Face of Trauma

It became her habit to stand still and wait for the switch in her mind to transport her from a gray agony to a former calm or even happy state. She did this without knowing that she was saving her life each time (Vincent & Pickering, 1988, p. 525).

Clinicians regularly associate dissociative responses and DID with trauma, violence, abuse, and most often childhood sexual abuse (Bentovim, 2002). Dissociative disorders have long been viewed as childhood defenses originating from traumatic situations, so much so that ijt

has been described as a chronic form of post-traumatic stress disorder (Zulueta, 2002). DID's long-standing link to trauma among therapy clients in the clinical literature has served to suggest such dissociative experiences are pathological.

As early as the mid 1880's, Janet and Freud recognized that dissociation was a response to traumatic experiences (Herman, 1992). Janet wrote about the patients he worked with during the 1880's, describing consciousness as consisting of many separate streams that may or may not travel together. His work suggests that early childhood trauma could cause a severe division of consciousness into the separate streams. This splitting of the streams may appear automatic and can take control of the person. Memories of child abuse may remain amnesic from the host personality if they enter an alternative stream of consciousness (Goodwin & Sachs, 1996). Freud also described symptoms of dissociative amnesia in many of the clients he diagnosed with hysteria (Loewenstein, 1996). In the 1880s, Freud worked on the seduction theory, alleging that all neurotic symptoms were some form of unconscious repetition of trauma or an attempt to protect one's self from the emotional aftermath of trauma. In what some theorists believe contributed to the decline of interest in the relationship between trauma and dissociation, Freud later rejected the seduction theory and suggested that symptoms of neurosis and hysteria were linked to sexual fantasies (Goodwin & Sachs, 1996).

One of the primary responses to trauma or abuse is that of avoidance (Bentovim, 2002). When humans are faced with traumatic experiences, they may be able physically to avoid it. For example, when I drive down the highway and pass by a bloody car accident being attended to by emergency personnel, I can choose to look away. I can refuse to allow such a painful image to enter into my psyche. However, physical avoidance is not always an option, especially in cases where an adult or child feels helpless to avoid a traumatic experience. When a father repeatedly molests an eight-year-old, the young, dependent victim may be unable to physically remove herself from the situation. Furthermore, her immature psyche may be unable to comprehend or hold onto the violent imagery and confusing experience of what is happening to her.

In many cases, the choice to dissociate or split is modeled after the experience of the trauma itself (Mollen, 2002). Very often, the perpetrator who molests a child in the garage on Sunday mornings may also be the beloved father who gently rocks that same child to sleep at night when she awakes with nightmares. The perpetrator splits his relationship with the victim, and the victim splits her response accordingly. The child does this because she needs to find a

way to protect herself, if not physically, then mentally, in order to survive the traumatic experience. She needs a way to make sense out of the contradictory messages she is receiving from the perpetrator/protector. She may find it soothing to imagine herself elsewhere, so much so that later she retains no memory of the painful incident. Once dissociation is found to be an effective method of protecting one's self during a traumatic experience, it becomes a viable option for future protection (Mollon, 2002).

Sinason, (2002) describes dissociation as a way to mentally separate one's self from a traumatic experience, in essence, a creative and resourceful way of protecting one's self, a form of creative resilience. Deborah Haddock (2001) points out that dissociation is a,

creative way of keeping the unacceptable out of sight...it allows strong, and often conflicting, emotions to be kept in separate compartments in the mind...it is a lifesaving defense...the purpose of dissociation is to take memory or emotion that is directly associated with a trauma and to encapsulate, or separate, it from the conscious self (p.11).

Frank Putnam (1993) has described the protective functions of dissociation as a) an automatization of certain behaviors; b) resolution of irreconcilable conflicts; c) escape from the constraints of reality; d) isolation of catastrophic experiences; e) cathartic discharge of certain feelings; f) analgesia; and g) alteration of sense of self, so that a traumatic event is experienced as if "it is not really happening to me" (p.40). Amnesia from traumatic events is automatically achieved by dissociating. Those who dissociate do not have to remember or face the intense emotional pain associated with the recognition that something atrocious definitely happened to them. As described by Putnam, this experience provides an amnesic barrier or shield from memories of traumatic experiences.

Dissociation as a resource to be drawn from in times of overwhelming trauma is an increasingly accepted view. Bentovim (2002) asserts "the development of an alternative self as a way of coping may well be an understandable response to reinforce the process of avoidance of thinking –the self without memory" (p. 26). John Southgate (2002) writes "The dissociative response of the multiple self to trauma is fundamentally creative and for survival" (p. 89). Indeed, though the immediate dissociation, albeit creative and resourceful, provides protection during a traumatic event, eventually, it has the potential to result in a fragmented sense of self.

Developmental

Childhood experiences have been described as the etiological roots of adult dissociative disorders (Midgley, 2002.) Much of the dissociative literature suggests that an adult manifestation of a dissociative disorder is often in response to early childhood sexual, psychological and or physical abuse (Herman, 1992).

However, Ray (1996) argues that dissociation is a normal cognitive process and that all individuals enter into the world in a dissociative state. He suggests that, prior to birth, the psychological process of the infant is a multiple one, always in relation to and a part of the infant's mother. The process of safely separating from the mother allows for the development of a unifying principle, the self. When the unified self does not develop, the infant remains open to dissociative experiences.

More recently, theorists have looked specifically to the developmental stages of childhood as a factor in the development of dissociative disorders. Bowlby's early childhood attachment model (1969, 1973, 1980) offers a developmental perspective on dissociation. Its chief concern is with the relationship that occurs between a child and his or her primary attachment figure, generally a parent. Initially the caregiver soothes the child; later, the child is able to soothe herself/himself. A caregiver's consistent behavioral responses and nurturing affords an infant a secure base and sense of self (Haddock, 2001; Karen, 1995). As the infant learns to trust that her or his needs will be met by her or his parental figure, the infant learns to generalize trust to other interpersonal relationships (Erikson, 1950). Bowlby (1969) originally identified three attachment types: secure, insecure-avoidant, and insecure resistant. Later studies of the Ainsworth Strange situation (Ainsworth, Blehar, Waters, & Wall, 1978) in which infants were exposed to two short separations from their mother identified a fourth attachment pattern termed disorganized/disoriented (Main & Solomon, 1990). Though the focus of attachment theory has predominately been on the interactions between an infant and a caregiver during the first few years of life, it is a model that is presumed to develop throughout a lifetime. During childhood, adolescence, and adulthood, experiences of inconsistent, insecure, weak, disorganized, or terminated attachments are considered to affect one's mental state (Main & Morgan, 1996).

Specific types of attachment patterns during early childhood may contribute to a child's vulnerability to dissociation when faced with trauma (Barach, 1991, Putnam, 1993). The

disorganized /disoriented attachment pattern in infancy has specifically been linked to an increased degree of dissociation in later life (Barach, 1991, Liotti, 1992, Main & Solomon, 1990). Children in the Strange Situation that were identified as having a disorganized attachment pattern displayed a number of contradictory responses, including a freezing or stilling of the body, when reunited with a parent. In many cases, the contradictory responses occurred when the child viewed the parent as either frightening or frightened. Not knowing what reaction a child will receive from a caregiver may lead the child to freeze and even to dissociate as attempts are made to choose between opposing behavioral responses (e.g., do I run to my mother? Or do I ignore her?), neither of which have consistently felt safe. A child that is raised with such an attachment, where the comforting caregiver is also the source of fear or abuse, may find it difficult to make sense of such inconsistency. As the child struggles to understand a discordant experience, one possible and creative defense may be to develop a multiple internal working model of attachment (Liotti, 1999). This model of attachment involves a dissociated self in which each personality develops a separate and unique attachment with the caregiver. The child may then be able to accept the good mother during nighttime tucking-in-rituals as separate from the terrifying mother who is abusive during the day.

History of Dissociation and DID

Dissociation has been observed and written about throughout the world. Reports of dissociative experiences can be traced back to early shamans and their trance states, or ecstatic experiences in most cultures (Eliade, 1964). In the Western World, witches performing magic, religious zealots engaging in intense prayer, or those reporting being possessed by demons are considered by some to have experienced the dissociative disorder that the psychological community now calls DID.

Since the nineteenth-century, the Western World has pathologized the experience of dissociation viewing it as a result of a weak ego (Janet, 1965/1907). William James and Pierre Janet are said to have first diagnosed a patient with DID symptoms in the 1800s (Haddock, 2001). The first psychotherapeutic cure for DID is attributed to Antoine Despine, Sr. in 1836. While looking at hysteria, Janet and Charcot, a nineteenth century neurologist, looked at second existences or multiple personalities occurring within one person. Charcot first presented the symptoms of hysteria and neurological damage in combination with amnesia to the public. He gave public demonstrations of such disorders using female patients who went into trances or

altered states. Alfred Binet wrote two major treatises on dissociation in the late 1800s. In 1895, Breuer and Freud originated the word “double-consciousness” to describe dissociative states. They collaborated on the case of Anna O, a woman who suffered from an exhaustive list of symptoms. Janet and Freud wrote, “altered states came from trauma and that somatic symptoms represented disguised representation of events repressed from memory” (Sinason, 2002). Sigmund Freud presented the case study of Emmy Von N. who appears to have had a distinct dissociative disorder in *Studies on Hysteria*. He was the first physician to specifically link sexual abuse and trauma to symptoms of what was then called hysteria. Jung later agreed that the split-off, unconscious complex formed a small self-contained psyche and described complexes as the result of trauma. However, Jung also saw complexes as a healthy incentive, forcing one to grow after being traumatized (Rowan, 1990). Freud later denied his theory of sexual seduction as a precursor to dissociation, leading to decades of misdiagnoses of clients suffering from trauma related dissociative experiences (Ross, 1989).

Although the experience of dissociation was a popular area of interest for the psychological community in the late 1800s, it soon became less fashionable as theorists pursued other psychological phenomenon. Ross (1989) attributes this decline in diagnoses of MPD to Freud’s repudiation of the reality of his patient’s childhood traumas, the increased diagnosis of schizophrenia, and the lessened use of hypnosis in clinical practice.

Much of the psychiatric community and the American public heard little about the experience of dissociation for years until the 1950s when an academy award winning movie based on a book suddenly garnered the attention of both communities. *The Three Faces of Eve* was a fictionalized account of a true story of one woman’s struggles with depression and what was then called MPD. Her case of DID was thought to be extremely rare yet heightened interest in the subject. In the sixties, seventies and eighties, a number of other events occurred that also brought the experiences of dissociation into the forefront. Feminism and the sexual revolution suddenly made it more acceptable to talk about women’s early childhood experiences, sexual activity, and even sexual abuse. Furthermore, with so many men arriving home from the Vietnam War suffering from Posttraumatic Stress Disorder, the psychological community was forced to address dissociative experiences. The book *Sybil* (Schrieber, 1973) fictionalized the true story of Sybil Dorsett, a woman who reported experiencing 16 distinct personalities. It was a dramatic tale and excited the general public after a popular television movie followed. In 1977, Hilgard

published *Divided Consciousness*, a seminal work that welcomed the modern academic study of dissociation. Soon after, the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III; American Psychiatric Association, 1980) added DID as a diagnosable condition. In 1984, the annual international conference on dissociation and DID first met. The International Society for the Study of Multiple Personality and Dissociation (ISSMP&D) formed. Soon, a number of scientific journals devoted special issues to the topic. Numerous other publications, both popular and academic have followed as the field of psychology and the public has continued to demonstrate a growing interest in understanding dissociative states as well as DID.

Controversies of Dissociation and DID

This movement towards diagnosis has not been without its pitfalls. The idea that multiple and separate personalities or selves can be contained in one body has been considered divisive and controversial. Some clinicians have argued that DID is an artifact of the therapy relationship and has a strong iatrogenic effect (Spanos, Weekes, Menary, & Bertrand, 1986). Critics of DID argue that clients often display symptoms only after engaging in therapy (Aldridge-Morris, 1989). They suggest that by discussing the possibility of a DID diagnosis with suggestible clients or by giving them DID reading material, such clients may feel encouraged and even pressured to conceptualize their experiences using the described symptoms or DID terminology. The subsequent symptoms then are viewed as being subconsciously mimicked as a way of pleasing the therapist. An over-zealous therapist may unknowingly encourage the multiple presentation of self in a suggestible client. For example, an otherwise shy client may seemingly act out of character, cursing while discussing the sexual abuse she endured. This shift may only occur after repeated suggestions by the therapist that surely the client must be angry with her perpetrator. The disorder is then viewed as possibly originating as a result of therapy.

Still other skeptics suggest that a vulnerable client may originally present to therapy with vague symptoms of memory loss, moodiness, vacillation or expression of emotions, or exaggerated personality fluctuations that, when attended to, affords a vulnerable individual the attention that he or she may be craving. These practitioners and researchers believe that clients are malingering and seeking attention (Aldridge-Morris, 1989). They assert that as the therapist chooses to focus on the alter personalities, the system of multiplicity is created, encouraged, or reinforced.

Practitioners who argue for the experience of DID argue on the contrary that it is precisely due to the safe, therapeutic alliance that the alternate personalities feel comfortable enough to present themselves. Phil Mollon (1999) writes:

The anxiety inherent in disclosing the hidden system of multiplicity can be enormous, as the patient then feels profoundly vulnerable, their psychological survival threatened...The whole internal system can be thrown into turmoil by the very process of seeking psychotherapeutic help...Any disclosure of the system to the therapist can be destabilizing because the system's inherent secrecy is thereby compromised...This is not a picture of compliance leading to iatrogenesis... However, it could, to the naïve observer, give the appearance of iatrogenesis because the alters may well become more apparent after disclosure to the therapist; once given the opportunity to talk and to be listened to, there may be a clamoring to come forward (p.63).

Though studies have proven that some features or symptoms of MPD/DID can be created in experimental subjects (Spanos et al., 1986), Colin Ross (1989) asserts that the disorder does not exist as dissociative symptoms alone. DID is only diagnosed in conjunction with a wide array of symptoms, experiences, signs and specific primary and secondary features of DID that have presented for decades prior to a diagnosis. These often include a history of childhood abuse, psychiatric symptoms, and years of involvement with the mental health community. Ross, Norton, & Fraser (1989) have provided strong evidence against the iatrogenesis of DID with two substantial studies. Their studies demonstrate that although college students were able to mimic some symptoms of DID, they did not experience the full range of features, a history of child abuse or trauma, as well as the life-long events associated with those who experience DID.

Furthermore, Taylor and Martin (1944) assert that iatrogenesis is not the most important issue to consider when diagnosing or treating those experiencing dissociation. Rather, the primary issue should be whether or not the abuse histories that are described by the clients are real or imagined. If the abuse actually occurred, then any form of iatrogenesis is seen as secondary. If the abuse was imagined than the presentation of the abuse as well as the presentation of the disorder is viewed as characterological in nature.

Treatment of Dissociation and DID

A person can be “healthy” without having to integrate all of his or her parts. Integration should be an option, but not the only option, in one’s pursuit of mental health and a good life. -I.R.T.

Integration is something I look forward to, although my parts would take issue with that! But just as the patterns of dissociative behaviors lasted for many, many, years, it is understandable to me that it will take awhile to unravel the reasons my mind originally “divided”...I think we will eventually know each other better and finally “come together. Vickie G.

We hate the word integrated. We work as a team and will stay as a team. -R.C.
(Cohen, Giller, & Lynn, 1991)

It seems any discussion of DID invites controversy including the appropriate method of treatment or specific intervention for such a complex experience. Prior to any discussion concerning the idea of integration, let us first look at the theoretical models that drive the work therapists engage in.

The primary theoretical approaches used in therapy with clients diagnosed with DID are cognitive behavioral (Fine, 1996; Ross, 1989) and psychodynamic (Barach & Comstock, 1996; Watkins & Watkins, 1996), both of which subscribe to a trauma model and often employ hypnosis or deep relaxation techniques (Peterson, 1996).

Within cognitive behavioral therapy, it is believed that dysfunctional thoughts can and should be changed because how someone thinks affects how they feel and act (Beck, 1976). In DID treatment, the therapist and client focus on cognitive, perceptual, affective, and behavioral incongruities. They proceed to name these incongruities and work to modify them by correcting distorted conceptualizations and attacking established schemas. It generally involves a structured treatment plan in which each alter receives a short-term course of treatment (Fine, 1996). One of the treatment goals is often integration into a unitary self.

The psychodynamic perspective (Barach & Comstock, 1996) views DID as a unitary self system and asserts that “multiple-self models reify the alters by depicting them as talking to, comforting, or fighting with each other” (p. 414). Psychodynamic psychotherapy moves toward integration by resolving the developmental deficits that resulted from repeated trauma.

Integration often spontaneously occurs, according to this theory, as the developmental tasks are dealt with and the wounds are healed.

Some of the therapies and interventions also being considered, implemented, and written about include: humanistic (Kowszun, 1999), trauma focused healing (Sachs & Peterson, 1996), relational work and attachment healing (Schwartz, 2000), inpatient treatment (Young & Young, 1996), psychotropic medications (Torem, 1996), art therapy (Cohen, 1996), and family systems approaches (Michelson & Ray, 1996). Though each approach maintains a unique slant on working with clients diagnosed with DID, most of them share a few common factors. All of the approaches mentioned above, other than psychotropic interventions, profess the importance of the therapeutic relationship, some degree of allowing the voices to be heard, a formal or informal mapping of the alters, and at least a minimal amount of direct interaction between the therapist and the alters.

One obvious difference lies in the question of integration as an expected outcome of successful therapy. Integration has often been discussed as the gold standard of therapy (Kluft, 1989), although some clinicians have suggested fusion, and a few have begun to speak up for a more collaborative effort between the alters. Not surprisingly, there appears to be some dissent over the definition of the word itself. Kluft (1993) defines integration as “an ongoing process of undoing all aspects of dissociative dividedness...from long before reduction of numbers through fusion to a deeper level” (p.109). In ego state therapy, Watkins and Watkins have defined integration as a “mutually needs-meeting resolution of differences” in which separation ends by the choice of the alters. This occurs between two ego states when their individual needs become so similar that they no longer need to separate or split. Fusion is viewed as “an amalgamation of all states into a single unit” (p. 442).

Colin Ross describes his well-documented therapeutic approach, originally born of Beck's cognitive model, as a mix of cognitive, psychodynamic, and systems techniques. Ross (1989) claims it is "an active, short-term therapy that goes on a long time" (p 217). Ross reports that he talks a lot, is somewhat directive, uses hypnotic interventions with his clients, speaks with the alters, and views integration as the goal of treatment (Ross, 1989). Kluft (1986) also works from the perspective that integration is the ultimate goal of therapy.

More recently, a few therapies have focused on viewing the alters or voices as creative resources, allowing them to choose between integration and collaborative internal multiplicity.

Anthony-Black (1999), a former client diagnosed with DID and currently a practitioner working in England with similar clients, argues for allowing the client to make the choice whether to seek integration. She prefers to recognize and live with her multiple alters in a harmonious fashion. Naomi Shemen, a feminist theorist (1993) also rejected the idea of complete integration into a unitary self thus forcing dissenting alters into retreat. She advocates for the community approach and hopes for “the possibility of respectful conversation among them” (103).

Various theories have addressed the treatment of dissociative experiences. Those in the cognitive behavioral, psychodynamic, and trauma focused models have been most explicit in their suggested treatment plans. In deciding to explicitly describe much of Kristen’s and my early work together and recognizing that my own theoretical background guided the treatment process, I have elected to discuss my theoretical orientations in the following section.

Theoretical Influences

Perhaps the manner in which individuals approach DID is linked to their worldview. Clearly, worldviews and paradigms influence how one views multiplicity. Authors suggest that attending to world view considerations can benefit the theory and treatment of DID in several ways. (Rosik, 2000)

As Kristen’s therapist, I worked from a particular worldview. I entered into the therapeutic relationship with a set of assumptions about multiplicity, the way change occurs in therapy, and, more generally, about human experience. Though I had little, if any, knowledge of DID when Kristen first presented with suicidal ideation and depression, I had some knowledge of Archetypal Psychology, the Assimilation Model of Voices, and Experiential Personal Construct Psychology. I brought to the therapeutic relationship knowledge of, and openness for, imagination, cultural myths, and archetypal images. Our collaborative work within an Archetypal framework allowed Kristen to safely access previously repressed aspects of her experience. Additionally, my interest in the assimilation or change process that can occur in therapy, and my respect for the multiple voices within us all as described by the Voices Model of Assimilation, created a safe place for the client as her disparate voices emerged. Furthermore, by maintaining a theoretical stance rich in reverence for the development of an intimate therapeutic relationship, termed a *ROLE Relationship* by Experiential Personal Construct therapists, I was able to better understand the subjective meaning making process of one who grasps tenuously to consensual

reality. The following three psychological theories influenced and guided my conceptualization and work with Kristen and her experience of internal multiplicity.

Archetypal Psychology

We conceive our psychological nature to be naturally divided into portions and phases, a composition of earlier and later historical levels, various zones and developmental strata, many complexes and archetypal personas. We are no longer single beings in the image of a single God, but are always constituted of multiple parts: impish child, hero or heroine, supervising authority, asocial psychopath, and so on. Because we have come to realize that each of us is normally a flux of figures, we no longer need be menaced by the notion of multiple personality. I may see visions and hear voice; I may talk with them and they with each other without at all being insane (Hillman, 1975, p. 24).

Whereas many Western psychological theories value the unitary sense of self, archetypal theory argues that living with the many is a better account of actual lived experience. Archetypal theorists discount the monotheistic or hierarchical view of psychology and instead, ascribe to a polytheistic psychology where there are many gods, goddesses, characters, egos, identities, archetypes, and selves (Rowan 1990).

James Hillman, in *Re-visioning Psychology* (1975), asserts that there is an inherent multiplicity to the psyche that includes personification. Identifying, naming, and giving voice to the parts of one's self (e.g., good girl vs. naughty girl), or acting differently in different experiences (e.g., ethical student who declines offer of test answers vs. taking home pencils from the work place) is natural and even healthy. Hillman suggests that engaging with a person's sense of multiplicity can be helpful in therapy as "personifying helps place subjective experiences "out there"; thereby we can devise protections against them and relations with them" (p.31). Indeed, Hillman (1981) ascribes to Lopez Pedraza's view of the many as including the unitary or primary self without neglecting or silencing any of the many. He wrote "Here the one is not something apart and opposed to the many, leaving them as inchoate fragmented bits, but it appears as the unity of each thing, that it is as it is, with a name and a face" (p.131).

In addition to the obvious differences between traditional beliefs in a unitary self and Archetypal Psychology's view of multiplicity, Western psychology also considers

subjective feelings or behavioral responses as primary tenets. However, the archetypal approach regards image and the processes of imagination as foundational to its theory. Archetypal theorists value the conception of imagination that focuses on an imaginal world, where Gods, the psyche or soul, dreams, shadow, evil, archetypal figures, and symbols all are valued separate from the subjective experience. In Archetypal Psychology, Jungian archetypes are reconceptualized via with an appreciation for the aesthetic and the soul. It is a psychology that focuses on poetic principles and polymorphic Gods, draws from the Ancients, the Renaissance Humanists, and the Romantics, and addresses animism, ensouling, and the nonhuman (Hillman, 1983). Hillman (1975) asserts that the purpose of life as seen from an archetypal viewpoint is “to make psyche of it, to find connections between life and soul” (p. 3). In making such connections, one must remain open to the imaginal, connect with archetypes through personification, value the imaginal dialogues of the others, and privilege image for image’s sake.

Remaining open to and interested in the imagination is an important element of Archetypal Psychology. It suggests that a therapist recognize the power and beauty of the imaginal. Imagination includes dreams, thoughts, artistic endeavors, poetry, writing, music, and an aesthetic appreciation for the lived experience. Asking for a dream; sitting with a client as she uses chalk to draw an imaginary, safe place to be; reading aloud a poem that has been brought in; and listening to a song that elicits tears are all representative of a therapist taking an imaginal perspective in therapy.

Coming to know the client’s world and the archetypes that the client engages with includes the recognition and valuing of the imaginal dialogues that occur. These dialogues can be both internal and external. Mary Watkins (2000) writes in her book, *Invisible Guests*, that “experientially imaginal dialogues can take several forms: conversation between a self and an imaginal other(s), between aspects of the Self such as “me” and “I” or between imaginal others with a self as audience to the imaginal scene” (p. 2). Entertaining such voices, allowing them greater independence, and enabling characterizations to open up in therapy might lead some to believe that the elicitation of dissociation or fragmentation is occurring. However, “the entertaining of a multiplicity of autonomous and vivid characters is common place in the creation of literature and the practice of religion, and is hardly synonymous with pathology” (Watkins, 2000, p. 135).

As a clinician, adopting the theoretical stance of Archetypal psychology involves remaining open to multiplicity, engaging with the ongoing life of imagination, recognizing the inherent archetypes of a culture, valuing individual dream work, and reestablishing the connections between soul and human activity.

The Assimilation Model (Internal Voices Theory)

The Assimilation Model (Stiles, 2002; Stiles, Elliott, Llewelyn, Firth-Cozens, Margison, Shapiro, & Hardy, 1990) is an evolving trans-theoretical description of the process of change for individuals in relation to problematic experiences as it occurs in therapy. It includes identifying a client's particular problem and tracking its change over time with the aid of session transcripts and tape recordings. The process of change has been described using the Assimilation of Problematic Experiences Scales (APES). APES is an eight-point scale that describes clients' inner change processes as they become increasingly aware of and work through problematic experiences over time. The APES ranges from a position of being warded off, avoided, or unaware of a problem (APES 0) to a level of mastery where the problem is worked through and incorporated into daily life (APES 7) (Stiles, 2002). The Assimilation model suggests that similar patterns of change occur for most individuals in successful therapy.

The Assimilation model is based on a multi-voiced view of the self. It begins with the idea that all experiences leave traces. A voice is comprised of traces of past experience. These traces can be reactivated at a later date and are often triggered by similar events. Voices are thought to have independent agency. They represent a part of the self that can speak and act somewhat autonomously. Internal voices get linked together through meaning bridges, or joint understandings. Although different voices reflect different experiences, they can become linked, or assimilated, to form a community. Voices that revolve around similar themes may link together to build a community of voices (Honos-Webb, Surko, Stiles, & Greenberg, 1999; Honos-Webb & Stiles, 1998). A well-functioning community is comprised of interlinked voices that can communicate with one another.

A voice is considered problematic when it is discrepant from the community, represents a conflicting position of the self, or is a trace of a traumatic experience. These discordant voices thus represent problematic experiences and are unable to assimilate into the community without some negotiation with the other voices.

Therapeutic change occurs through dialogue between the therapist and the client, as well as between the client's internal voices (Honos-Webb et. al 1999). The multi-voiced model's initial premise is that all individuals contain internal multiplicity. What distinguishes health from pathology is the degree of communication between the voices.

Experiential Personal Construct Psychotherapy

EPCP (Leitner, 1988) also influenced my work with Kristen and was the primary relational lens I wore when I first entered the therapy room with her. EPCP is considered one of the constructivist theories and is specifically derived from Personal Construct Theory (PCT).

In 1955, George Kelly first wrote about constructive alternativism in *The Psychology of Personal Constructs* and described it as the universe remaining open to an infinite variety of interpretations. Though Kelly described the universe as being real, he asserted that each person construes it in a unique way. Constructivist theories all begin with the "philosophical position that, rather than there being a reality out there to be discovered, individuals maintain an integral role in creating the reality they perceive and grasp experientially" (Leitner & Epting, 2001, p. 421). The process of creating a reality includes, for example, a continual construing and reconstruing of experiences, events, feelings, values, and relationships. Therapy often involves identifying and elaborating on the unique set of personal constructs or meanings that a client may uphold.

The PCT therapist maintains a credulous approach when working with a client's constructs, accepting everything the client says to be true for the client. The client's story is viewed as his or her psychological reality. Each set of constructs communicated by the client represents important components of the client's way of being. This does not imply that a therapist should be gullible (Leitner, Dunnett, Anderson, Meshot, 1993). A therapist who takes the credulous approach accepts the client's presentation as possessing truth about the ways in which the client perceives and engages with the world (Neimeyer, 1987). Constructivist therapists strive to create a safe therapeutic environment for a client to share his or her personal constructs. Genuinely inviting a client to share his or her experiences as opposed to expecting the client to explore helps to make the therapy feel safe. The invitational mode is an important aspect of PCT therapy (Leitner & Epting, 2001; Kelly, 1955).

George Kelly's theory of constructivism is comprised of one fundamental postulate and eleven corollaries. EPCP elaborates on the sociality corollary of Kelly's construct theory. The sociality corollary states "to the extent that one person construes the construction processes of another, he may play a role in a social process involving the other person" (Kelly, 1955, p 95). EPCP builds on this corollary by suggesting that we are primarily relationship-seeking individuals.

Truly intimate relationships are desired and sought after. Yet, few seem to find the depth of personal contact they are seeking in their daily lives. Most of us yearn for those moments of mutual connection where a friend, family member, or lover understands us in a way that no other has before at the same moment that we understand them in a similar fashion. These relationships, the ones in which reciprocity in sharing the deepest parts of ourselves with another occurs, are indeed rare. EPCP theorists call them ROLE relationships and identify them as both potential validators and invalidators of human experience (Leitner & Faidley, 1995). ROLE relationships serve to validate our experience when the other understands and finds value in our meaning-making process. These relationships also have the power to disconfirm us, as we are obliged to face our blunders and ineffectual meaning-making processes in relations with others. For those who choose to fully engage in a ROLE relationship, they risk the likelihood of facing invalidation at some point in the relationship. Therefore, the choice for a meaningful relationship also means the choice to lay your sense of self on the line. Sometimes others view our interpersonal actions as awkward, inappropriate, or offensive and they essentially reject our way of being. Many shy away from such potential invalidation out of fear or self-protection. Their relationships often remain superficial, empty, or safe. There is little depth in their conversations and few would say they feel close to such an individual. An alternative way of avoiding invalidation includes removing one's self from others, either physically or psychologically. Such isolates interact with a relatively small group of individuals, if that. However, some individuals courageously risk the invalidation of their way of doing things or seeing things. They seek out human interaction, face invalidation, and grow in the process of making change after being disconfirmed. Most of us do both in relationships. Just as we seek out enriching relationships where we share our heart and minds, we also retreat from such potential invalidation in our relationships. Leitner argues that the result of retreating from intimacy is the experience of emptiness, meaninglessness, and guilt (1985). The ways in which we as humans struggle to

connect and avoid ROLE relationships both inside the therapy room (with the therapist) and outside (with significant others) are significant (Leitner, Faidley, & Celentana, 2000).

An important goal for the therapeutic relationship in EPCP is to work towards optimal therapeutic distance (Leitner, 1995). Optimal therapeutic distance is achieved when the therapeutic relationship is deeply intimate. It is described as the therapist being emotionally close enough to the client to feel the client's experience yet far enough away that the therapist recognizes the feelings as those of the client's, not of the therapist's. It is a metaphor that honors the process of coming to know the meaning making of another and represents the therapist resonating with the client's experience in a profound way. Optimal therapeutic distance is in contrast to therapeutic strangers where the therapist is unable to feel the client's subjective experience and instead, remains tragically distant from the client (Leitner, & Epting, 2001). It is also in contrast to therapeutic unity where the therapist is unable to tell the difference from the client's subjective experience and her own feelings about an event.

EPCP theorists consider diagnosis as valuable when it communicates an understanding of the client's experience, includes clients' strengths, and serves to guide a treatment for the client that produces positive change (Faidley & Leitner, 1993). As we are essentially relationship seeking, pathology is then viewed as excessive retreating from ROLE relationships, resulting in an empty and meaningless life. In EPCP, diagnosis is not meant to label another's pathology; rather, diagnosis suggests ways of helping the client to change by elaborating his or her system of meaning making (Leitner & Thomas, 2003). This is referred to as a transitive diagnosis, i.e., one that directly informs the treatment. The Diagnostic Axes of Human Meaning Making, a three axial diagnostic system described by Leitner, Faidley, and Celentana (2000), serves to identify 1) early developmental traumas, 2) interpersonal components, and 3) experiential components that impede optimal ROLE relationships from developing.

The first axis focuses on developmental/structural arrests that can occur in response to traumatic experiences during early childhood. If a traumatic event occurs in early childhood, a child may be incapable of making sense of or tolerating the trauma. A structural arrest or freezing may then occur in any of the following areas: self versus other, self-other permanence and self-other constancy. Leitner et al. (2000) describe structural arrests as "the freezing of the meaning-making process, such that self, other, and relationships are predominantly experienced as they were in these earlier periods of life" (p.180). Working with a client's core constructs, or

ways of making meaning in life requires an understanding of early childhood experiences. This is essential as core beliefs and ways of relating originate in the client's earliest of interactions with others. Bowlby's attachment theory details the ways in which an infant first interacts with its caregiver as well as the templates for future relationships that the infant/caregiver relationship creates (1969). Understanding a client's early childhood construal process is essential for an EPCP therapist. However, it is also necessary to recognize the actions the client takes based on those early understandings of self and other.

The second axis describes five interpersonal styles (undispersed dependency, excessively dispersed dependency, dependency avoidance, physically distancing self, and psychologically distancing self) that people actively use to ward off or deny the awfulness and emptiness experienced due to a lack of true ROLE relationships. Each of these interpersonal styles appears, on the surface, to have the potential to lessen one's relational pain. Ultimately, issues of dependency and distancing serve to intensify the pain of relating to others. An understanding of clients' interpersonal actions around these issues can guide much of the therapy work.

The third axis describes nine experiential ways of connecting or retreating from ROLE relationships. They are discrimination, flexibility, creativity, responsibility, openness, commitment, courage, forgiveness, and reverence. Exploring these areas can provide the therapeutic dyad with an understanding of both a client's struggles and strengths as he or she attempt to negotiate intimate relationships.

Since EPCP views humans as fundamentally relational beings, a diagnostic system is most useful when it both illuminates a client's pattern of connecting and disconnecting with others and offers direction for changing negative patterns of relating. A diagnosis made using this system will provide amplification of the client's relational constructs for both the therapist and client.

In elaborating Kristen's experience from an Experiential Personal Construct viewpoint, I will use the Diagnostic Axes of Human Meaning Making (Leitner, Faidley, & Celentana, 2000) to provide a diagnosis of her meaning making process. I also will discuss the ways in which Kristen has used the experience of dissociation in her struggles to connect with and retreat from others in ROLE Relationships.

Case Study

Referral

Kristen is an eighteen year-old, Caucasian female who is a senior in high school. She is an only child and lives at home with her parents. Kristen is involved in special education classes due to some identified learning disabilities and most recently has been working part-time in a grocery store on the weekends. Kristen initially reported that she had few friends during her childhood but has, in the last year, engaged in a small number of interpersonal relationships and has dramatically increased her social activities. Kristen suffers from severe allergy attacks, asthma, and frequent headaches.

At age sixteen, Kristen became distraught after her high school counselor called Children's Services. The school counselor requested assistance from Children's Services due to her concerns over Kristen's unusual self-disclosures at school. Kristen shared with both a teacher and a school counselor that she had an elaborate imaginary world that she had believed in since third grade. She described her imaginary world to the school officials as being filled with both violent and sexual imagery. The subsequent involvement of children's services left Kristen fearing that she might be removed from her home and placed in foster care. The thought of leaving home terrified both Kristen and her parents. Kristen's mother responded by calling the Clinic for help as Kristen had previously received assessment and therapy from the Clinic.

Early Childhood History

Kristen's early childhood development remains somewhat unclear. Mrs. Barnes has shared that she endured a very difficult pregnancy with Kristen. After Kristen was born, Mrs. Barnes suffered from a severe case of post-partum depression for at least two months, possibly more. She reported initially feeling unable to care for her infant due to the depression. She physically distanced herself from Kristen during the first few months of her daughter's life. Mrs. Barnes remembered later feeling extreme guilt over not having been a better mother to her newborn.

Kristen's parents reported that an extended family member accidentally dropped Kristen on her head when she was under the age of two. Kristen was treated at the hospital but the parents were unable to identify exactly what she was treated for. Prior to age four, Kristen experienced six months of regular nighttime vomiting and little sleep. Despite

numerous tests and visits to the hospital, the doctors were unable to diagnose any illness. As a toddler, Kristen was cared for by various family members while both her parents worked.

After Kristen entered elementary school, she continued to experience a number of difficulties. At six years of age, school officials and the Barnes reported that Kristen often picked her skin and regularly complained of headaches. She continued to vomit frequently and was reported to have daydreamed excessively in school and at home. Kristen had few positive peer relationships and was regularly teased or bullied at school. The Barnes have confirmed Kristen's memories of her childhood as one in which she was the recipient of intense bullying, name calling, and social alienation by her peers. Her parents took her to numerous specialists and doctors for assistance. At one point, a neurologist diagnosed Tourette's syndrome, Attention Deficit Hyperactive Disorder, and tremors. Following these diagnoses, Kristen was prescribed a number of medications that, by all reports, did not decrease her identified symptoms. Kristen's parents, psychiatrist, and teachers soon rejected the diagnoses, questioned the high number of medications, and requested a new assessment and therapy for her. They were referred to the university clinic for further assessment and treatment.

Kristen refers to her childhood as an unhappy one in which she experienced severe bullying at school and a number of medical problems that required an intense focus on her health. Her severe asthma and head injury required numerous trips to the doctor. Her parents described a mysterious six-month period of time when Kristen woke up each night with repeated episodes of vomiting. At that same time, a close family friend was suffering from cancer. Kristen was aware of the friend's illness, and the Barnes feel that knowledge impacted Kristen's belief about what would happen to her as well. Kristen shared that she regularly worried about dying as a small child. When Kristen was seven years old, she heard of a distant uncle's death. She reacted by running outside, laying in the middle of the street, and waiting to be run over. Kristen became preoccupied with illness and has maintained a fear of death.

Assessment History

Though Kristen presented for her most recent course of therapy at our clinic at the age of 16, she was a former client of the Clinic from ages ten through fourteen. During that time, Kristen worked with three therapist trainees and, at ten years of age, received an

assessment from a psychologist at the university Clinic. The psychologist described Kristen as an attractive and likeable girl who was experiencing considerable difficulties in the classroom and was being teased on a daily basis.

Psychological testing indicated that Kristen's cognitive development was considerably below average and was in the borderline range between mild mental retardation and low average intellectual functioning with a full scale IQ of 80. Her educational achievement was generally consistent with her cognitive functioning although she had particular difficulties with written expression. Emotionally, Kristen also was like a younger child, expressing herself concretely and with little insight into people's motivations and inner thoughts. Kristen, at age ten, expressed anxiety, particularly around issues of personal safety, health, parental conflict, and in feeling less adequate than the peers around her. She responded with agitation and distress to ambiguous material and indicated that, when stressed, she had more difficulty using the resources that she did have. The psychologist stated that Kristen demonstrated "a mix of problems that do not yield a simple diagnosis" and experienced "deficiencies in cognitive functioning, general immaturity and problems around affect modulation..."

Process of Voices Emerging

During our first six months, Kristen and I explored both her real world and her imaginary world using talk therapy and some play therapy. From the start, it was evident that Kristen's real world interpersonal relationships were minimal. She interacted with few of her peers socially. Kristen chose to spend most of her free time with her parents or at home alone, often in her basement. She had maintained only one friend since early childhood and she reported that she always felt lonely. In therapy, we discussed her confusion and distress about interpersonal relationships. We also worked on practical ways that Kristen could initiate and maintain friendships.

As I came to know Kristen better, it appeared as though her complex fantasy world was the creation of a very strong imagination in response to the felt sense of loneliness she first experienced in her early life. As an only child with minimal social skills, Kristen spent a great deal of her childhood isolated from her peers. It seemed that Kristen might have used her interpersonally complex fantasy world as a way to survive the very lonely everyday life she experienced. In therapy, Kristen presented her imaginary world in narrative form,

complete with well-developed characters, each of whom was named. She spoke of numerous characters in the third person and described many of their activities and interactions as those of a violent or sexual nature. I recognized that characters in the imaginal world often seemed to express or represent the feelings that Kristen was unable to express in the real world. For example, on one occasion, Kristen reported that she was unable to tell her father how mad she was at him in the real world. Later, she reported that a character in the imaginary world had temporarily killed her imaginal dad. Her characters appeared to have either an exaggerated sense of power or, the opposite, an absence of power. During our therapy sessions, we spent time exploring Kristen's feelings of powerlessness in the real world and her creative development of an imaginary world where parts of her remain all-powerful.

As the therapeutic dyad strengthened, Kristen demonstrated positive change. She shared more of her imaginary world and the structure that held it together. On occasion, she tentatively expressed her own feelings to others during everyday interactions as opposed to repressing them. Kristen began to reach out to her peers of her own accord and, perhaps for the first time, was successful in making new friends at school. She began learning to drive and looked for a job.

After eight months of therapy Kristen began to present her imaginary world in a very different way. It was no longer discussed in a dream-like or abstract manner. Rather, it was presented as if Kristen was an active, engaged member of the imaginal world and currently experiencing what had previously only been reported in the past tense. She began to occasionally speak of the characters in the imaginal world in the first person and would speak of herself as “Kristen” in the third person. She also demonstrated short losses of time and memory during the therapy session. For instance, on one occasion, she had no recollection of previously using a tissue when, at the end of our session, I asked her to throw it away. In addition, I began to notice that I often mentioned something we had previously discussed and she appeared confused as if she had never heard the content of our discussion before.

During the first summer vacation that we had from therapy, Kristen and I maintained limited email contact. Kristen sent me emails signed with her imaginary world characters' names. These emails often reported on Kristen and occasionally requested help for her.

Upon our return from summer vacation, we spent time exploring Kristen's presentation of each of the many characters in her imaginary world. At first, she and I spoke of them as parts of herself or voices of her experiences. These voices or characters seemed to represent distinct aspects of her personality. For example, one character presented as more aggressive while another character appeared more maternal. They were developed to the point that they not only had different names, they also displayed unique personality traits that contrasted with Kristen's sense of who she is in the real world.

As our sessions continue, her presentations of the characters in the first person also continue. When these parts of her appear to dominate or take executive control of her immediate experience, Kristen speaks of herself in the third person. For some part of the fifty minutes we spend in therapy, one of the alternate characters speaks. When another character identifies her presence, Kristen's physical presentation often changes, as does her vocal presentation. She will slouch or pull herself up depending on who is speaking. In addition, her hands will suddenly become quite animated or she will begin swinging her legs repetitively. Kristen's voice will sound deeper or the pace of her speech will increase. Her normally nasal voice will predominantly clear up.

After one year of therapy, I made a visit to Kristen's home at her request. While there, Kristen gave me a tour of her world in the basement and throughout the house. As she guided me through the house, she identified herself as the character, Zac, a more aggressive part of her personality. During one part of the tour, she pointed to an empty wall and said that was where another of the characters (Mama Jean) was stuck in a painting. When we proceeded to the basement of her house, she guided me through a number of rituals such as turning left at the end of the stairs, sitting in a certain chair, lining up numerous candles and figurines, and saying specific words. She then proceeded to demonstrate Zac's ability to perform as she danced to a song by the pop music group Hanson.

Since the home visit, the characters have continued to present themselves regularly during therapy as well as through email communication. During sessions, they report on their own and Kristen's experience in both the real world and imaginal world. When she is feeling overwhelmed by what she perceives to be an intense interpersonal interaction, one or the other characters often steps in to help Kristen get through the interaction. Originally Kristen reported this shift as occurring without her having any choice or control over it. However, Kristen reports that most recently she has been

able to make some particular choices about when one of the other voices takes over. For example, when Kristen is forced to speak with some of her male peers with whom she feels uncomfortable, she often will call forth the more masculine, aggressive Zac to take over. More recently, after three and one-half years of therapy, Kristen appears better able to reflect on her experience of shifting from one voice to another. She recently telephoned the clinic at a time when she was under extreme duress and discussed her desire to switch. Later that night, she reported that she had decided not to switch.

Description of Voices

The following alternate characters emerged in the first two years of therapy, they said, “to meet Kristen’s helper person,” provide additional information to help Kristen, and to share their individual stories.

Kristen

Kristen appears to be the host personality and is the one that the other voices say they were created by. She appears to be the character or voice that initially sought therapy. Kristen is eighteen years of age and can be described as depressed, shy, and passive. She is unable to express any anger and, most often, denies ever feeling angry. Kristen says that the others are much smarter than her. She worries about her parent’s marriage and struggles to understand their relationship. Kristen often reports feeling ill and has missed numerous days of school. She is the only one that suffers excessively from allergies and headaches.

Kristen has had few friends in her life. She has expressed conflicting sexual feelings toward both males and females but plans to remain a virgin until her eventual marriage to a man. Her style of dress is much more feminine than any of the other voices. Her clothes are often pastel colors. Her vocal tone is quite nasal and, on occasion, difficult to understand. She generally presents in therapy with a flat affect.

Zac

Despite Zac’s male name, she is a female with masculine characteristics. Kristen describes Zac as being “always and forever age 18.” She is all-powerful in the imaginal world and appears to be the reporter, the one that is able to report on most everything that occurs in the system. Part of Zac is assertive and even aggressive at times. Another part of Zac is kind and friendly. She has a good sense of humor, laughs often, and recognizes the irony in life. Zac seems to want to help Kristen have a better life and regularly steps in to protect Kristen when she is overwhelmed or under duress. Zac is the one who is strong enough to speak up to Kristen’s

parents or her peers when she disagrees with them. When angry, Zac is able to express it, often in a violent way. In the imaginal world, she regularly kills those with whom she is angry.

Zac is a famous musician, who often leaves on tour. She is a lesbian who reports that she has a very active sex life in the imaginal world with numerous girlfriends. Zac maintains a secret marriage to Madonna (another voice of Kristen's). Her vocal tone is clearer and assertive. Her body movements are broader than Kristen's (e.g., she regularly swings her feet and arms while talking). Zac often dresses in masculine clothes and favors a flashier pop culture style of dress.

Hanson

Hanson, named after the pop music group Hanson, is female and 130 years old. She was described by Kristen as "the most evil of all, almost like a demon." Hanson reported that she experienced a horrible childhood, one in which no adults stepped in to help her. She said that she was born a witch during the witch trials and was persecuted unmercifully. As a baby, people attempted to kill her by hanging her repeatedly. The hangings were not successful and she survived only to live a long life until she died of natural causes. When Zac was born, Hanson's spirit entered Zac's body and, according to Hanson, she is always in Zac's head. She is the part of Zac that violently kills in the imaginal world. Hanson said that, when Zac gets violent, it is actually Hanson inside of Zac getting angry. She also is a small part of Jessie (another voice of Kristen's) and is the part of Kristen that is suicidal. She rarely comes out and, according to Kristen, if she did, Kristen would end up in jail.

Madonna

Madonna is female and similar in many ways to the famous pop vocalist Madonna. The character shares her physical looks and some of her lifestyle with the famous singer. She is quite busy with her performing schedule and regularly goes on tour but will occasionally come to therapy to share information about what is happening with Zac or Kristen. When things get chaotic for the client, either in the imaginal world or in the real world, Madonna is often the voice of reason. She reports in person or by email as to Zac's behavior or Kristen's problems. Madonna is secretly married to Zac and has boyfriends on the side. It is a secret marriage because Madonna's mother continues to control her in many ways and she would not approve of a lesbian marriage. Madonna always appears happy to help and often asks for advice during our therapy sessions. In many ways, she is a peacemaker and a caregiver. Her vocal tone is clear and calm. She dresses in a feminine, more mature style of dress.

Tay

Tay is a sister of Zac. She is 20 years old and sexually active. Tay is a lesbian and says that her entire reason for being around is to have sex. Tay will occasionally step in to help Kristen when Zac is away on tour. She appears less capable of being in charge for any period of time and is easily stressed. She and her sister Ike (another voice of Kristen's) often play tricks on Zac, as they are the ones who protect Zac from acting out of control while she is on tour in the imaginal world. She is also a good driver and has stepped in to drive for Kristen on occasion.

Ike

Ike is another sister of Zac. She is 18 years old and sexually active. She is heterosexual and reports having numerous sexual liaisons. Ike will occasionally step in to help Kristen. She reports that she "won't jump in as quickly as Zac will." Ike prefers to let Kristen try to help herself. Ike and Tay often act as bodyguards for Zac.

Zachary, Isaac, and Taylor

These three male characters are the brothers of Zac, Ike, and Tay. They seem to be secondary characters in Kristen's system and rarely enter the conversation or therapy room. Two of the brothers seem to cause Zac a great deal of problems, often getting her in trouble when she is away on tour. Zac has called Taylor and Isaac "Dumb Asses," whereas Zachary is often referred to as nice.

Jessie

Jessie is female and the twelve-year-old sister of Zac. She lives with her and Zac's biological parents. Kristen reports that Jessie also has a part of Hanson in her head and even has direct access to her. According to Kristen, Jessie is less able to handle Hanson being inside of her than Zac is because of her young age. However, Jessie is quite resilient when it comes to handling other problems. Jessie reported that bad times are part of her daily routine. She said that her mother beats her daily if she talks to Zac, comes to Kristen's therapy sessions, or comes out to others. Zac drew Jessie with numerous bruises all over her body. Jessie has said she likes secretarial duties and took over for Kristen when she was temporarily employed as a secretary.

Max

Kristen remains unaware of Max. He is Zac's little brother and is the youngest character in the system according to Zac. Though he is only five, he acts much older. Max reported that he has sex all the time with a number of different people. Zac has explained this by saying that the

characters in the imaginary world age very differently than those in the real world. Zac described Max as intelligent and able to articulate some important things. However, Max, according to Zac, remains oblivious to the true problems of their shared biological family in the imaginary world.

Wes, the Probation Officer

Wes is male and the probation officer. He serves as the voice of authority and attempts to keep Zac in line. He has some power over Zac when it comes to keeping her out of trouble. In the imaginal world, he gives regular drug tests to Zac and has sent her to boot camp to shape up her out-of-control behavior. During one therapy session, Zac reported that on the way to therapy, Zac threw Wes out the window of the car.

Mama Jean

Mama Jean is a middle age, female know-it-all. Zac introduced her to me during my visit to Kristen's home. While touring the house, Kristen reported that Mama Jean was stuck in the wall, over her parent's bed, in a picture, unable to get out. After being introduced, Mama Jean described herself to me as a very busy individual who knew most everything about all of the characters in the imaginal world. She has only presented herself on that one home visit.

Megan

Megan is female and a girlfriend of Zac. Megan is open-minded, kind, and accepts people for who they are. She is modeled after an idealized acquaintance of Kristen's in the real world. She is strong and able to stand up for herself.

Assessment Tools

In a traditional, Western conceptualization of extreme dissociation, there are suggested protocols for the assessment process. In cases of individual psychotherapy initiated outside of an inpatient setting, the process generally begins with a thorough history being taken within a clinical interview. If dissociative symptoms are reported or suspected, some form of dissociative questionnaire should be given to the client, such as the DES. The client might also complete various personality measures and projective tests. Kristen's results will be discussed on the Dissociative Experiences Scale (DES), Sentence Completion, House Tree Person, Robert's Apperception Test for Children, sand tray work, and the Minnesota Multiphasic Personality Inventory-Adolescence.

Dissociative Experiences Scale (DES)

The DES (Bernstein & Putnam, 1986) is a 28-item self-administered dissociative experience instrument. It is not intended as a diagnostic instrument but is considered descriptive of a client's experience. It is a screening tool that measures the frequency of dissociative experiences. The test questions focus on a variety of dissociative experiences, many of which are considered normal experiences. Subjects that receive a high score on the DES should not necessarily be diagnosed as having a dissociative disorder. The test is administered by requiring the client to mark a point on a scale between two extremes (0-100%). The client determines where to mark a point according to how often an item is experienced. A total DES score is the average of the scores for all the items and will fall somewhere between 0 and 100. Total scores of over 20 should be considered noteworthy and discussed further in therapy with the client. After one and one-half years of therapy, Kristen agreed to complete two DES's. Zac completed one DES questionnaire and Kristen completed the second one.

Kristen's score on the DES was forty-five, clearly indicating a high degree of dissociation. Zac's score, however, was twenty-two, still worthy of clinical exploration, but not a high enough number to elicit extreme concern. A primary difference between the two sets of answers was Kristen's increased reporting of dissociative experiences. She scored highest with regard to others accusing her of lying, hearing voices, and finding evidence of things she can't remember. Whereas Zac consistently reported fewer dissociative experiences, she did admit to becoming easily absorbed in movies or television. In addition, Zac reported that she is always being called by the wrong name. When these results were shared with Zac, she remarked, "Yeah, everyone calls me Kristen, and I get sick of it." The DES results highlight the difference between Kristen and Zac. It appears that Zac does not experience many of the dissociative experiences that Kristen does. For example, when Kristen is angry with someone, it seems that she cannot handle the emotion and dissociates. Zac steps in and handles the issue in a very clear-cut manner. Perhaps Zac has no need to dissociate, as she is able to act on her anger. She is able to argue with Kristen's parents or yell at an offending peer. After the incident ends or at a later date, Kristen returns, only to find herself unaware of what has transpired during her absence. When her parents punish her for the offense or when her peers ostracize her, Kristen is confused. In addition, Zac, as

the system's reporter, appears to be somewhat present and retain memory of most of what occurs for Kristen, no matter who is control. Therefore, Zac consistently reports fewer dissociative experiences than Kristen.

Minnesota Multiphasic Personality Inventory –Adolescent (MMPI-A)

The MMPI was initially designed to provide in quantitative form an evaluation of a client's personality status and emotional adjustment (Dahlstrom, Welsh, & Dahlstrom, 1972). The MMPI-A is a form of the MMPI that was developed specifically for younger test takers in 1992. It consists of 478 items and includes items and scales specifically relevant to adolescence. It also incorporates most features of the MMPI and includes all of the 13 basic scales. As with the MMPI, the MMPI-A identifies areas of conflict, concern, and psychopathology and provides age-appropriate norms (Duckworth & Anderson, 1995). Due to the test's length (testing time often exceeds two hours), the testing session may be broken into several shorter periods (Butcher et al., 1992) Graham (1977) has demonstrated support for reading the items to some special needs clients with either the examiner or the client recording the answers.

Kristen's MMPI-A Results.

In January, Kristen and I sat down to complete the MMPI-A. At the beginning of the test period, twice during the testing, and at the end of the test, Kristen identified herself as being Kristen. On several occasions, she asked for clarification of a word that she was unfamiliar with. She responded quickly to questions that seemed to be easily understood by her. Throughout the test, I felt that her answers remained consistent with the content and personality style that Kristen presented in therapy on the occasions that she has identified herself as Kristen.

The resulting MMPI-A profile (see Appendix A) displays numerous areas of potential concern. On all of the subtests, she scored in the clinical range. Her results are representative of one who has numerous unusual and distressful experiences.

Kristen's profile suggests that she is willing to describe her problems, is help seeking, and is particularly candid. These attributes have been demonstrated in therapy as she has courageously opened up about her internal experiences. In addition, her answers on the MMPI-A demonstrate consistency. Her character lines and stories have exhibited internal consistency from the start of our work together.

The results of the MMPI-A suggest that Kristen experiences numerous somatic complaints and general ill health. Since early childhood, Kristen has missed many days of school each year due to asthma, allergies, colds, and severe migraine headaches. The results also represent her inhibitions of aggression, and a need for affection. Kristen is unable to stand up for herself and desperately wants friends.

Kristen's elevated scores also reflect her adverse reaction to stress, including the development of physical problems and additional somatic complaints as a response to pressure. Kristen has said that she often feels sick or experiences a migraine headache after an interpersonally stressful event.

The results further reflect Kristen's reported family problems and poor school adjustment. Kristen struggles to fit in at home or at school. Since early childhood, Kristen has only been able to maintain one friend. This friend does not attend her school so contact is limited. In high school, Kristen eats alone at lunch. Her parents have described her as introverted. She does not have a social group at school and spends most of her free time alone in her room or in the basement after school.

According to the MMPI-A, Kristen's identifies with typically female qualities. She often wears some make-up, curls her hair, paints her nails, and presents in a feminine manner to therapy.

As confirmed by her profile, Kristen experiences anxiety, disagreements with her parents, persecutory ideas, and uncontrollable thoughts. She is interpersonally sensitive and naïve. Kristen regularly feels misunderstood and quickly trusts others. She has experienced a great deal of suicidal ideation since early childhood. Her scores do suggest that she may experience a high degree of suicidality and the possibility of sexual or physical abuse. Kristen has regularly reported in therapy that she wants to hurt herself. However, dating back to the university clinic's first interaction with Kristen as a ten-year-old child, she has never reported any experience of sexual or physical abuse. She does report that her imaginal world is filled with torture, rape, murder, and sexual activity.

Zac's MMPI-A Results.

In February of 2003, the client completed a second MMPI-A in the same manner as the first MMPI-A. At the beginning, twice during the testing period, and at the end of the test, the client identified herself as being Zac. Once again, the client answered questions at a similar

speed to her presentation in therapy when she identifies herself as Zac. On occasion, she requested clarification regarding a word that she did not understand. Her answers appeared to be consistent with the presentation of Zac in therapy.

The second profile (see Appendix B) is less elevated than the first profile completed by Kristen. Though Zac does appear to suffer from highly unusual experiences and symptoms, she displays less depression, physical complaints, unusual experiences, and social introversion than Kristen.

The validity scales of Zac's MMPI-A profile do appear to be similar to those in the first profile and continue to confirm severe symptoms of psychopathology. Zac's responses reflect consistency just as Kristen's did.

The elevated scores reveal Zac's experience of family discord, problems with authority, aggression, and involvements with drug and alcohol. Zac has readily admitted in therapy to all of the above behaviors and has presented herself as the all-powerful one who puts up with little opposition. She is the one who kills off or tortures those she is displeased with in the imaginal world. She does not like to be told what to do and often rebels against Wes, the probation officer.

According to the profile, Zac can be described as paranoid, argumentative, hostile, destructive, or acting out. The results of the MMPI-A suggest that Zac also engages in externalizing behavior representative of a physically abused or sexually active teen. As stated earlier, since therapy first began seven years ago, Kristen has never reported being abused in the real world. However, Zac reports that she (Zac) was abused as a child by her imaginal parents, is a lesbian, and is heavily engaged in sexual behavior in the imaginal world.

Unlike Kristen's identification with feminine qualities, Zac's MMPI-A confirms that she identifies with typically masculine attributes. Despite being a female, Zac dresses and acts in a traditionally macho way and often arrives at therapy dressed in very boyish looking clothes. When she leaves our sessions, she often shakes my hand with a firm grip.

Projective Tests

In December of 2002, Kristen completed a clinical interview, the Children's Sentence Completion Form, House-Tree Person (HTP), and Robert's Apperception Test for children (RATC). Several overall themes emerged throughout the evaluation. A predominant theme was Kristen's feelings of being alienated, and at times confused by her internal complexity. She mentioned several times during the test period that she wished she

could be more "normal." Kristen also reported feeling separate from her peers because of her slower learning style. A secondary theme that emerged was her concern surrounding death and safety issues. Kristen seemed distressed by a recent death and was concerned that strangers or monsters would harm her or others in fairly violent ways. Kristen also mentioned therapy several times. She said that she needed help and that she needed someone to listen to her problems.

Clinical Interview

A clinical interview is a dialogue with a client that allows the tester to obtain a basic understanding of any issues that may be of specific concern to the client. The highlights of Kristen's interview, as described by her tester, Meredith Glick, are as follows:

During the clinical interview, Kristen discussed three things: her family, school, and her concerns about her internal complexity. Kristen described her family life as "better" since her parents reunited from a brief separation earlier this year. Kristen reported that she is at times lonely being an only child, but generally gets along well with her parents. Kristen reported that on a recent vacation, she had fun but was often left to look after her younger cousins. It seems she was too old to enjoy playing with the children, yet too young to be included in the adults' activities. Kristen admitted that school is hard for her academically, as well as socially. She reports being teased through the years for being a "slow learner."

Kristen also reported feeling different and alienated due to her internal complexity. She said others often don't understand her. Whereas Kristen used to deal with this by writing down her thoughts and feelings, she stopped when the school found a somewhat threatening letter she had written to a classmate. Kristen insisted that she meant no harm and has since decided to keep much of her thoughts private. Kristen reports that she is able to discuss some of them in therapy, which helps, but still feels confused by her own complexity.

Sentence Completion

Sentence completion tests consist of a series of open-ended sentences that are left incomplete in order for the client to fill in the blank with his or her own responses. Though similar to word association tests, sentence completion tests generally tease out longer and more thoughtful responses (Anastasi, & Urbina, 1997). Kristen's results are described by the tester, Meredith Glick and are as follows:

Madonna's presence was felt in the sentence completion form, which was given orally. Kristen said she would like to see Madonna and wishes that she were rich enough to actually go see Madonna. When asked about boys, she described them as "stupid, retarded, insane, they shouldn't be here." This answer seems developmentally young for a 17-year-old, though her response was likely influenced by a recent break-up with a boyfriend. Another fairly young and concrete answer was in response to what one thing she would change about herself: "my hair." When told she could have three wishes, her answers were less concrete and fairly abstract. She wished for (1) "me to see Madonna"; (2) "have cures for every sickness, including AIDS"; and (3) "nobody would see the difference in people, like color or being slow of learning." She mentioned the theme of being teased and feeling hurt for being a "slow learner" a few other times as well. The last dream she remembered was about being lost in the forest and kidnapped by a monster (a theme that also appeared in the Robert's Apperception Test for Children). She said the best thing that ever happened to her was buying her parents tickets to a rock concert. This shows her affection for her parents and the important role they play in her life. She seems close to them, but perhaps less independent than most 17-year-olds.

House Tree Person (HTP)

The House Tree Person (Buck, 1948, Buck & Hammer, 1969) is a projective test in which the client is asked to draw individual pictures of a house, a tree, and a person on separate pieces of paper. The tester then initiates a discussion about the drawings and what they mean to the client. The tester also observes how the pictures are drawn as well as certain, specific features of the drawings. Often, a detailed and integrated story emerges which helps the clinician to understand the client's worldview and psychological health (Anastasi, & Urbina, 1997). Meredith Glick's analysis of Kristen's HTP is as follows:

Kristen spent about four minutes drawing a picture of a house (see Appendix C). She made quick yet careful and purposeful pencil strokes and did not make any erasures. She first drew the frame, then the door, roof, peaks, and then the window in the bottom portion of the house. The most prominent feature is the excessively large roof. This tends to indicate that an individual seeks satisfaction in fantasy. This fits with Kristen's elaborate imaginal world, where she spends significant amounts of time interacting with imaginal characters and scenarios. Kristen drew an excessive number of windows and reported that

the number of windows would indicate more floors than it really has, stating, “I just like to draw windows.” It’s possible that Kristen doesn’t want to ever feel secluded and hidden away from the world, and windows allow for two-way access. The house very much resembles a cat (complete with pointy ears, eyes, and a nose), which she herself commented on. Kristen made some other notable comments during the post-drawing inquiry. She said it was her house, the one she plans to buy once she’s rich and famous. Kristen said her bedroom would be located in the top floor “because it’s unusual.” Her desire to be in top/attic portion fits with her tendency to live in a world of fantasy and imagination. She said the house reminded her of a cat as well as someone trying to be different. When queried, she said it reminded her of Madonna. The peaks of the roof reminded her of the cone-shaped bra Madonna wore in one of her videos. She said the weather in the picture was dark, cloudy, and stormy which she said is the weather she likes.

Kristen spent only two minutes drawing a tree (see Appendix D), and drew with similar swiftness and confidence. There doesn’t appear to be anything terribly unusual about her tree, other than the fact that she said it was different than most because it grew coins. The trunk contains a fairly large knothole, which sometimes conveys a history of trauma. There is no evidence of physical or sexual trauma in Kristen’s history, though her description of the hole is worth noting. When asked if any part of the tree were dead, she replied that the hole was dead because it didn’t receive enough care. She said it died 20 years ago (and said the tree was probably “ten-hundred” years old). When asked if it was a healthy tree, she replied, “Kind of, because it’s still living. But it is has an unhealthy part—the hole—dead for people to see.” When asked if the tree looked more like a man or a woman, she said, “Both, because I can just see it.” She pointed to the point in the leaves where she saw “a man giving a mean look” on the right-hand side and then pointed to “a woman with her hairdo blowing” on the left-hand side. When later asked what the tree reminded her of, she said, “It reminds me of two people coming together and then dying at the end.” Kristen continued to focus on issues of death, stating at the end that if the tree were a person, it would be her babysitter’s sister who had died right before Christmas and complicated her life.

Kristen drew a person (see Appendix E) in about three minutes. She first drew a circle for the head and proceeded to draw the rest of the body. The only erasure she made

was on the legs. She had originally drawn two lines, indicating the inside boundaries of the legs, but removed one of them so that legs were pressed together. She then drew the belt, eyes, and necklace. She thought she was finished, but then said “oops” and drew in the mouth and nose. On the whole, the person was not very detailed except for the belt and necklace (which she fashioned after her own). The scribbled hair and basic facial features seemed more like what a younger child would draw. Perhaps the two most noteworthy features were the unusual eyes and lack of feet. She said the reason she drew one eye looking up and the other looking down is because she feels it’s very complicated having to live in two worlds, but only having one body. When asked if she wanted to say anything else following the post-drawing inquiry, she said, while laughing, that she had forgotten to draw the feet. Kristen said the drawing was herself: a 17-year-old girl. She said the girl was thinking about how crazy and insane she is. She said she was happy on the outside but not on the inside. When asked if the girl made her think of anything, she replied, “Madonna.” She said the girl feels as if she’s the only person who’s different. When asked if anyone had ever hurt the girl, Kristen said, “emotionally, but not physically.” When queried, she elaborated that she had been called a lot names and everyone turned against her. She said what the girl needed most was somebody to listen to all of her problems.

Robert’s Apperception Test for Children (RATC)

The RATC attempts to combine the flexibility of projective tests with the scoring, administration, and procedure of more standardized tests. It consists of 16 cards that show children involved in interpersonal situations with other children and adults. The pictures depict everyday events that might suggest problematic areas for some children. The tester engages the client in a discussion about the pictures and looks for specific areas of concern the child may have (Anastasi and Urbina, 1997). Kristen’s results on the RATC, according to the tester, Meredith Glick, are as follows:

Kristen followed the directions quite well and did not need to be prompted to ask what the characters in the pictures were thinking and feeling. Her stories were elaborated with a lot of details, and filled with emotion. About half-way through the cards, she asked if she could refer to the characters by name, so that would make it easier to tell a story. She proceeded to use a variety of boys’ and girls’ names with great ease, as if they were their rightful names. Most of the stories she generated seemed within normal limits of children

her age. However, three stories seemed filled with particularly distressing content. When shown a picture of a girl who looks as if she's falling, she initially responded that it looked like fun. She then said, "It looks like a scary thing. The girl went walking in the woods—thought it would be fun to walk around—it was a real windy day—she and parents had watched the news that a serial killer was out who liked little girls was out in the forest—she hears footsteps—turns around and sees nobody—she goes into a shack, turns on the light, and the serial killer is there—she screams, but no one can see her because she's so far out in the forest."

A similar theme showed up in her story explaining a scene in a card where a young boy is peaking into a bathroom where a woman is taking a bath. Kristen said, "Jennifer decided to get a bath because her husband is coming home—she wanted to make him dinner—they live in a safe neighborhood—leave their doors unlocked—she'd heard on the radio that a rapist was loose but thought: not in this neighborhood—it's nice and nothing ever happens—she heard the door open—thought, oh John you came back early—but she got raped—now her husband always locks the doors, even when he leaves. These two stories, along with a recent dream she'd had, suggest that Kristen is concerned about safety issues.

The third story that stood out was about a girl who is holding a chair in the air, as if she's about to throw it. Kristen instead interpreted this as a girl hitting herself in the leg because she thought it would make her feel better after being hurt from nasty rumors about her. She said the girl went into school the next day with a broken leg and everyone was nice and tried to figure out what she had done. A large part of this story seems autobiographical (she feels that her peers have started rumors about her and treat her as an outcast), though the unusual aspect is Kristen's interpretation that the girl was going to physically hurt herself in order to feel better. Kristen has reported suicidal ideation in the past, though it is uncertain if these thoughts have recently intensified.

Sand Tray

The sand tray is a therapeutic technique as well as a projective assessment tool used predominately with children, although, increasingly, therapists are using it with adults (Labovitz-Boik & Goodwin, 2000). Sand trays are used in conjunction with talk therapy and

potentially carry the interpretive components of psychotherapy. Sand tray work is considered especially effective with clients who have been traumatized.

A sand tray consists of a box filled with sand and a number of miniature toys, figurines, vehicles, furniture, trees, and animals that are placed in the sand box by clients. It is called a projective assessment because the client attaches some meaning onto the toys he or she places into the sand tray. During the session, a therapist works at understanding what the meanings are for the client. A common practice during assessment is for the therapist to ask the client to “show me your world.” The client then proceeds to place toys into the sandbox in a way that represents or means something only to the client. During sand play, Carl Jung theorized that children go into a slight trance allowing the therapist to tap into the child's unconscious processes (Weinrib, 1983). The therapist and the client discuss the client's choices and what the choices represent. It is during the discussion that the therapist has the chance to confirm or disconfirm the impressions that he or she is considering about the world in which the client lives. In session, the therapist and the client collaboratively arrive at a holistic impression of the world the client has laid out in the sand tray. The sand tray's effectiveness is based on the client feeling that she is in a safe relationship where she is free to explore or play in the sand. Additional continued discussion over the course of therapy can relate to or elaborate on the original impressions that are co-constructed.

Early on in therapy, when Kristen presented her imaginal world in the third person, I asked her to “show me her world” in a sand tray on two separate occasions. I was, in a sense, asking her to show me her core constructs in a visual manner. At the first session, Kristen completed a sand tray that represented her real world experience. During a later session, she completed a second tray that represented her imaginal world. In each case, as she placed the toys into the sand tray, she shared with me what the toys and their placement meant for her. I took photos of the sand trays, and we continued to discuss them over the following months.

The first sand tray (see Appendix F) was a bleak picture of her daily real world experiences and relationships. In her sand tray, Kristen had placed several toys and plastic characters. Only three of these toys represented people she cared about or who cared about her. They were her mother, father, and one friend. The rest of the toys represented things

she liked such as horses, or cartoon characters, such as the Smurfs. The sparse tray appeared to represent a very isolated, lonely child.

In stark contrast, the imaginal world tray (see Appendix G) was full of toys and appeared quite chaotic. Almost every inch of the sand was covered with characters that represented both friends and foes. Zac's power was immediately evident as Kristen's first move was to place a toy crystal ball in the middle of the tray, which she informed me, represented Zac's complete power in the imaginal world. In addition, there were foster families, half families, and birth families of the primary character, Zac. There were drug dealers and probation officers. There were also toys representing killing machines and sexual torture chambers. As demonstrated in her second sand tray, Kristen's imaginal world was rich with complex relationships and various experiences.

The vastly discrepant sand trays seem to represent the severe split that Kristen experiences between the real world and her imaginal world. They demonstrate Kristen's experience of loneliness in the real world and the exciting, empowered life that she has created for Zac in the imaginal world.

As Kristen's therapist, I have learned about her by using such diagnostic tools as the DES, the MMPI-A, Sentence Completion, HTP, RATC, and sand tray work. I also have also been informed by her psychological history and a long-term period of therapy where her internal multiplicity consistently presented itself. Taken as a whole, Kristen's test results, history, and therapy confirm a traditional diagnosis of DID.

However, there are alternative ways of viewing and understanding a person's experience of dissociation. Considering non-reductionistic views of health, pathology, and treatment may provide alternative ways of conceptualizing extreme dissociation. Using an EPCP lens to view Kristen's experience might present further information about her experience without reducing it to a diagnostic label. This added information might suggest alternative ways of working in therapy with Kristen. Therefore, I next will present an EPCP conceptualization of Kristen's experience using an elicitation of construct pictures and the Diagnostic Axes of Human Meaning Making.

EPCP Case Conceptualization

Elicitation of Construct Drawings

According to EPCP, the elicitation of a client's core constructs and ways of relating to others is vital for therapy. Coming to know a client is an essential ingredient of good therapy. Certainly, one way of understanding a client's world is to ask for a verbal description of the client's world. However, not all clients' can articulate their beliefs. Children often have a particularly difficult time telling others what they are feeling or experiencing. In Kristen's case, she told me about a session of play therapy she engaged in at age eleven where "the room was filled with all these people, but I couldn't tell her (the therapist). I didn't have the words. I thought I was crazy." Another way of coming to know a client that is particularly effective with children is to ask the client to draw out what she is trying to describe.

With DID, a common technique used by therapists is to have clients draw a map of their systems of internal voices (Haddock, 2001). Ross (1989) insists that it is impossible to work with DID clients without mapping out the personality system, either by drawing it or writing it down. He suggests that a complete map also includes gathering personal history such as the "name, age, time of appearance, function, degree of amnesia, position in the system, internal alliances, and any other relevant traits of each alter personality" (p.235).

Ravenette (2003) has used drawings extensively in personal construct therapy with children to facilitate their developmentally limited communications about their worlds. In a personal consultation, Ravenette (2003) suggested that I ask Kristen to draw the characters as she and the others in her system view themselves. After asking open-ended questions about her initial drawings, he suggested I talk with her about each picture and what it meant to her. I hoped that it would be therapeutic for her initially to get her construct system comprised of her characters out on paper. Having the pictures in front of us as Kristen talked about each character should allow us to elaborate hers and each of the alters' set of constructs. As therapy progressed, the drawings also might serve to facilitate a conversation between the voices. For example, as we sat together, I could point to the picture of Zac and ask Kristen, "What would Zac say about this?" I hoped that the visual image in front of the client might facilitate one voice moving towards the other in an empathic understanding of the other's position.

After two years of therapy, I talked to Kristen about possibly drawing her world so we could have the physical representation of the voices in front of us as we talked about them in therapy. She agreed but repeatedly asked if Zac could draw the voices. Kristen asserted that Zac was “the reporter person” and a much better drawer than she was so, naturally, “Zac should draw the voices.” After some discussion, I agreed; and we set a date for Zac to start drawing the characters. The drawings continued over a month of therapy sessions with Jessie stepping in to draw herself (see Appendices H-N).

At first glance, all of the alters, except Hanson, have similar characteristics. They each present as young, smiling, and colorfully dressed. Kristen is blonde and wearing an actual outfit of Kristen’s. The pictures of Zac, Ike, and Megan each have a pentacle drawn in the background, a symbol that Zac has often drawn in our therapy sessions. Zac is presented as “18 forever.” Ike is described as “age 20” and Megan as “age 18.” Zac and Ike each have two different colors of hair with a part down the middle. Zac has said this split represents their splits between the real world and the imaginal world. Zac, Ike, and Jessie have bruises on their faces and hands due to the abuse they receive in the imaginal world. Zac, as a pop music singer in the imaginal world is dressed in flashy star-studded jeans. Jessie is wearing a Zac Hanson (the actual name of a pop singer) t-shirt. Max as the youngest character presented in therapy is drawn as the shortest one. Zac has said that Max will never age and will be “5 forever.” Jessie drew the picture of herself, and Zac drew all the other pictures.

In sharp contrast to the smiling faces of the others, Hanson looks particularly gruesome. Her eyes are red and her teeth appear pointed and sharp. Her clothes, skin, and hair are all drawn solely with a black crayon. Hanson has a pentacle necklace on around her neck as well as on the ball and chain that she is carrying. In her other hand, she is carrying a knife with blood dripping from it. Zac signed her picture of Hanson after writing “Hanson The worst Picture you will ever see.”

These pictures as drawn by Zac and Jessie illuminate Kristen’s world and constructs in ways that words alone cannot. In looking at the alters, we now see them as Zac, the all-knowing reporter, and Jessie see them. We are able to understand that Kristen and the others experience a severe internal split. The split between her imaginal world and the real world are evidenced by each of the alters’ severely divided opposing hair colors. Kristen’s feelings

of being abused by others can also be seen in the numerous bruises on Zac and Jessie's bodies. Her fears about the dark sides of herself are also witnessed in the copious pentacles that appear in the drawings and in particular, as seen by the grotesquely drawn Hanson.

Throughout the therapy process, the portraits were examined and discussed as we explored the role each alter played. Kristen's construct drawings allowed me to understand her unique experience of internal multiplicity.

Diagnostic Axes of Human Meaning Making

Kelly believed that diagnoses should only be used if they lead to ways of conceptualizing clients that assist in their personal growth (1955/1991, Faidley & Leitner, 1993). EPCP theorists agree that diagnoses are most helpful or transitive when they serve as guides for the therapeutic work. A therapist who comes to understand the meaning making process of another has the potential to connect more deeply with a client and then may consider additional treatment options. EPCP diagnosis focuses on clients' particular struggles with ROLE relationships and the ways in which clients connect and disconnect from others (Leitner, Faidley, and Celentana, 2000). This diagnostic system addresses three axes: 1) developmental-structural issues, 2) interpersonal components, and 3) experiential components of the client. Under each of these axes, there are numerous issues that clients struggle with.

Insert Table 1 here

Kristen's strengths and struggles in developing intimate relationships are discussed according to the EPCP diagnostic system and theory in the following section.

Developmental Structural Issues Axis

Children begin to experience senses, feelings, and thoughts about ways of relating to others shortly after birth. These first interactions with primary caregivers are influential in children's earliest understanding of self and other. As they mature, children continue to modify their ways of being with others by further interactions with extended family members, peers, and even strangers. With each encounter, children are actively forming core constructs about their sense of self and others. These core constructs serve as templates for all future relationships (Simons, Paternite, Shore, 2001). For example, when the early relational encounters are experienced as safe and trustworthy, the child grows into adulthood predicting that future

relationships also may be safe. However, if a child's initial encounters are inconsistent, frightening, or traumatic, the child's core relational constructs often are steeped in fear. A primary task for an EPCP therapist is to understand the core relational constructs of a client.

Self Versus Other. As previously discussed, beliefs about self versus others begin to develop immediately after birth through initial interactions with primary caregivers. As babies develop, they progressively construe themselves as independent agents with increasing degrees of separateness from their caregivers. How this recognition comes about for a baby, either in healthy or hurtful ways has profound implications for socioemotional development and serves as a template for the baby's meaning making processes in terms of both self and other. Infants that are intertwined with over-bearing caregivers may believe that love is enmeshment. Children that are neglected may struggle to connect intimately with others. Infants, who intermittently receive both love and neglect, may remain confused about relationships. Such children may have difficulty believing that true connections are possible, that they are worthy of relationships with others, and that they have some effects on others.

As an infant, Kristen's first few months were ones in which she was both physically and psychologically distanced from her mother. The separation appears to have been related to a severe case of undiagnosed post-partum depression as experienced by Mrs. Barnes. Kristen's parents described their baby's earliest months as a period of time in which Mrs. Barnes had limited interactions with her. Kristen's mother remembers feeling overwhelmed and despondent after the birth of their much-anticipated only child, and for the first few months of Kristen's life, she often slept past noon and paid little attention to her baby. Kristen's father confirmed this report and said that he and various other family members primarily cared for Kristen. However, even after those first few months, Mrs. Barnes continued to feel guilty and anxious around her daughter. By both Mrs. Barnes' and Kristen's report, their attachment to each other has felt inconsistent and tenuous throughout Kristen's life. After suffering for years from extreme mood shifts, Mrs. Barnes shared that recently she initiated drug therapy and has found some relief. After Kristen's diagnosis of DID, Mrs. Barnes suggested that her own psychological distress might have affected Kristen's feelings of self-worth. Even today, as a teenager, Kristen laments the lack of connection and love that she feels from and for her mother.

Some of Kristen's current self-other struggles could be viewed in her frequent suicide threats. For example, when Kristen has felt suicidal, she has stated that her death or absence

would be of no consequence to her family or to me, her therapist. As soon as she feels interpersonally overwhelmed, she has, in the past, immediately wanted to end her life. This happened once when she continued a relationship with a boy she did not like rather than confront him and end the relationship. As she became increasingly weighed down by their everyday interactions, Kristen wanted to kill herself without considering the ways her absence would hurt others. She feels certain that her parents would “be sad for awhile, but then it would be easier on them.” Indeed, even when I pointed out how I might respond if she were to kill herself, she seemed stupefied. At one point, Kristen sent me this note, “I hate me, you hate me, and everyone hates me. Why doesn’t everyone kill me now and it will all be a big fucking dream when I wake up? I am all bloody and cannot move. Oh well, this is a big huge fucking dream.” When we discussed the horrific imaginary scene she wrote so casually about, Kristen was surprised that it bothered me. It appears that it is difficult for Kristen to imagine that her presence or lack of it has any effect on others.

The interpersonal aspects of Kristen’s ability to view herself as a separate being, worthy of care and affection, and capable of affecting others may have been hampered by a freezing early on in the basic construction of her understanding of self versus other. These struggles in self versus others are seen most often as the person wrestles with self-other permanence and constancy.

Self-Other Permanence. A person must have a sense of one’s own and another’s permanence in order to engage in healthy ROLE relationships. Self-other permanence from the EPCP model means to accept that another is caring for you even if the other is physically absent. Despite the distance or absence of the other, the other has not ceased to exist, and the relationship has not ceased to exist. An infant who does not experience a consistent caregiver may not have the ability to see the other as permanent. As the infant grows, she clings to the caregiver, imagining that when separated from the caregiver, the caregiver and, perhaps, the baby cease to exist. As an adult, any separateness from a loved one is feared as a potential threat to the existence of self and other.

Permanence of self also means having confidence in your own ability to maintain a sense of permanence about who you are when interacting with others. Sharing one’s self intimately in relationships with others requires a permanent sense of self. Those who quickly discard personal

attributes only to replace them with perhaps more exciting aspects can be seen as overly malleable and as having low self-permanence.

It appears that Kristen has struggled to see others as permanent. Early on in therapy, she frequently sought me out between sessions as a way to stay connected. She often would call the clinic with a crisis at school one or two days after our sessions. After I spoke with her on the phone, she would calm down as if hearing my voice was enough to remind her that I had not deserted her. Connecting to me appeared to be a way of centering or remaining present in the real world, and it was impossible for her to imagine that we could be connected if I were not physically accessible. In the beginning of our therapy, Kristen often dissociated more frequently in my absence. She struggled whenever I left town for the holidays or on vacation. In one note Kristen wrote, "I HATE TO INTERRUPT YOUR VACATION. If you do not want to talk to me any more just please call me to let me know that it is over with our meetings. I would still want to come, please call to let me know if we can still have our meetings or not. Please let me keep talking to you. I am crying right now because I am scared of what you are going to say, but it is not my choice, it is yours." Many of her most intense crises have occurred immediately before I left town or as a response to my leaving town.

From the beginning of therapy, Kristen struggled to accept any absence on my part. Perhaps as a way to keep me interested in and available to Kristen, Zac originally appeared in session only a few weeks prior to our first summer break. At that time, Kristen's fears about my leaving and being absent from her intensified to such a state that she stopped coming to therapy and Zac came instead. Rather than face what she perceived as my lack of permanence, Kristen experienced her own lack of permanence and disappeared.

Kristen continues to be quite fearful of ending our relationship and cries when the possibility of termination comes up in therapy. Separation deeply frightens her. Kristen has repeatedly said that when I move to another state or country, she will follow me there as a way to keep our relationship intact. Early on in therapy, Kristen struggled with the possibility of her parents separating saying she could not imagine how her mother could live in another place and still be her mother. Kristen's security in her own and others' existence is tied to constant physical and emotional presence. It appears that she is unable to carry the emotional presence of another with her as an internalized representation of the person and the relationship. Instead, she may require constant reminders and reassurance of the other's presence.

Kristen also appears to lose her sense of self when in relation to others. She readily suspends characteristics of her own personality as she takes on the attributes of those that she admires. With her peers, whenever someone was kind enough to spend time with her, Kristen quickly adopted her acquaintance's interests or mannerisms. For example, Kristen felt particularly in awe of one girl's religious zeal. In a six-month period of time, Kristen joined her new friend's evangelical church, became baptized, went to prayer meetings at school, and attended several sermons throughout the week. This might have been a positive experience for Kristen. However, she shared her imaginal world with the pastor and subsequent meetings entailed the members' repeated efforts to cast out the devils within her with intense prayer and the laying on of hands. Although these actions deeply frightened her, she continued to attend the church. Kristen was able to leave the church only with direct intervention by her parents.

Furthermore, Kristen is particularly drawn to celebrities and privileges their attributes over her own. Her parents have reported that she has been "obsessed" with various celebrities since early childhood. She idolizes Madonna, the Hanson brothers, Brittany Spears, and N-Sync. Kristen fanatically collects their music, sees their movies, arranges their pictures in her room in a certain way, and purchases many items endorsed by these stars. In the imaginal world, many of the various parts of her are named after these celebrities. These alters have shoved aside Kristen on numerous occasions in order to lead their namesakes' exciting lives. This willingness to lay aside her sense of self for other, more exciting personalities may point to continued struggles with Self-Other Permanence.

Self-Other Constancy. Self-other constancy "is the ability to experience self and other as stable (constant) despite variations in mood, personality, and behavior" (Leitner, 2004, p.). Understanding that loving people may experience a wide range of emotions towards you (e.g., anger) and still remain steady in their love for you is essential to viewing others as constant. Furthermore, recognizing that you also are capable of caring for others despite occasionally feeling angry with them allows you to view your self as constant. Maintaining a connection with another despite the ups and downs of a changing relationship or individual is most successful when both parties have a sense of self-other constancy.

Kristen's early childhood memories include recollections of her mother as moody, hot-tempered, overworked, and distant. Both Kristen and her father seem to have frequently walked on eggshells around Mrs. Barnes. Even by Mrs. Barnes' report, Kristen's earliest interactions

with her mother generated feelings of anxiety and depression for both of them. Despite some positive memories of Mrs. Barnes as caring and supportive, the infant Kristen seems to have been unable to integrate such dichotomous shifts in mother's personality into her own meaning-making system.

In fact, Kristen reports having always felt a stronger connection to her father. However, she describes him as also being unavailable, overworked, and hotheaded on occasion. Furthermore, Kristen has described numerous relational problems between her parents; and Mr. and Mrs. Barnes have themselves reported struggling with their marriage. Kristen's parents' relational pattern appears to be either hot or cold with little stability. They have separated on a few occasions; and, according to Kristen, they regularly engage in intense verbal arguments. At other times, Kristen reports that they have periods of passionate engagement. Her parents' shifting temperaments and their relational struggles may have created an inconsistent, interpersonal environment for her to develop a healthy sense of self and other constancy.

I, too, have let Kristen down, as every human inevitably does in relationships; and she has had every right to experience anger with me. Yet, Kristen denies that I have harmed her. I have been idealized whereas others who harm her are seen as rejecting. I have occasionally remarked to her in therapy that it will be necessary to watch how her view of me changes after I eventually elicit anger, shame or rejection from her during our work together. Despite my predictions, Kristen assures me that she can never be angry with me. Interestingly, Zac recently came to therapy and expressed anger at me for missing a session with Kristen. I believe this occurred because Kristen is unable to see herself as both angry and caring at the same time. She seems unable to see me as someone who would miss a session and still care for her. According to EPCP, Kristen's sense of self-other constancy appears limited by this inability to accept herself and others as simultaneously caring and angry.

Disorganized Attachment. Ultimately, our early experiences of self vs. others, self-other permanence, and self-other constancy coalesce to create the unique way each of us attaches or connects to others. A person's attachment style begins to develop with an infant's earliest interactions with his or her primary caregiver. The degree of consistency, love, and safety that the primary caregiver shares with the infant serves as a template for the baby's meaning making process. As children age, their understandings of self and others mature, yet they may attach to

new people and relationships in ways that replicate their earliest experiences of attachment (Leitner, Faidley, Celentana, 2000).

Children who experience a strong sense of permanence and constancy about self and others develop a secure attachment style and are able to build relationships on safe foundations. People with secure attachment styles learn that they can trust intimate friends and family members to be there for them during stressful times, just as they are there for the ones they love during times of adversity.

Those who develop a disorganized attachment pattern did not experience a sufficient amount of constancy and permanence in relation to their selves and others as infants. Their interpersonal behavioral responses often are contradictory and, in particular, they fail to show a coherent behavioral strategy for separating and connecting with intimate others (Main & Solomon, 1990). They often are incapable of prolonged relationships due to their struggles to view others as permanent or constant. They may experience extreme fear around issues of potential abandonment and rejection. Interpersonal encounters often feel like rejection even when they may not be.

Given Kristen's early environmental history and her struggles with permanence and constancy, it is no surprise that Kristen shows a disorganized attachment style. She has often said in session, "it is hard for me to trust." As much as she wants her parent's love, she believes her parents hate her and would rather not have her around. She assumes her peers have snubbed her prior to any hint of actual rejection. In our therapy sessions, she questions her worth to me and imagines that I don't like her. She offers up statements such as "I am probably a pest to you," "You are mad at me," and "You're going to hit me." These responses seem to stem from her early childhood where she suffered inconsistent attachments with her primary caregivers.

Interpersonal Components Axis

The focus of the interpersonal axis is on the ways in which we act when engaging relationally. Leitner (1985) has said that choosing to connect deeply with others means facing the terror of invalidation. As we come to be known, and as we learn to know others, we act on our desire for meaningful connections. When our struggles to connect are driven by a need to stifle a sense of emptiness or loneliness, we actually are viewing potential interactions as a means to an end. We end up objectifying the other in our quest to meet our own needs. In order to successfully engage in rich, meaningful relationships (ROLE relationships), the initial motivation

for connecting must be born of a genuine caring for another, not of seeking to cure our own relational wounds. This axis highlights the ways we use dependency and distancing in relationships as we act on our motivations for connection.

Dependency Struggles. EPCP theorists do not suggest that dependency, in and of itself, is a problem (Leitner & Thomas, 2003, Walker, 1993). Few would argue with an infant's dependence on caregivers for survival reasons, both physically and psychologically. In EPCP, we are most interested in the ways humans negotiate their dependence on others.

Adults that remain completely dependent on a limited few for validation of self are described as having undispersed dependency. Relying on one individual as a sole source of validation can lead to a heightened sense of pain if abandoned or rejected. For most of us, feelings of invalidation might occur if loved ones fail to be there for you. However, trusted others may provide support by stepping in to increase their validation of our experience. For someone who struggles with undispersed dependency, where validation can only occur from one relationship, the loss of the other is monumental. Indeed, for those who struggle with undispersed dependency, invalidation can be felt even when abandonment and rejection have not actually occurred as the anticipated abandonment is equally unbearable.

Others who depend on numerous acquaintances or even strangers to validate or invalidate them are struggling with excessively dispersed dependency issues. These people generally have difficulty discriminating between whom to trust as an intimate friend and whom to keep as a friendly acquaintance. Those who shun validation or invalidation from anyone are limited in their relationships by dependency avoidance. They reject any close friendships because connecting to others always suggests potential harm to them.

Early in our therapeutic work, Kristen demonstrated undispersed dependency. She looked entirely to me, as her therapist, to meet many of her emotional needs. Kristen counted therapy as her most important activity of the week and often rearranged her schedule to attend extra sessions. She called me and emailed me repeatedly between sessions asking me for confirmation on a wide variety of issues, such as whether or not she said the right thing to a boy. She sought out counsel with me rather than speak with her parents about simple school issues. Kristen regularly asked my permission about many of the decisions she was considering, such as quitting a part-time job she hated. On one summer break, she was encouraged to call my supervisor in case of emergency when I was unavailable. After experiencing suicidal feelings, Kristen choose

not to call my supervisor, despite the fact she had known this person throughout her time at the clinic. She later reported that she did not call because she did not know if it was really okay with me. Kristen also frequently asked if I could meet her cousins or her peers. She bragged about me to her parents and bought t-shirts with funny sayings about therapists on them. In many ways, Kristen seemed to idealize me. Kristen arrived at therapy wanting to please me and, at the same time, wanting me to have sole responsibility for confirming or disconfirming her deepest experiences.

At times, Kristen clearly struggled with excessively dispersed dependency as well. She has been invalidated by the shortest of interactions with people who should mean little to her. She often has taken strangers' comments to heart and felt suicidal after superficial interactions. On one occasion, a cruel comment from an unknown peer at the lunch table resulted in Kristen feeling dramatically invalidated. A boy who sat next to her on the bus in the mornings led her to want to kill herself.

Kristen has used dissociation as a way to avoid dependencies on others as well. If Zac, Madonna, or any of the other alters are available to come in and take over for Kristen during interpersonal interactions, Kristen is not dependent on any one to validate or invalidate her. She simply removes herself from the immediate interaction and the relationship altogether.

More recently, Kristen has reached out to try to build relationships with a boyfriend and some female friends. Not too long ago, she went out to dinner with a group of women from work. She also has become more comfortable turning to adults at school such as the school counselor and the vice principal for help. Furthermore, Kristen has tightened her personal boundaries and limited her vulnerability to be hurt or invalidated by casual friends. When some old acquaintances began to harass her on her cell phone, Kristen chose to confront them and then have her number changed rather than allow them to repeatedly hurt her feelings. Kristen recently has gone through a period of time with fewer episodes of dissociation. In doing so, she has been less avoidant and allowed others both to validate her and invalidate her as Kristen.

Physically Distancing Self. People often demonstrate their strengths and struggles with ROLE relationships through their physical movement toward or away from intimate relationships. Choosing to spend time with someone who may invalidate you is risky business for anyone. For someone who has been invalidated repeatedly in relationships with others, the choice to stay physically close can be terrifying. An additional struggle around this issue is

remaining frightened at the thought of separation from significant others and, in response, insisting on an almost suffocating physical closeness instead.

Kristen often physically distances herself as a way to keep herself protected from interpersonal invalidation. In response to the invalidation she received from repeated episodes of bullying, Kristen had, for years, separated herself from the other children on the playground. She stayed away and acted oblivious or unharmed rather than tell them to stop. When faced with her peers' cruel comments, Kristen removed herself physically from the situation. Her father reported that, on numerous occasions, he would see her standing alone on the playground or walking far behind the other children when in line at school. Long after the taunting stopped, Kristen ate alone and stayed away from most interactions with her high school peers. She spent her free time alone in her bedroom or in the basement of her house rather than join in extra-curricular activities.

With regard to our therapy relationship, Kirsten has occasionally, after particularly intense sessions, become quite ill and cancelled the following sessions. Her cancellations kept her from having to speak with me about experiencing any anger, frustration, or fear after the earlier session. Kristen, anticipating rejection, has said, "you might stop seeing me if I tell you." By not attending therapy, she remained safe from potential invalidation.

Psychologically Distancing Self. Physically distancing one's self from others is not the only way to keep safe from invalidation. Many people distance themselves psychologically. Leitner et al. (2000) have described objectification as one way of psychologically staying clear from developing a potentially invalidating ROLE relationship. For example, if a partner is treated as a one-dimensional sex object to be used for personal gratification, there is little chance of either partner coming to know the other's uniqueness as well as vulnerabilities. Without a genuine understanding of another, those that objectify believe they are safe from potential relational harm.

Dissociation also can be viewed as a way to maintain psychological distance from the other. If dissociative experiences originate from a traumatic experience or invalidation from a loved one, then the separation of self occurs specifically to distance one's self from what is happening or who is making it happen. For example, children who cannot physically get away from horrific abuse often remove themselves via their imaginations. They imagine themselves to be flying above it all, playing at the park, or running through a forest. Occasionally, they imagine

themselves to be another, stronger person who is better equipped to handle the situation. If painful interactions or events continue and distancing one's self psychologically is experienced as effective, then this imaginative detachment process is repeated in future situations. This process then may solidify into an extreme and complicated form of dissociation.

People who tend to objectify others, or dissociate, distance themselves psychologically from ROLE relationships and traumatic events. Though both of these distancing techniques are created to protect an individual from psychological harm, the irony is that those who objectify or dissociate also experience loneliness and emptiness as a result. This occurs because they allow few, if any, people to know them in a holistic sense.

When I first met Kristen, she regularly dissociated, often without her knowledge. Alters repeatedly stepped in and took over her body, leaving her with long periods of lost time. Her dissociative states appeared to happen indiscriminately and seemed to control her. For example, Zac might jump in and take charge of Kristen's body for hours or days at a time. Much of Kristen's suicidal ideation stemmed from the fear or confusion she regularly experienced following a period of dissociation. Early in therapy, Kristen could not explain or understand the intensely frightening process that she was experiencing. Kristen not only separated herself physically from her peers at school, she also separated psychologically by dissociating when faced with their bullying.

More recently, Kristen has begun to understand that she has some choice in dissociating or psychologically separating herself from others rather than risk invalidation or rejection. For example, as Kristen is quite lonely, she occasionally attempts to make a new friend. However, because she has been hurt so often in the past, she dissociates as a way to protect herself from potential invalidation and, therefore, does not present Kristen but presents Zac or Madonna instead. These new friends come to know the more confident alters rather than Kristen. Therefore, Kristen does not risk invalidation, nor does she experience friendship.

On occasion, Kristen arrives at our sessions in a dissociated state. The presenting alter will explain the event that led to her taking executive control of Kristen's body. It is always in anticipation of, during, or after a troubling interpersonal encounter. During our sessions, Kristen often brings in an alter to explain something she has no knowledge of, such as Zac's life history. During the picture drawing sessions, she begged to bring in Zac, as "Zac is a better drawer and the reporter person." After I return from a vacation, an alter often works with me for a few

sessions until Kristen seems to know it is safe to return to therapy. I have understood this as her way of handling her anger, hurt, and feelings of abandonment over my departure. When she returns to therapy as Kristen, she insists that our time away from each other was fine and that she understands why I left. As Kristen continues to deny that I have caused her any pain, I am limited in my ability to know her. Splitting clearly limits the depths to which her intimate relationships are able to develop in therapy and in her personal life.

However, dissociation is not only used as a way to distance self from others, Kristen also dissociates in attempts to connect with others. For example, when she brings in Zac or Madonna to interact with her peers, it is often because she knows the other teenagers will find either of them much more appealing than quiet, good girl Kristen. She believes that she can keep more friends if she is viewed as exciting. Occasionally, during extended periods of silence in therapy, Kristen appears uncomfortable and suddenly offers to bring forward another person to talk to me. Kristen struggles to believe that I might find her interesting enough to work with separate from the more stimulating alters. This idea of calling forth her more compelling alters as ways of connecting to others is something we continue to explore in therapy.

Experiential Components Axis

This axis focuses on the experiential components of meaning making (Leitner & Thomas, 2003). Leitner and Pfenninger (1994) outlined nine interrelated aspects of empathic sociality. They suggest that each of us maintains both strengths and struggles within all nine of these experiential components as we engage in intimate relationships.

Discrimination. To discriminate, from an EPCP perspective, means to understand the differences between self and other and recognize how those differences can have an effect on ROLE relationships (Leitner & Pfenninger, 1994). Some people under discriminate and engage in relationships with many people without considering the ways their differences may ultimately harm the development of a ROLE relationship. Others over discriminate and view any difference in an individual as a basis for avoiding a ROLE relationship.

In therapy, Kristen and I have explored her struggles with under discrimination. At times, she is unable to evaluate the differences between herself and others, as well as the impact others' differences will eventually have on her. Kristen regularly befriends individuals who are quite different from her and from each other. After she began to understand her dissociative processes, Kristen told a number of her peers about her internal multiplicity without considering

if they were capable of understanding or containing the information. Unfortunately, the results of this inability to successfully discriminate resulted in continued invalidations as the friendships ended when the teens became frightened or disgusted and rejected her further. In many ways, Kristen opens her life up to many people, regardless of their differences. She risks interacting with others whom she has not more fully construed. Kristen is beginning to hold back parts of herself with the belief that peers may not be capable of understanding her experience.

Kristen also over-discriminates. When it comes to sharing the deepest parts of her self, she has been unable to open up with others. She has told none of her peers about the pain their often-cruel invalidations have caused her. Kristen does not trust anyone to know her deepest fears, shame, and pain. She is unable to tell her parents about her experience of multiplicity, despite saying that she wants them to know. Instead, she has asked me to meet with them for limited therapy updates. She further insists that they not ask her questions afterwards. In addition, Kristen never has told them when she felt suicidal. Her relationships outside of therapy do not include a genuine sharing of her core process; rather she admits that she does not open up to others at all. Instead, she dissociates rather than share the complexity of herself in relation with others. This causes her to limit further development of any close relationships. In some ways, she has risked everything (being validated or invalidated) in one relationship as Kristen has only shared some of her deepest feelings and core processes with me in therapy (undispersed dependency). This step towards an appropriate and safe level of discrimination has begun in therapy.

Flexibility. Flexibility in EPCP theory means to recognize that people are continually evolving, as are constructs. It also means not bringing the same rigid set of constructions to each new relationship nor does it mean suddenly giving up one's constructs. Flexibility involves negotiating a balance of opening one's self up to another's constructs while maintaining your own meanings.

Even though Kristen consistently displays openness to others' constructs, her process does not demonstrate what is termed in EPCP as flexibility. Kristen readily opens her self up to an other's constructs but is unable to maintain her own meanings when presented with another's. Historically, she has given up her constructs to take on another's. She has allowed others to define her way of being and has been willing to present herself to others as whatever or whoever they wished her to be. For example, when a girl who was strictly religious befriended her,

Kristen set aside her own beliefs about God. She soon became an active member despite feeling frightened by the church's services.

Kristen also uses dissociation as a way to temporarily ignore or reject the rigid constructs that she, as Kristen, holds. For example, when her friends talked about sex, a subject Kristen could not talk about, Zac, who is quite comfortable with the topic of sex, stepped forward to engage in the conversation. Either by consistently privileging others' constructs or through dissociation, Kristen struggles to maintain her own constructs. According to EPCP theory, Kristen demonstrates acquiescence by losing her own meanings of self in both the emergence of another part of herself and in the presence of others. Ultimately, she resists flexibility by dissociating.

Creativity. Creativity, as defined by Kelly (1991a, 1955/1991b), involves allowing old constructs to be held loosely (open to negotiation) and then tightened (made more exact). Kristen has demonstrated creativity in our therapeutic work as she has loosened and tightened her construing in order to invent new ways of experiencing the world. The best example of this can be seen in her willingness to consider alternative ways of viewing her life. For example, during our discussions in therapy about the peers that have harmed her in her past, she recently has let go of the idea that it was entirely her fault that they bullied her. Kristen is beginning to consider that her childhood tormentors might have been in the wrong. Kristen trusts me and follows through on many of the practical suggestions we have discussed in therapy. When I suggested that she talk to a new group of peers in an after-school club, she tried and had some success. She also has begun to generalize her feelings of trust to others and has opened up to other adults at school and a few peers.

Kristen has loosened her constructions in therapy as she considers new insights about the many disparate parts of herself. For example, she and I have looked closely at her alters and the way they step in to protect her from relational harm. Kristen has demonstrated her tightening of constructions as she has, at times, corrected my inaccurate reflections of her dissociative experiences. Additionally, Kristen has demonstrated creativity as she has agreed to try new ways of looking at her experiences such as working on her dreams, sharing favorite music, drawing pictures, playing in the sand trays, and participating in empty chair and two-chair work. Kristen is beginning to demonstrate a balance between holding her own set of constructs and yet,

remaining open to others' constructs. Weekly, Kristen struggles with being creative as she interacts with me in therapy.

Responsibility. Responsibility as described by Leitner and Pfenninger (1994) is the willingness to examine one's construct system and its implications for others. In relationships, each member ideally accepts responsibility for the beliefs they bring with them as well as the new meanings that are co-created between them. Demonstrating a desire to explore one's past and present relational constructs and the ways they affect others means to take responsibility in EPCP terms. Kristen demonstrates both struggles and strengths in this experiential component.

In many ways, Kristen's dissociation can be viewed as an avoidance of responsibility. Rather than examine what is happening in the moment and perhaps reconstrue her system of beliefs about herself and others, Kristen often chooses to remove herself from an awkward or painful situation by dissociating. For example, when her parents are angry with her for not completing a chore, Kristen calls in Zac to cope with the tense interaction. She does this rather than reconstrue her belief that her parents are incapable of both loving her and getting angry with her. Furthermore, by dissociating, she avoids facing the ways in which her disappearance, as well as Zac's presence affects her parents.

More recently in therapy, Kristen has been demonstrating a sense of responsibility for the meanings she has constructed. Though her parents initially brought her to the clinic out of their concern, Kristen has continued therapy on her own because, as she professes, "I want to understand myself better." She reminds her parents of her appointments, currently is driving herself to them, refuses to cancel for trivial reasons, and actively engages during therapy sessions. In addition, between sessions, Kristen thinks about our work and attempts to generalize what she has learned to her real world. She actively questions how her dissociation affects others. In therapy, we have discussed the ways in which Kristen uses dissociation to protect herself from potential relational harm. We have talked about the ways that she occasionally chooses to bring an alter in rather than face an interpersonal interaction and how, ultimately, dissociation keeps others from knowing her and her from knowing others more completely. Her dissociation keeps her from having ROLE relationships and she is beginning to see that. As difficult as the work may be, she is willing to examine her own construct system and its implications. In much of our therapeutic work, Kristen is an active and responsible agent of change.

Openness. Openness can be described as a readiness to reconstrue when disconfirmed by another (Leitner & Pefininger, 1994). Kristen has struggled with an unwillingness to reconstrue after invalidation. In many ways, her dissociation is used as a defense against reconstrual. It allows her to keep parts of herself away from others and to keep from modifying her constructions about herself or others. For example, she believes that her parents can love her only if she presents the compliant, depressed part of herself. In their presence, Kristen does not permit herself to act out anything but submissive attitudes and behavior, as she believes her parents prefer this type of behavior. However, as a teen, she is beginning to ask questions about her parents' rules and beliefs. As the compliant Kristen is unable to rebel against her parents, she has allowed the alters to do the teenage testing. Rather than argue with her parents as most teenagers would when they begin to separate from them, Kristen allows Zac to test out the safety of disagreeing with them. Despite her sexual curiosity, the compliant Kristen holds rigidly to her moral values and refuses to act out sexually. Instead, she allows Tay, Ike, Madonna, and Zac to engage in imaginary sexual relationships. As she dissociates during many of the tests of her meanings, she does not have to reconstrue old ways of understanding the world. Kristen can remain the static, submissive child she believes her parents approve of.

Another example of Kristen's struggles with openness can be seen in the numerous times she has told her peers about her internal multiplicity. Her inability to reconstrue after previous invalidations has led her to automatically tell new friends about her experiences of dissociation. Kristen does this armed with the rigid belief that her new friends are somehow different and more mature than her former friends. Unfortunately, this consistently has resulted in invalidations as the friendships inevitably ended when the teens became frightened or disgusted.

Kristen's refusal to reconstrue her meanings about herself has led to an intense sense of anger, or hostility, that Zac and Hanson personify. Johnson et al. (2000) describe hostility as "the continued use of a construct that has already been invalidated" (p.155). Zac's feelings of hostility towards Kristen and her continued unwillingness to face the problems of the real world rather than repeatedly dissociate were evident in the following note she sent me: "She left again. Two days now. I guess I can't leave her alone any more, because she gets too depressed. I will stop everything I am doing to help her but I can't handle a week. If she leaves me for a week, I don't know what to do. I am going to die. I saved myself for Kristen and I am going to shoot myself!! I can **KILL** her for it, but I can't it would be just like getting a pet and **KILLING** it... When

Kristen comes back you need to have a talk with her about leaving and totally shutting me off like this. It is KILLING me. You better hope to God or who ever the HELL is in charge of this world that I can get a hold of Kristen. I cannot take two worlds on my hands!" Hanson's notes to me demonstrated an overt sense of *hostility* also aimed at Kristen. Hanson wrote, "Just copy this FUCKING letter and show it to her FUCKING face and maybe she will actually find out that this is so very FUCKING hard on me! What happens to her is way too much on me!" By not changing old meanings after repeatedly being invalidated and by allowing parts of herself to feel such hostility, Kristen demonstrates that she is, for the most part, refusing to reconstrue.

However, it is important to note that in therapy, Kristen has been more willing to reconstrue meanings when our work together invalidates her previous way of thinking or acting. For example, when I asked Kristen to tell me about the part of her that was angry with me after I left for vacation, she initially resisted. Later, she agreed that a part of her was very angry with me for leaving. Kristen continues to work on trusting me and tries to open up more during each session, despite her fears, as she increasingly recognizes that dissociating distances her from a more intimate relationship.

Commitment. Commitment takes time and involves a continuous desire to validate another's set of constructs (Leitner & Pefininger, 1994). As maintaining an intimate relationship is new to Kristen, she continues to struggle with validating another's process over time and results in an under commitment. Prior to therapy, Kristen never had never extensively opened up to another human being. Rather than remain constant with one person for any period of time, she dissociated when faced with interpersonal stressors. For example, when Kristen saw a boy approach her at school, she switched to Zac, the protector who could handle male-female interactions. By dissociating, she kept the boy from knowing her completely and she remembered nothing of the encounter. The next time she ran into the boy, she acted like a stranger to him. He could not have felt validated by her. The relationship never developed because Kristen could not commit to it. In her other peer relations, she has moved quickly from one best friend or casual boy friend to another. In each case, it was the other who ended these friendships, perhaps because they never came to know her.

Despite our regular therapy sessions, emails, and phone calls, Kristen also has struggled to commit to our relationship. On numerous occasions, Zac has presented for entire sessions when Kristen refused to come to session rather than tell me about something that she felt shame

or anger about. In therapy, she continues to commit on the physical plane to attending every session, yet still struggles to attend therapy regularly and occasionally sends Zac to do the work.

Courage. Demonstrating courage in ROLE relationships requires putting one's inner most self at risk. It means exposing one's vulnerabilities with a hope of being validated but an expectation of potentially being invalidated (Leitner & Pefininger, 1994).

When faced with potential invalidation, Kristen often dissociates rather than expose her vulnerabilities. If she is approached by boys at school, she regularly pulls out and leaves an alter to face the discomfort of an awkward male/female interaction. If she is engaged in conversation with an outgoing peer, she dissociates and allows a more outgoing self to interact. Kristen wants to be able to connect with her peers; but, as Kristen, she feels unable to speak. When relating with her parents, she often allows Zac to take over rather than face their disapproval. If she feels any sort of anger at her parents, she immediately pulls out. While part of this dissociation is based on her fear of confrontation, another part of it is based on a real fear of rejection if she does not present as a good girl. Kristen arrived at therapy with little understanding of her dissociative experiences and with serious struggles of courage in her daily relationships. Yet, from our first meeting, Kristen has courageously risked the terror of opening up to me. Initially, she demonstrated courage in therapy by sharing her imaginary world for the first time after keeping it secret since age eight. After six months of therapy, she then exposed the characters as parts of herself, despite the fear that I might disconfirm her. She has shared her process of dissociation with the fear that I might tell her she is "not normal." When Zac first came to a session, her biggest fear was that I would try to kill her off, perhaps echoing Kristen's fears that I might take away her defense mechanism of dissociating. However, Kristen and Zac, as well as the others, have persisted in working with me. Not only have they attempted to relate in an intimate way with me in therapy, Kristen has made some recent attempts to relate to others at school. Though I am not certain that Kristen trusts me completely, she has shared facts and feelings in therapy that she reports not having shared with anyone before. Despite her struggles with courage in many of her interpersonal relationships and her continued choice to dissociate, the process of therapy has, in and of itself, taken great *courage*.

Forgiveness. We experience pain when we are faced with invalidation. In response, we often choose to avoid future potential relational pain. However, in order for us to experience the beauty and wonder of intimate ROLE relationships, we must risk being hurt and invalidated once

again. In EPCP terminology, forgiveness means to reconstrue self and others so that previous invalidations are unable to hold us back from future intimacy with others (Leitner & Pfenninger, 1994). We must forgive those who supplied the initial invalidation so that we are able to enter into new and deeper relationships. Prior to achieving forgiveness, we must first look closely at the invalidation, feel the pain of being invalidated, explore how it changed our construal process, grieve the loss of central meanings, and understand what it means to modify original constructions. Attempting forgiveness before such work is completed often results in a type of premature forgiveness that leaves a residue of pain, resentment, and anger that may prove toxic to future relationships.

Kristen has said that she forgives those who traumatized her as a child; however, she has not experienced forgiveness in the EPCP sense of the word. For example, she has been unable to recognize the depth of invalidations that she received as a young girl at the hands of her peers. Kristen says she forgives them “because they didn’t know better.” She overlooks her childhood peers’ bullying behavior rather than face the horror of what they put her through. Even today, she continues to ignore the inappropriate ways that her peers use her. Kristen enters each new relationship assuming that the injuries she received, as a child, will be replicated in all her future relationships. She readily accepts being the doormat for her new friends as they persuade her to pay their ways into movies and buy presents for them at the mall. Kristen continued to chauffeur one ex-boyfriend around town who was cruel to her even after their break-up until her parents stepped in and demanded she stop.

Kristen seems to have bypassed the stage of being angry with her abusers by dissociating her anger into other parts of herself. A primary goal for her is expressing anger with those who have and continue to hurt her. Prior to achieving forgiveness, Kristen first needs to acknowledge the pain of the abuse. Kristen, thus far, has not been able to forgive the major invalidations she received at other’s hands as witnessed by the continued anger she holds inside Zac and Hanson but is unable to face herself. Kristen has claimed to forgive her peers as a way to avoid the pain of confronting the numerous invalidations she received. Zac and Hanson are allowed to feel the anger and confront the pain but Kristen continues to see herself as deserving of the abuse she receives. If Kristen has faced the magnitude of her peers’ bullying, experienced rather than dissociated her anger for their acts, and forgave her

childhood transgressors, she might be able to risk the development of new ROLE relationships. Kristen continues to struggle with genuine forgiveness.

Reverence. ROLE relationships involve revering the construal process of another. It means a reciprocal sharing of core constructs and a mutual potential for validating each other. When one validates the other's core meaning making process, it is an uplifting experience. Reverence can be described as the knowledge that one is affirming the meaning making process of the other within the ROLE relationship (Leitner and Pfenninger, 1994).

At this time, Kristen is unable to experience *reverence*. Kristen's repeated dissociations in the presence of others and memory losses after the interactions limit her from truly knowing and affirming another's process of connecting. When Zac steps in to speak with Kristen's peers, Zac is left with the memories of that particular interaction, not Kristen. If Kristen remembers anything about the encounter with her peers later, it is usually fragmented. Kristen is unable to be present with another and is therefore unable to understand the uniqueness of another.

Kristen not only struggles to see the complex mystery and creativity of others, she also struggles to revere herself. The shame she continues to carry from numerous traumatic, early-childhood experiences such as feeling disconnected from her parents and being bullied by her peers limits her from such self-reverence. Kristen is unable to see the ways in which she is important to others. In our therapy sessions, she often discounts her part in the changes she is making. When others compliment her, she ignores it. She is repeatedly shocked that others want to be her friend. She often says to me, "I don't want to bother you." Kristen feels unworthy of being revered and refuses to affirm another's experience of revering her.

ROLE Relationships. Kristen's EPCP diagnosis illuminates the ways in which she both connects and disconnects from the intimate ROLE relationships that have the power to both validate and invalidate her. Clearly, Kristen's dissociative experiences impinge on her ability to initiate and sustain ROLE relationships. Leitner (1987) has suggested that splitting the self lessens the impact of potential invalidation because a fragmented presentation of the self is complex and, therefore, difficult to understand. Others are less likely to invalidate the core constructs of one who experiences severe internal multiplicity if they are unable to understand the person. Furthermore, splitting off different facets of the self into multiple alters allows a person who experiences dissociation, at some level, to choose and limit what is disclosed in any given relationship.

Originally created as a way to protect herself from early interpersonal harm, Kristen's experience of dissociating continues to keep her safe from invalidations by others. For example, when Kristen is faced with an interaction she fears, such as flirtatious behavior with a boy or an angry response from her parents, she pulls out and allows a seemingly better equipped alter to handle the interaction. Zac, the confident rebel, is often the one who steps in to deal with the sexual tension or to smart off to the parents in a typical teenage way. When a boy at school approached her, slung his arm around her, and began to engage in flirtatious banter of a sexual nature, Kristen immediately dissociated, allowing Zac to reject the boy's requests in a rather crude and straightforward manner. The boy soon walked off, cussing under his breath. Later that day, Kristen returned and acted as if nothing awkward had happened between her and the boy, since, to her, nothing had happened. She retained only a vague memory of the boy walking up to her.

Dissociation also protects Kristen from witnessing her parents' anger at her or experiencing her own anger at them. For example, she does not have to stay around to be reprimanded by her parents for not completing a household chore or for taking the car out without their permission. As soon as Kristen feels their anger escalate (and her own anger, as well), she dissociates. Zac steps in for her, ready to absorb their outbursts, yell back at them, and to stand up in Kristen's defense. Kristen returns hours later, with no recollection of the event, and remains, in her eyes, the good daughter Kristen who rarely talks back or breaks the rules.

In both instances, the amnesic barrier between Kristen and Zac protects Kristen from experiencing feelings of embarrassment, rejection, anger, or shame with either the flirtatious boy or her angry parents. Dissociation distances Kristen from painful interactions with others; and, because at least some painful interactions are inevitable in close relationships, her ability to relate to others in a meaningful way is limited.

Kristen also has dissociated as a way to be more amenable and interesting to others. By bringing out the parts of herself that she perceives as more exciting, Kristen is able to attract potential friends and move towards them. During interpersonal encounters that intimidate her, Kristen appears to feel insecure and finds it difficult to share her true self. She repeatedly says she is "not normal" or "not smart enough." While it is difficult for her to imagine that anyone could be fond of her, she desperately wants others to like her. Kristen knows enough about Zac, Madonna, and Tay to identify them as more exciting, social, and confident than she is. Kristen

describes Zac as “smarter than me,” “more outgoing,” and “more fun.” Madonna is “caring and beautiful.” Tay is “a better driver” and “second only to Zac” in taking charge. Therefore, when Kristen wants to connect with someone who she feels could not possibly like her, Zac, Madonna, or Tay step in as the more engaging personalities. Kristen uses dissociation to connect with people who she believes would not like a “boring” person such as herself.

Kristen’s choice to dissociate also can be viewed as a way of testing or screening others prior to creating a ROLE relationship. For example, if the other is willing to stay engaged with and committed to Kristen despite her chaotic presentation, Kristen may feel safe enough to more completely open up. As her numerous dissociative splits often confuse and chase away those around her, dissociation serves as a filter that screens out those who are not seriously committed to her. It was after numerous crises and six months of intense therapy sessions that Kristen reported feeling safe enough to talk directly about the magnitude of her internal multiplicity with me. Furthermore, Kristen has shared that one of the reasons she chooses to tell people about her dissociative experiences is that it scares away people she does not like. She has said, “I like to scare them and see what they do.” In an earlier period of therapy, Kristen seemed to find a perverse pleasure in shifting from one alter to the other without identifying herself. During these sudden shifts, I was left to guess which alter was present. Kristen appears to experience a sense of power and satisfaction in dissociating around people for screening purposes.

However, dissociation eventually prevents Kristen from moving closer to those who she might want to know more intimately. ROLE relationships remain difficult for her to develop and almost impossible to sustain because, with amnesic barriers, Kristen is unable to maintain a coherent history with any one person. For example, when Madonna spends time with a potential friend, Kristen may retain only fragmented memories of the encounter. If the same peer approaches her later and refers to their earlier interaction, Kristen pretends that she remembers what they previously discussed. Others often misinterpret this struggle and view Kristen as being forgetful, less intelligent, spacey, or uncaring. They recognize that she is acting in a different way than she did earlier. The potential friend is confused or angry and often retreats from the relationship. This pattern of prolonged dissociation followed by a complex cover-up is also quite taxing on Kristen physically. The outcome is such that Kristen often sleeps for hours after such an interaction.

Despite Kristen's desire for intimate relationships, dissociation regularly keeps her from developing them. Ultimately, ROLE relationships are difficult to form if one member of the dyad retreats repeatedly from the fear of potential invalidation.

Discussion

Diagnosis

Kristen's clinical history, her results on the DES, Sentence Completion, HTP, RATC, sand tray work, and the two MMPI-A's, as well as the fragmented sense of self she consistently presented in therapy, support a traditional diagnosis of DID as outlined by the DSM-IV-TR. However, by viewing Kristen's experience of internal multiplicity through a Western World's model of pathology, the DSM, our understanding of her dissociative experience is reduced to her struggles, weaknesses, and ultimately, a specific set of pathological symptoms. Though DID does accurately characterize Kristen's symptoms, the EPCP diagnostic system provides a much richer and more comprehensive understanding of her lived experience.

Whereas a DSM diagnosis of DID labels Kristen with severe mental illness, these interrelated axes describe her dissociation in a relational way that is continuously in flux and therefore, amenable to being worked on in treatment. The EPCP diagnostic system offers a richer diagnosis because it provides a historical context as to when or how a client's symptoms may have originated, illuminates a client's experience from a developmental perspective, tracks changes in symptomology over time, and highlights both a client's strengths and struggles around relational issues. Exploring Kristen's experience through an EPCP lens allowed me to see her as more than a set of symptoms or criteria.

The first axis of the EPCP diagnostic system describes Kristen's struggles as Developmental/Structural arrests, in the areas of self versus others, self-other permanence, and self-other constancy. These arrests may account for her predisposition to splitting when faced with trauma and suggest a freezing in early childhood that, in some ways, keeps her an emotionally neglected infant. This significant freezing may have resulted in the creation of amnesic barriers that were meant to protect the baby Kristen from experiencing the intense pain of disconnection. Kristen's struggles around these three developmental and structural issues are evidence of a disorganized attachment style first formed as an infant in relation to her primary caregivers. The EPCP diagnostic system suggests that when arrests occur on this foundational axis, struggles on the other two diagnostic axes inevitably occur.

On the Interpersonal Components Axis, Kristen struggles with all three of the dependency components: excessively dispersed dependency, undispersed dependency, and dependency avoidance. These struggles illustrate how Kristen's current pattern of confusion over dependency issues result in a dissociative experience. At various times, Kristen has 1) relied on many casual acquaintances to validate her, 2) trusted a limited few to validate her, and 3) avoided any dependency on others at all. This uncertainty over who to look to for validation leads to profound internal pain. This axis also alludes to the ways the alters serve Kristen's interpersonal needs for it is during this time that an alter generally steps in to halt the internal chaos by avoiding any dependency. Kristen's struggles around the Interpersonal Components are most reflective of her use of dissociation as a resource during times of overwhelming interpersonal confusion.

The Experiential Axis, which shows how people move towards and retreat from ROLE relationships, highlights Kristen's various strengths and weaknesses. This is in contrast to the DSM, which describes the pathological parts of Kristen and ignores her positive attributes. For example, some of Kristen's strengths include her commitment to our relationship and an increasing sense of responsibility for exploring and accepting her construct system. However, Kristen's proclivity to both under discriminate and over discriminate in her relationships demonstrates an area of weakness. Though the EPCP system would highlight her recent growth in areas of creativity, flexibility, forgiveness, openness, and courage, her continued dissociative experiences demonstrate her persistent struggles. Ultimately, Kristen is unable to experience genuine reverence, although recently, she has displayed a few tentative steps in this direction. Kristen's struggles to relate intimately with others as described by all three axis of the EPCP diagnostic system illuminate her difficulties in making meaning out of a seemingly chaotic world and her use of dissociation in response to the internal chaos she experiences.

Transitive Diagnosis

In various ways, Archetypal Psychology and the Voices Model of Assimilation significantly guided my work with Kristen. However, they did not explicitly provide a diagnosis. The DSM-IV TR provided a diagnosis (DID) that, although descriptive of Kristen's symptoms, did not guide the treatment. Indeed, the DSM diagnosis is unable to guide the treatment because it does not illuminate the process Kristen regularly employs as she dissociates. Examining her unique process of construing will allow us to make adjustments as necessary in therapy.

Therefore, the DSM diagnosis is not clinically informative or what Kelly referred to as a transitive diagnosis.

The EPCP diagnostic system provides Kristen with a fluid diagnosis, one that is always changing as she herself moves through the change process. Kristen's diagnosis offers important implications for the therapy process by highlighting the areas she feels comfortable with at any given time as well as the areas she is struggling with. This diagnostic system guides the treatment by pointing to potential therapeutic goals in specific areas. For example, by recognizing the ways in which Kristen struggled with developmental and structural issues, I was able to guide the therapy work towards an exploration of her early childhood wounds. Consequently, we have regularly talked of her earliest memories of mom and dad as well as her relationship with them now. Countless therapy sessions have focused on Kristen feeling unaccepted, even unloved, by her parents. She has opened up about the acute sense of loneliness she remembers feeling even as a toddler. As of this writing, we continue to explore her sense of self and others in the therapy relationship. We have particularly focused on the ways in which I validate or invalidate her in relationship constructions. More recently, Kristen has generalized some of her new understandings to relationships outside of therapy such as with family and friends.

In the area of dependency issues, the EPCP diagnosis guided me to work with Kristen on her boundaries around appropriately opening up to others. In exploring her pattern of confusion over depending on others, we were able to talk about her choices to sometimes move towards others seeking validations and at other times pull away fearing invalidation. We talked about why she trusted one person and not another. We explored what constituted genuine trust. We talked about Kristen's readiness to acquiesce herself when faced with someone more exciting or social. Finally, we explored the times she switches to an alter and why dissociating both succeeds and fails in meeting her need for connection. Our work in this area led to a period of more intensive therapy in which Kristen courageously began to face whether or not she had some control over the times she dissociated. As Kristen's symptoms of dissociating can be understood as both facilitating and hindering her connections in ROLE relationships, helping her to understand the ways that dissociating affects her ability to move towards meaningful connections as well as pull back from the terror of potential invalidation within ROLE relationships has been essential to therapy.

Recognizing both her strengths and struggles on the experiential components axis led me to speak with Kristen about her courage and commitment, as well as her strong sense of responsibility. Kristen admitted that initially it took her almost nine months to open up as to the depth of her imaginal world. She recognized that it was her growth in the area of courage that allowed her to finally bring her alters to the therapy room. She has accepted that it is her courage to change as well as her sense of responsibility to the therapeutic dyad that keeps her coming back to therapy despite the oft-times painful process we engage in. We have also talked about the ways that Kristen over commits, continually giving to someone even when all signs point to her being used. In addition, we have examined openness, discrimination, and flexibility as areas she would like to grow in. As therapy progressed, Kristen and I looked to the ways her strengths could assist her as she struggled.

Leitner et al. (2000) identify treatment in therapy as the application of theory to distress, and suggest, therefore, that a diagnostic system must be relevant to the therapist's theory. As I believe many of Kristen's dissociative experiences and daily life struggles stem from a desire for intimate relationships mingled with a fear of them, it is appropriate to use the EPCP diagnostic system to conceptualize her meaning making process. In maintaining an EPCP theoretical stance, I was able to understand and diagnose Kristen's experience of dissociation as it relates to the ways she negotiates ROLE relationships. Using the EPCP lens allowed me to understand Kristen's construing process and to know her developmental, interpersonal, and experiential struggles in ROLE relating.

Implications for EPCP Theory

Clearly, the theory of EPCP can successfully be applied to Kristen's case. However, can Kristen's experience of dissociation inform or modify the theory of EPCP? Stiles (2004) suggests that analyzed case studies have the potential to move beyond a simple application of theory to case and instead, may serve to extend and enrich a theory. Whereas a clinical study of a case simply applies theories to cases, a scientific study of a single case is expected to elaborate on the theory. Leitner and Epting (2001) further assert that, ultimately, science is about theory building and meaning creation rather than the discovery of truth.

This exploration of Kristen's meaning creation exposes distinct ways that the theory of EPCP and its diagnostic system may be deficient. As a scientific case study, it implies areas worthy of further elaboration. Despite its illuminating description of Kristen's experience as well

as its clinically applicable information, this case study suggests that EPCP and its diagnostic system may be lacking in their ability to specifically account for experiences of internal multiplicity.

Although the EPCP diagnostic system allows me to 1) identify historically the ways in which dissociation may have been Kristen's response to early childhood trauma, 2) understand the times when she switched as a perceived resource during interpersonal stress, and 3) address the ways that dissociation both facilitated and hindered her ROLE relationships, ultimately, I am limited to Kristen's experience. As Kristen spends much of her time dissociated, the system only accounts for approximately 1/10th of her daily experiences. While I am able to describe Kristen's experience, I am unable to account for the ways Zac or any of the alters feel or act in the imaginal world and after taking control of Kristen's body in the real world.

As the two MMPI-A's suggest, Kristen and Zac have vastly different ways of feeling internally and acting externally. In fact, all of the alters in Kristen's system display unique ways of being. For example, although Kristen is shy and insecure, Zac is outgoing and confident, Madonna is maternal and care giving, the probation officer is strong and domineering, and Hanson is evil and homicidal. These alters are significantly unlike Kristen. Not only are their personality styles and behaviors distinct, they also report developmental histories that are significantly unlike Kristen's. Whereas, Zac describes her biological parents in the imaginal world as abusive, Kristen consistently reports her parents are not and have never been. While Madonna defines herself as actively bi-sexual, Kristen want to remain a virgin until she is married to a man. Whereas Tay was raised in foster care, Kristen was raised in her nuclear family.

Perhaps, they are intentionally divergent because in Kristen's dissociative system, a weakness in one sense of self can be compensated for by creating an alter who possesses the missing strength. Assuming that the alters were created to compensate for a deficiency in Kristen, it is plausible that they personify a wide variety of developmental, interpersonal, and experiential strengths and struggles. In using the EPCP diagnostic system to describe Kristen's experience, I am not accounting for the parts of her that were created specifically to be dissimilar. Ultimately, I am only diagnosing one level of Kristen's multi-layered sense of self. Though Kristen experiences internal multiplicity, this diagnostic system does not accurately reflect it.

In maintaining a credulous approach with Kristen, it is essential, according to Leitner & Epting (2001) that we view her experiences as true “in the sense of communicating important aspects of the client’s experience” (p. 423). A diagnosis limited to a description of Kristen’s experience separate from the experiences of her alters would communicate disbelief in her narrative and appear theoretically objectionable. As Zac so eloquently stated, “Who can say which one of us is the main person? Can you say it is Kristen or Tay or I? We are all important. No one seems to understand. It is so complicated. None of us is more important than the others.” Any assumption that Kristen is the primary self-state discounts the client’s experience. Therefore, Kristen’s diagnosis must encompass her multifaceted ways of being. However, as the EPCP diagnostic system currently stands, I am limited in addressing the alters’ unique experiences unless I write separate diagnoses for each alter. Indeed, separately describing the various alters’ unique struggles and strengths on all three diagnostic axes might be one way to account for Kristen’s experience of internal multiplicity.

For example, on axis one, I could argue that Zac and Madonna do not have the struggles with self versus other that Kristen experiences. Whereas Kristen feels invisible and unloved, they each believe they are worthy of loving connections and that they make a difference in the lives they touch. One example of this is seen in their relationship together. During the first year of therapy they married to demonstrate “how strongly we feel about each other.” In the imaginal world they remain in a loving relationship and in therapy, Madonna occasionally comes to ask for my help with Zac when she is particularly worried about her. Furthermore, despite Zac’s early childhood struggles with her abusive family members, she maintains a large, loyal, and loving group of brothers and sisters that step in to protect her when she gets out of control while partying or performing. Indeed, all of the alters I have visited with in therapy seem to have a clear idea of who they are and who they are in relationship to others. Perhaps this is most evident in their connections to Zac and Kristen. For example, Tay identifies herself as second in line to Zac and protects Zac so that Zac is well enough to “keep Kristen alive.” The various alters are clear about their roles in the imaginal world and what they provide for these two more dominant self-states.

In the area of self-other permanence, I would find it difficult to diagnosis Zac with any real struggles. Zac, a musician who travels extensively in the imaginal world, never worries about losing the care of another when she is physically absent from her. Despite the distance or

absence of Madonna, Meagan, Tay, or Ike, they do not stop caring for her, nor do they cease to exist. Zac understands that her job takes her away and that they will be there for her when she returns. She has also told me that Kristen is silly to believe that when I am away on a trip, I stop caring for Kristen. Zac views herself and others as permanent unlike Kristen.

I also would hesitate to diagnose Zac as having difficulties with self-other constancy as she sees herself and others as stable even when their moods, personalities, or behavior change. Zac often tells me how much she cares for Kristen, even though she genuinely gets frustrated and angry with her for her passivity. In the imaginal world, Zac often kills those she is angry at but resurrects them later when she calms down. Zac then proceeds to maintain some relationship with the resurrected other. During therapy in the real world, Zac has reflectively analyzed Kristen's struggles with accepting that her parents can yell at her in moments of anger, yet still love her.

On axis two, Zac may be described as having some minor struggles with dependency avoidance, at least in the real world. When Zac steps in for Kristen, her role is often one of pushing away those who are hurting or threatening Kristen. Zac often smarts off and offends Kristen's parents or her peers. She definitely does not demonstrate dependency on anyone in the real world. However, she may do this because Kristen needs Zac to be strong in this area to compensate for her confusion over dependencies. Additionally, in the imaginal world, it would be easy to point to Zac's immediate disposal of those that anger her as evidence of an avoidance of dependency as well but her readiness to accept the systems' care for her suggests otherwise. For example, after getting in trouble for indecency on tour, Zac good-naturedly laughed about her manager getting her safely out of the country and admitted it is "her job" to help her. On another occasion, while hospitalized, Zac accepted Madonna's round the clock care. She also accepted and even expected Tay to step in for her for days while she was unavailable to help Kristen. Despite her seemingly fierce independence, Zac does rely on others to help her when she is struggling

On the Experiential Axis, which describes how people move towards and retreat from ROLE relationships, each alter portrays dissimilar strengths and weaknesses. For example, one of Zac's strengths includes her commitment to help Kristen; whereas Hanson, the evil alter, shows little commitment to anyone other than herself. Max, Zachary, Isaac, and Taylor also demonstrate weaknesses in this area and seem unaffected by any sense of responsibility for the

system. In the area of discrimination, Zac never under discriminates and rarely over discriminates as Kristen does. Zac, the savvy, confident alter, knows full well whom to trust and whom not to trust in both the imaginal world and the real world. Her assessments of people in both worlds seem insightful and generally quite accurate. In the imaginal world, she purposefully surrounds herself with trustworthy characters that she can rely on. In addition, Zac regularly steps in for Kristen in the real world to help her interact with a limited number of safe people and to push away various others who threaten her. With regard to openness, Hanson has, thus far, failed to reconstrue after being challenged by Zac and me. She has refused to change her evil ways and has dug her heels in, occasionally making Kristen feel suicidal when she experiences interpersonal rejection. Zac, though suspicious at first about possibly being killed off by me after Kristen initially entered therapy, has reconstrued her beliefs. She now recognizes the importance of change for Kristen and for the system as a whole. Clearly, much more could be said about each of the alters on the experiential axis as each of them display varying degrees of creativity, flexibility, forgiveness, courage, and reverence.

Perhaps, it is sufficient to say that the alters are significantly different from each other and from Kristen in numerous ways. Individually diagnosing each one on the EPCP diagnostic axis would be an exhaustive undertaking. In addition, whereas separate and parallel diagnoses could be clinically illuminating, taken together, the accumulated set of diagnoses might not accurately reflect Kristen's complex, dissociated system. A system in which all of the alters, although distinct with separate strengths and struggles, are interrelated, work collaboratively, occasionally overlap and, most obviously, share one body. Such a set of separate diagnoses might paint a portrait that is not entirely reflective of the system as a whole.

Kristen's experience of internal multiplicity suggests that EPCP could benefit from an expansion of its theory as well as its diagnostic system. In discussing the model, Leitner et al. (2000) concede, "We expect this system to evolve because we are open enough to learn more from our clients...we make no claims that this system is, or ever will become, the ultimate understanding of human struggles" (p.177). If we have learned anything from Kristen and her struggles, it is that any theory or diagnosis we use fails her if it does not encompass her multifaceted ways of being.

Furthermore, a theory or diagnosis should not only account for experiences of extreme multiplicity such as Kristen's but also for the post-modern experiences of the plural self (Cooper,

1999), subselves (Rowan, 1999, Martindale, 1980), internal voices (Stiles, 1999), ego states (Watkins and Watkins, 1979-80), and potentials (Mahrer, 1996). Though such everyday experiences of internal multiplicity are clearly not DID, these conceptualizations account for the polypsychism that many identify with. Cooper & Rowan (1999) describe the postmodern individual as one “who encounters his or her world from a plurality of positions, through a plurality of voices, in relation to a plurality of self-concepts, yet who still retains a meaningful coherence, both at the level of constituent pluralities and at the level of the total system” (pg. 2). The authors state that “while a self-pluralistic perspective proposes, therefore, that a person may not always be one person, nor the same person from moment to moment, the individual is always seen as encountering their world in the mode of personhood, and these personhoods together are seen as forming a meaningful whole” (pg. 3). For example, the part of me that is maternal, care giving, and self-sacrificing and the part of me that is childlike, selfish, and wants to be cared for are two unique aspects of my plural self. Sometimes, I am a complex mixture of mother and child. Other times, I vacillate between these opposing parts of me. Occasionally, I stifle the self-sacrificing caregiver in order to make room for the selfish child within and act accordingly. At other times, I negotiate a compromised position and attempt to give them equal voice in my relational encounters. Each position has its own perspective and way of relating to others, yet together they represent my total combined experience. Though my plurality is unlike Kristen’s in countless ways, (perhaps most obviously that I lack the amnesic barriers that separate her self-states) it is essential that any psychological diagnosis around my way of relating to others account for these disparate, yet vitally important parts of myself. Just as discussing Kristen’s experience without consideration of her many alter’s experiences is erroneous, so too would a description or diagnosis of my experience suffer without an elaboration of both my mother and child positions as well as the complex ways they collaborate.

With these considerations in mind, the question remains, is it possible for EPCP to account for such varying experiences of internal multiplicity? Because constructivist theories focus on exploring and understanding clients’ unique constructs, which are infinite in number, EPCP implicitly considers plural views of the self. However, as constructs are explicitly defined as “bipolar and dichotomous dimensions of sense making” (Epting & Prichard, 1993, p. 34), post-modern readers might feel restricted and, therefore, be dissuaded by a theory that appears to be dependent on dichotomies. Concrete, bi-polar beliefs, such as I am good or bad, things are

black or white, people are victims or perpetrators, and, most relevantly, a unitary view of the self is healthy and a plural view of the self is pathological, have particularly been embraced by the Western World. Casual readers of personal construct theories might imagine that the goal is simply to elicit such dichotomous constructs. For those who resonate with a less distinct way of being, as in the case of Kristen, EPCP may not appear to fully encompass their experience. They may, instead, embrace a more oblique perspective. In addressing the limitations of bi-polar constructs, Don Bannister (2003) used the example of feeling versus thinking to write that such bipolar constructs have “prevented us from adequately elaborating the notion of a person” (p. 64). Bannister also reminded us that even Kelly repeatedly stated that constructs serve to both liberate us and restrict us.

However, those who read more deeply into personal construct theories come to understand that dichotomous constructs are elicited as a way of describing what the unique nature of meaning is like for each individual. Landfield and Epting (1987) assert that a construct system is not focused on the dichotomies themselves but around the ways that particular dichotomies are used. Furthermore, Kelly’s fragmentation corollary (1955) suggests that people may use a variety of incompatible construct systems as they make meaning. Construct theorists would assert that any construct system, as well as any person, is constantly in motion, changing with every interaction, and can never be fully known or pinned down. Despite using such dichotomous language with regard to constructs, personal construct theories such as EPCP encourage the exploration of the many unique choices we make in developing and extending our unique construct systems. In order to stay relevant to an increasingly changing, multicultural, multifaceted world, there is a need to promote the ways in which personal construct theory has always argued for multiple views of self and other. EPCP might benefit from an increased focus on and an elaboration of the fragmentation corollary, as well as an explicitly spelled out acceptance of multiplicity.

A theory that has the potential to accurately account for views of the self as plural should also have a diagnostic system that can do the same. In this case, the EPCP diagnostic system might be read as suggesting that on each of the three axes there is meant to be a dichotomous discussion of a unitary individual either struggling or finding success with each of the components. For example on the Interpersonal Axis, the three dependency components are listed as excessively dispersed dependency, undispersed dependency, and dependency avoidance. The

assumption could be made that everyone must consistently disperse their dependencies too much, too little, or not at all. However, this is not the experience for many individuals. In Kristen's case, she experienced all three of these struggles in a variety of ways at different times. Her alters also had varying degrees of both struggles and successes with dependency issues, none of which I elaborated on in Kristen's diagnosis. A further example that negates such an assumption and relates to the postmodern view of plurality is that the mother in me struggles less with dependency issues than the child in me does. Indeed, both the mother and the child have struggles and strengths around dependency in relationships. However, each aspect of my self has a position and my experiences around dependency as a whole are much more than either of those distinct positions. A diagnostic elaboration of the many dependency positions one might take for various reasons at different times might be more reflective of both Kristen's and my experiences of internal multiplicity rather than either a struggle or a strength discussion. The loose structure of the EPCP diagnostic system in comparison to a rigidly formatted DSM diagnosis allows room for this type of discussion.

Clients who view themselves as maintaining multiple perspectives, personas, self-states, inner voices, parts of the self, or ways of being could be described on each axis, under each component, in the ways that the various parts of their systems function both separately and together. For example, Kristen's struggles with self versus other are clearly not Zac's. Perhaps, discussing the differences between these two stances and the ways that Zac's strengths appears to have been created specifically to compensate for Kristen's area of weaknesses might have better served the client and her diagnosis. In the area of discrimination, I might have included a discussion of the ways Zac over discriminates as a specific response to Kristen's struggles with under discrimination. I might have included a description of the ways that Kristen's holistic system has the potential to collaborate more effectively by increasing communication between the disparate parts. In therapy, a discussion around this communication process might connect the alters more succinctly. As the system works together, there is potential for a softening or moderation of both positions, rather than a dichotomous presentation. Ultimately, both Kristen and Zac might then experience healthier ways of being. An EPCP diagnosis that included an elaboration of the ways that Kristen's system as a whole has been resourceful in negotiating the various struggles and strengths would be more accurate of her experience. The intention would be for the complex system to be discussed as greater than any of its distinct parts.

One suggestion might be to decrease the dichotomous language that is used in EPCP by reevaluating the use of words such as *versus*. At a literal level, labeling a component self *versus* other communicates a message of separateness and opposition, rather than highlighting its potential for plurality and collaboration. Simple changes such as labeling a component self *and* other or self-other might send such a more inclusive message to readers.

A final consideration might be to attach an additional paragraph to all presentations of the diagnostic system that addresses these issues and clarifies the unique potential that the EPCP system has for including multiplicity. Such a paragraph might specifically address any tendency of readers to stagnate on the product of bi-polar constructs and instead, encourage elaborations around clients' multifaceted experiences of self as they elicit such constructs. Perhaps what will assist EPCP theory in remaining relevant in today's multifaceted world is to expand and include language that is representative of a less dichotomous, Western World view and more reflective of a post-modern, global worldview.

In presenting Kristen's case from an alternative perspective, I intended to expand the field's understanding of DID, dissociative experiences, and internal multiplicity. Furthermore, I am hopeful that in telling Kristen's story, the theory of EPCP and its diagnostic system have been challenged to more explicitly describe its accounting of such plurality. Clearly, further research and discussion are necessary to explore the ways that the EPCP diagnostic system and, indeed, any diagnostic system can accurately account for Kristen's unique experiences, as well as the ways in which all of us experience various degrees of internal multiplicity.

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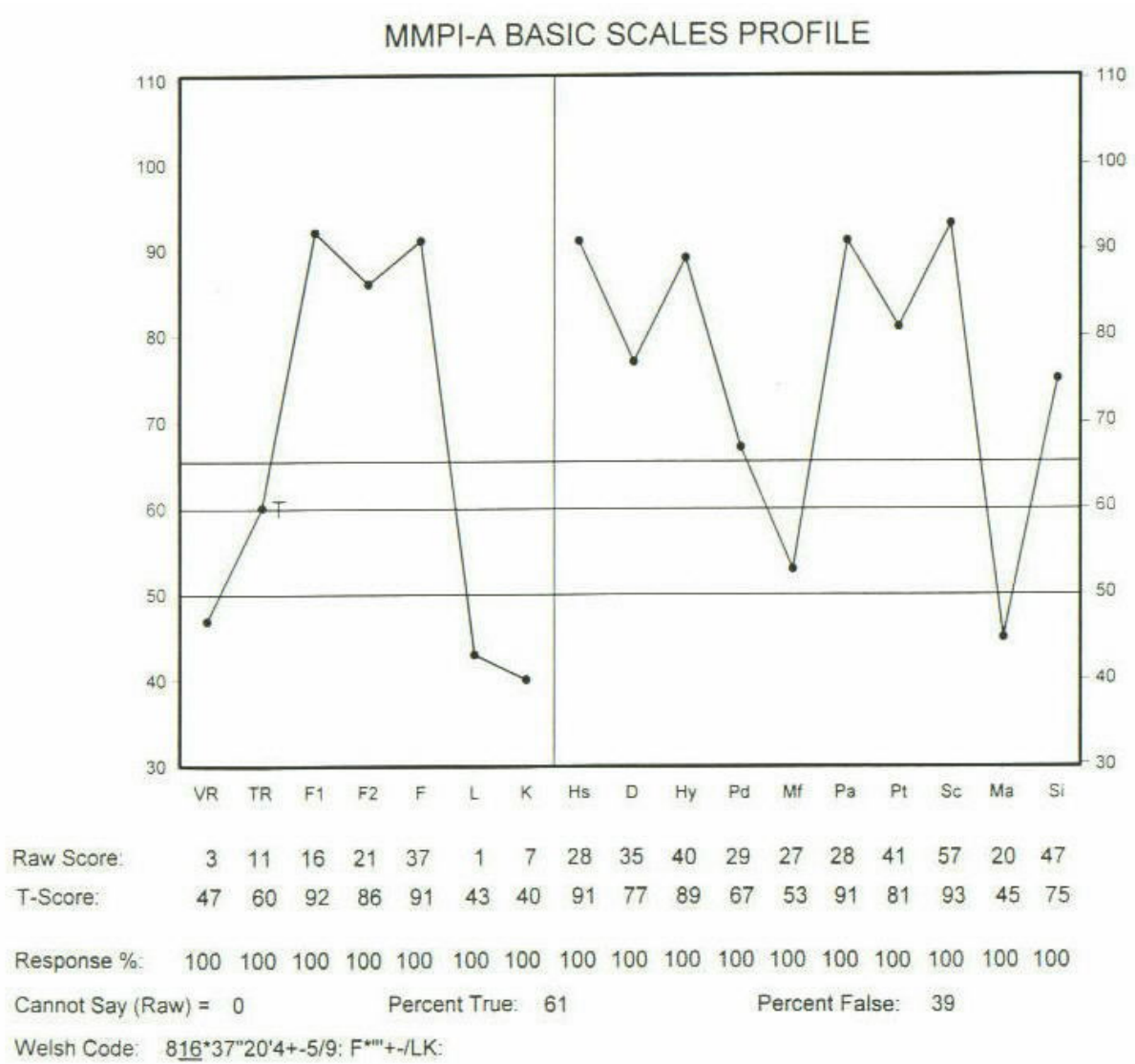
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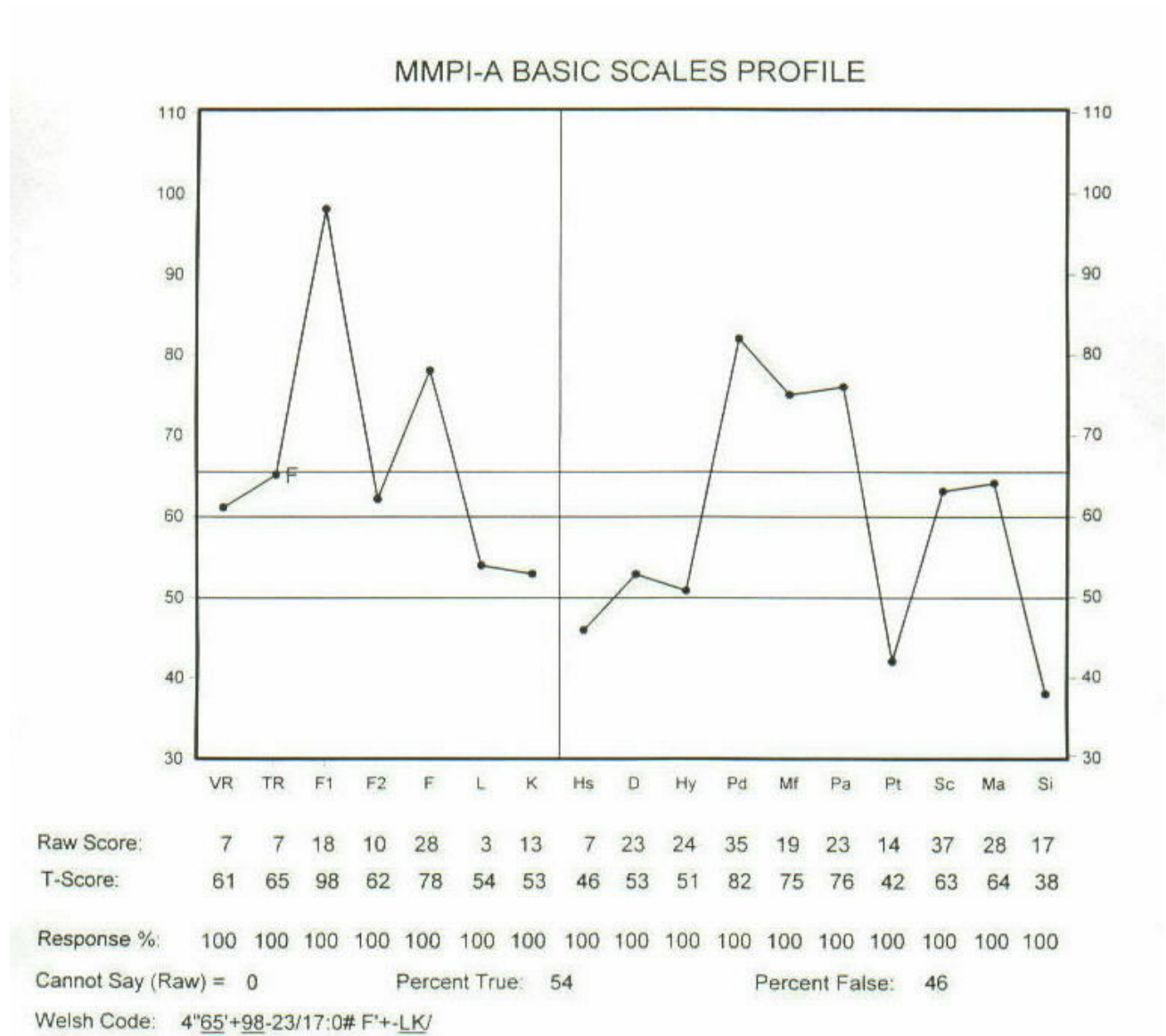
Appendix A

Kristen's MMPI-A



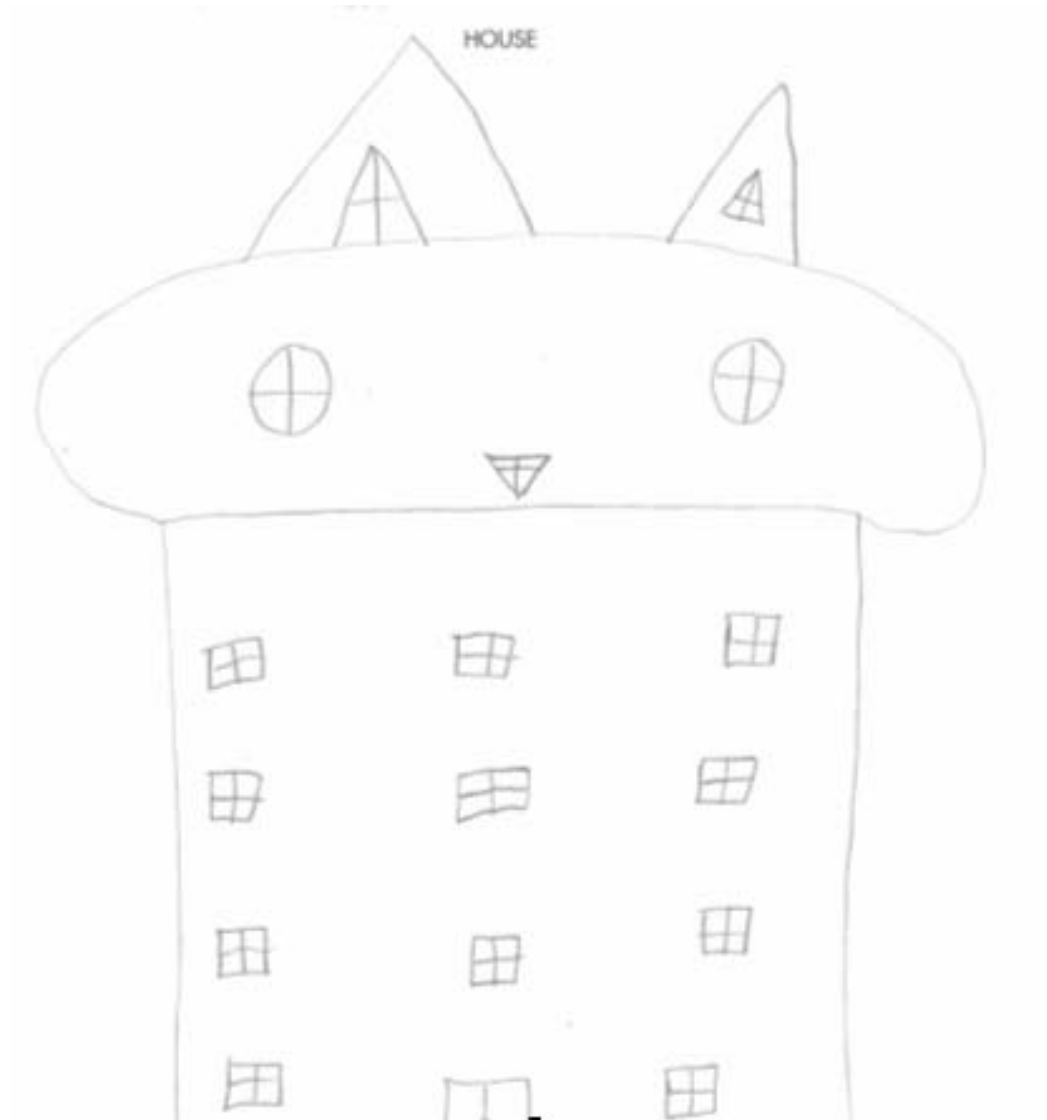
Appendix B

Zac's MMPI-A



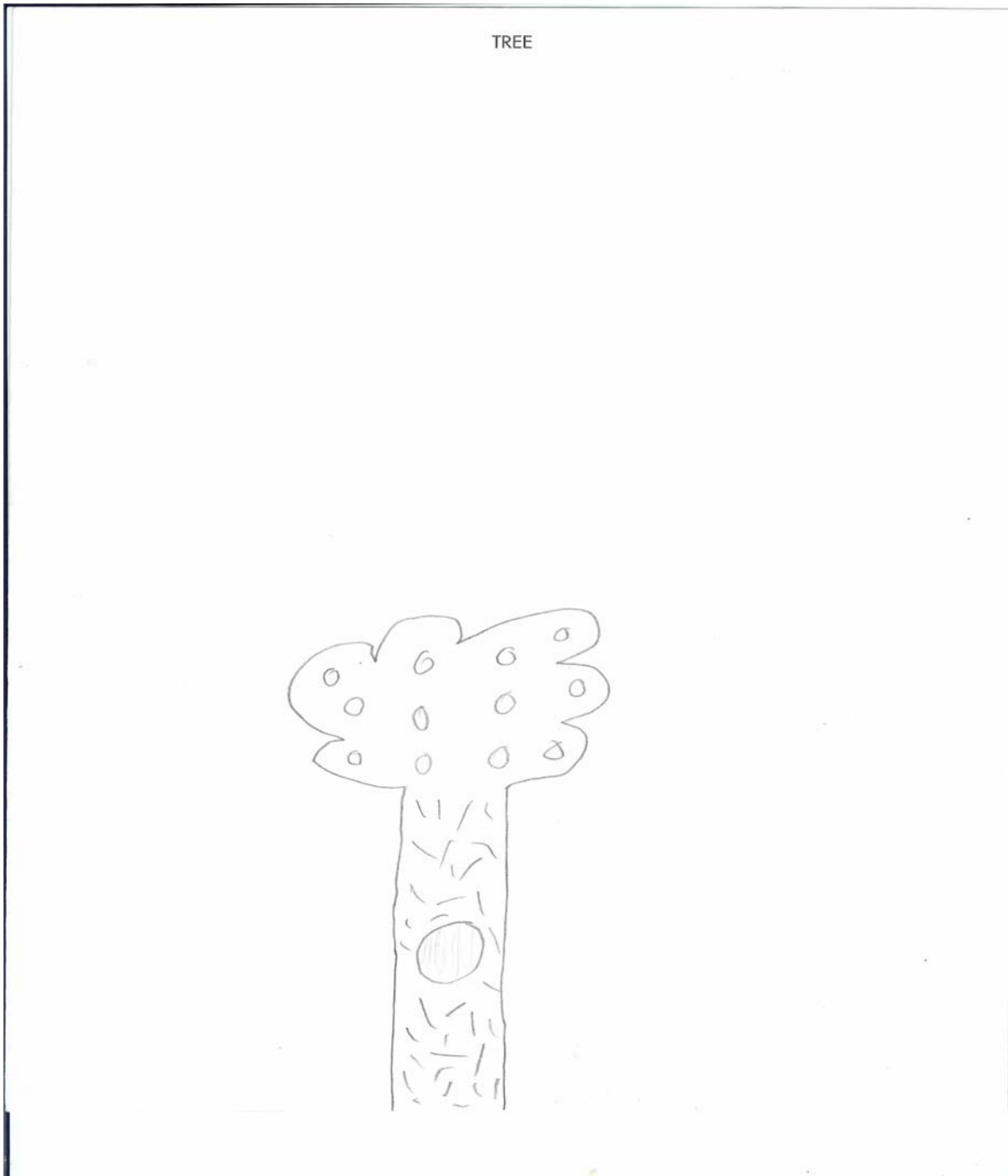
Appendix C

House Drawing by Kristen



Appendix D

Tree Drawing by Kristen



Appendix E
Person Drawing by Kristen

PERSON



Zac's Sand Tray

Zac's Sand Tray



Appendix H

Kristen as Drawn by Zac



Appendix I

Zac as Drawn by Zac



Appendix J

Hanson as Drawn by Zac



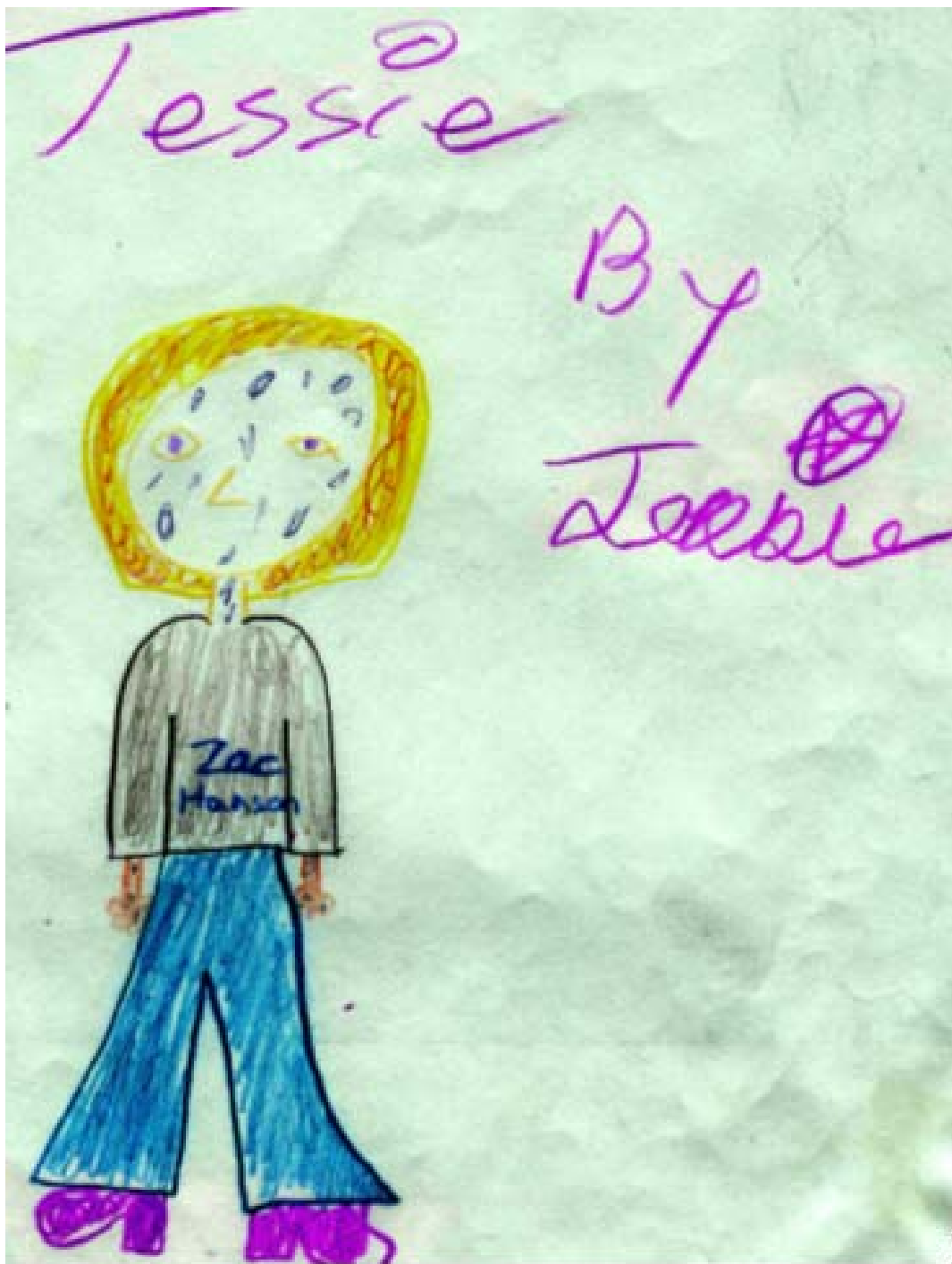
Appendix K

Ike as Drawn by Zac



Appendix L

Jessie as Drawn by Jessie



Appendix M

Megan as Drawn by Zac



Appendix N

Max as Drawn by Zac

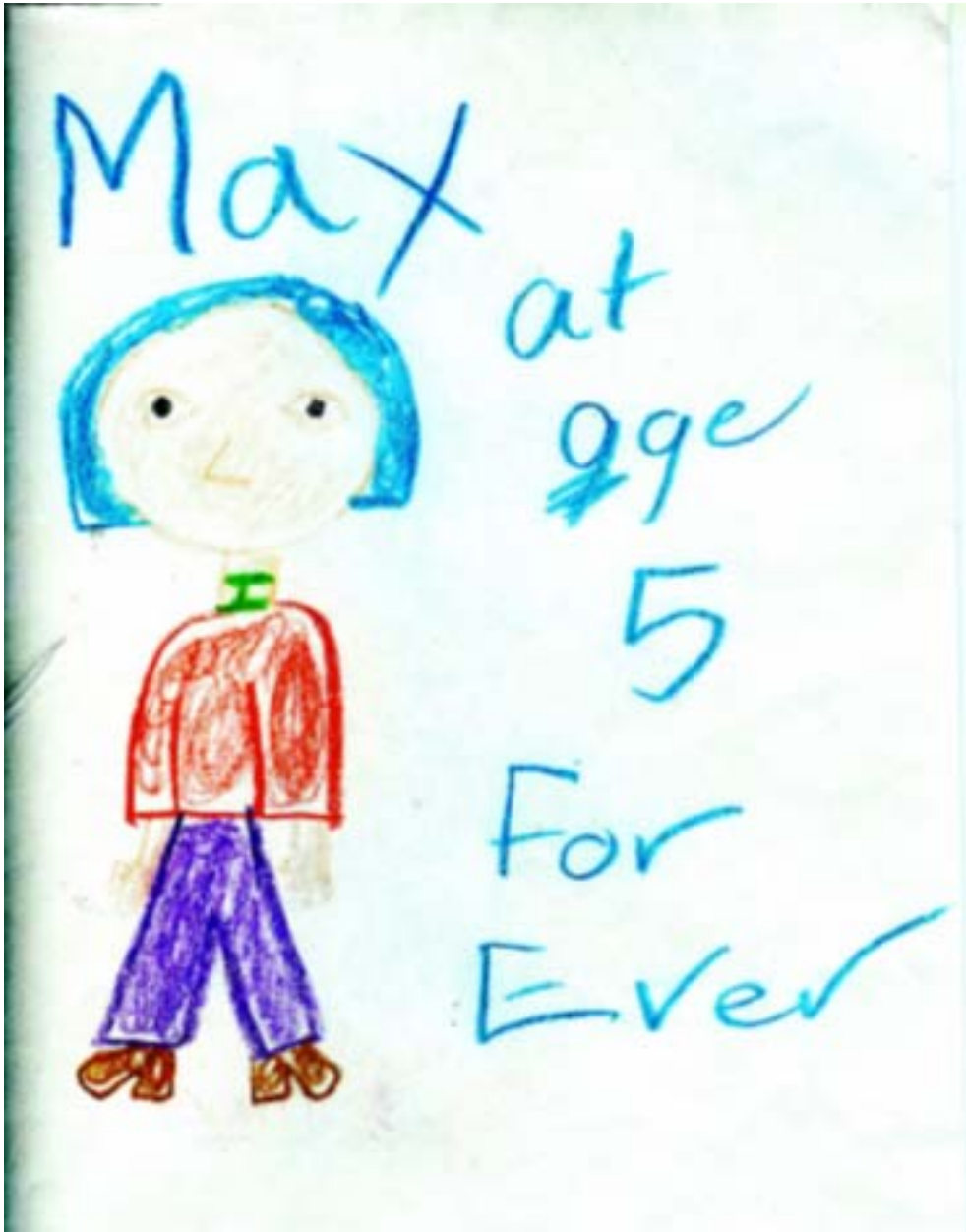


Table 1

Diagnostic Axes

Developmental/Structural Issues	Interpersonal Components	Experiential Components
Construct of Self vs. Other	Undispersed Dependency	Discrimination
Self-Other Permanence	Excessively Dispersed Dependency	Flexibility
Self-Other Constancy	Dependency Avoidance	Creativity
Attachments	Physically Distancing Self	Responsibility
	Psychologically Distancing Self	Openness
		Commitment
		Courage
		Forgiveness
		Reverence