What happened to me?
Knowing and not-knowing
in Dissociative Identity Disorder

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Fig. 1 'Graceful female hand smoke on black'

(Coffeemill, 2023)

Abstract

This paper explores the meaning behind the search for knowing and not-knowing in clients with dissociative identity disorder (DID). I have researched early psychoanalytic thinking around dissociation and repression in terms of multiple personality and psychosis up to more recent contemporary thinking. I have looked at the work of Janet, Breuer, Freud and Fairbairn around this subject, considering how opinions resulted in the confusion and misdiagnosis of DID over subsequent years. I consider the effect of physical and emotional abuse upon attachment and future relating, and how this will repeat within the therapeutic relationship. In order to understand the meaning of the client's compulsive search to know what happened to them, I have used clinical examples from three of my clients and have shown how this is not so much about what happened but what didn't happen that should have happened in terms of attachment and the 'facilitating environment'. I have found the work of Fairbairn and his object-relations theory, along with Balint's 'basic fault', and Winnicott's 'fear of breakdown' particularly helpful as I have applied these theories to my clinical examples to understand the repetitions and re-enactments. This study has provided me with a much deeper and wider understanding on my own original thoughts about the search *to know*. My sense that there was more to this dilemma of knowing and not-knowing suggested that this came from the countertransference feelings towards all that is unconsciously defended against knowing. This exists alongside the internal world of parts and a host personality who are in a constant battle over wanting to know and not-know.

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In 2012 I set up a Christian based mental health charity with the aim of providing a therapeutic recovery programme for those with complex needs who were unable to access therapy, either due to finances or lack of mental health service provision, along with providing a space for those wanting to explore a faith perspective within therapy. Originally, the charity was set up as a resource for the local church network across the region to refer into, but over time the charity evolved into a service that GPs and secondary care services were also referring into, along with self-referrals. Whilst the charity maintained a Christian foundation and interest, more clients from a non-faith background came for the reason that we had experience in more complex difficulties associated with childhood trauma and abuse. For six years the charity ran a number of daily support groups and a variety of workshops, before moving on to offering individual psychodynamic psychotherapy, Eye Movement Desensitisation Reprocessing (EMDR) (Shapiro, 2018), and group therapy. This was a move that was prompted by working with clients presenting with severe Dissociative Identity Disorder (DID) which had a huge impact upon the charity and other clients. ICD-11 (2022), describes DID as follows:

> Dissociative identity disorder is characterised by disruption of identity in which there are two or more distinct personality states (dissociative identities) associated with marked discontinuities in the sense of self and agency. Each personality state includes its own pattern of experiencing, perceiving, conceiving, and relating to self, the body, and the environment. At least two distinct personality states recurrently take executive control of the individual's consciousness and functioning in interacting with others or with the environment, such as in the performance of specific aspects of daily life such as parenting, or work, or in response to specific situations (e.g., those that are perceived as threatening). …There are typically episodes of amnesia, which may be severe. … The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

I became aware that a small number of clients began recounting similar stories of satanic ritual abuse (SRA) including details of severe sexual and physical abuse. The depravity was something previously inconceivable to me, especially when this occurred at the hands of church leaders. I found myself dealing with a small number of extremely traumatised clients, some of whom displayed the symptoms of DID. They each came from within our local area and went to different churches now in adulthood, but having grown up going to one particular church youth group where they described the abuse as having started. This was reported independently of each other. Those with DID experienced sudden 'switching' (Fonagy, 2011) into alternate personalities, including into that of young children, thumb-sucking nonverbal babies, or obnoxious foul-mouthed teenagers, with either semi-conscious awareness or complete amnesia of what was happening in the moment.

These different states are sometimes described as 'alters' (Gottlieb, 1997), but also often referred to as Emotional Personality (EP) states (the part that responds to perceived threat in defence of the system), with the part who continues to function and manage daily life referred to as the Apparently Normal Personality (ANP) (Nijenhuis, van der Hart, Steele, 2010). I will use the terms alter, part, or personality.

As I heard more graphic detail of sexual depravity, torture, and even murder I found myself feeling alone, suspicious of others, and unable to recognise the powerful countertransference feelings at times. I found it hard to bring these clients to supervision, feeling instead a pull to stay silent in order to protect them in those early days. I also became accustomed to the disappointing reaction from the police, GPs, and the mental health team; the look of disbelief and even ridicule that I had believed the client. I noticed the same reactions at times within my own team, with some of them denying the existence of ritual abuse or DID. In terms of DID at least, I had not believed in it myself previously, seeing it as a form of acting out that a client had conscious control over. This was until I encountered it in its most extreme presentation in Carly* and realised that this was not something that a person could either control or had conscious awareness of.

Over the years there have been differences of opinion over whether Borderline Personality Disorder (BPD), complex post-traumatic stress disorder (C-PTSD) and DID are one and the same or exactly how they overlap (Howell, 2019). Each are seen as an outcome of relational trauma which causes dissociation. Whilst these conditions can co-exist in the same person, research over the development of ICD-11 (2022) now shows limited overlap between conditions such as BPD, post-traumatic stress disorder (PTSD) and C-PTSD (Howell, 2019), with DID listed separately under the heading 'Dissociative Disorders'. It is important to note that if the person does not experience multiple distinct personalities that take over executive control of the person, then they do not have DID (ICD-11, 2022).

DID is more common than originally thought, with research suggesting that between 1-10% of both in and out-patients will have DID (Steinberg, 2019), and 30-70% of those with DID also have BPD, with 64% of those with BPD having a dissociative disorder (Howell, 2019). Although often misdiagnosed as psychosis, there can be similar symptoms between both schizophrenia and DID (Howell, 2019).

In this paper I will be considering the division that occurred between Janet and Freud and the impact it had leading up to current thinking on DID. I will also consider the differences in thinking between Janet and Freud on trauma, sexual abuse, and infantile wishes and phantasy.

Interestingly, a published case series on DID with between 50 to 355 cases per series, 88.5 - 96% of participants reported childhood physical and/or sexual abuse (Scott, Ross, Dorahy, Read & Schafer, 2019). I have chosen two clients with no history of sexual abuse and one with a history of ritual abuse to focus on. My research here however is concerned with what it means when a client reports that they don't remember what happened to them and says that they feel driven to *know*, whilst simultaneously doing everything they can to *not-know*. Whilst this is undoubtedly frustrating for the client, I began to feel that there was more to the question around what happened to them than the fact of the missing narrative itself.

My hypotheses is that the sense of not-knowing is not only linked to their story being split across multiple self-states, but to the loss of a sense of self as an integrated being, which is what I set out to explore from historical and more recent theories with my own clinical experiences. Hazell (2000) suggests that the knowledge of once being an integrated being is retained (and longed for) within the central nervous system and unconscious from at least the intrauterine phase, even if not experienced postnatally. This theory helps in part to make sense of the dichotomy between knowing and not-knowing. In terms of the developing self and fragmentation Ferenczi describes how

an increase in trauma during those early formative years will cause "splits in the personality" and describes the confusion with each fragment behaving as a separate identity without awareness of the others. (1949, p.229)

In my clinical examples I will be focusing on how helping to integrate the narrative of what happened brought a greater sense of agency and normal functioning in one individual whilst not in the others, and consider why that might have been. I will be considering the impact of trauma through attachment and object-relation theories in relation to DID in an attempt to understand the meaning behind the question as to what happened to them. I have found the work by Janet, Balint, Fairbairn and Winnicott, and more recently by Sinason and Mollon most helpful in understanding my own thinking behind the question I am looking into.

I am interested in a very specific question that I noticed with several of my DID clients, but am aware that there is a much wider discussion needing to be had which is beyond the scope of this paper.

Three of my clients were in individual psychodynamic psychotherapy and group therapy with me. Two also had EMDR. I used EMDR to assist in the processing of trauma and recovery of memory, alongside understanding and working through with them from a psychodynamic perspective. Therapists working with DID clients will usually find that they need to draw upon more than a single theoretical approach (Sinason, 2011) and the combination of psychodynamic, EMDR and group therapy worked well in these instances. It is my personal feeling that this approach didn't threaten the psychodynamic frame, but strengthened the therapist/client relationship, particularly as these clients usually need more gentle holding and remain in something more akin to a pre-therapy phase of continual assessment, while proceeding with caution at every step is imperative (Mollon, 2011).

According to Mollon (2000), dissociation, trauma or abuse were really not very well understood in the twentieth century "[a]lthough 100 years ago Pierre Janet developed a sophisticated theory of trauma and dissociation … which was highly congruent with modern perspectives [but] his approach was eclipsed … by the psychoanalytic theories of Freud, which emphasised repression rather than dissociation" (Mollon, 2000, p. 194).

I believe that the argument between Freud and Janet over the originator of ideas pertaining to DID has done a great disservice to many with DID. Teaching on the condition is not included in many psychotherapy trainings and yet it is now listed as a condition in the ICD-11. Whilst my research is on understanding the meaning of what is missing for those with DID, there is a much larger scale repetition of the problem when we consider how this is missing from psychodynamic and other clinical trainings. I believe it is of vital importance to include this subject in order to better equip psychotherapists and other medical professionals to recognise and manage this condition as experience has shown that this is more common than many want to believe.

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Clients with DID will often present with the perceived experience of having been failed, not just in their childhoods and day to day adult lives, but also, sadly, by those to whom they have been referred for help. Reflecting here on the meaning of those failures, alongside the fact that trainee psychodynamic psychotherapists are not trained to recognise DID (Sinason, 2012), led me to explore the history of dissociation. I'm interested in exploring the link between historical thinking about DID with the perceived experience of having been let down, and how this links to the question over the reality of what actually happened to them.

In terms of the split in thinking about childhood sexual abuse (CSA) and DID, is this simply a case of our own disavowal of the idea that CSA may be going on all around us because we also don't want to know (Sinason, 2011)? We seem to have a societal tendency to turn a blind eye towards CSA, although this is improving as more historical cases are being reported. But therapists and doctors too?

Looking deeper into the history of psychoanalysis reveals the split in theories that occurred between Freud and Janet. This is well documented (Berman, 1981), and I will explore this briefly within the limitations of this paper, considering whether this generational split continues to have an impact upon theories and ideologies today and why that might be. Also, does the process of dissociation get projected into others resulting in a shared disavowal (Sinason, 2011), including the denial of the existence of multiple parts.

Breuer and Freud (1893/2001) emphasised the importance of finding the initial cause of hysterical symptoms but, in the case of psychical trauma (such as child abuse), they found that the memories could only be accessed through hypnosis. They explained that certain experiences were not accessible any other way because the patient had not sufficiently reacted to the traumatic event. Hypnosis enabled them to bring the original event into conscious awareness and if the patient were then able to appropriately react to the trauma it led to a recovery from the symptoms. An appropriate reaction included being able to put words to what happened (Breuer & Freud, 1893/2001). They write that "language serves as a substitute for action; by its help, an affect can be 'abreacted' almost as effectively" (Breuer & Freud, 2001, p. 8). Their understanding of this was that if the person didn't want to think about what happened then the memory of it was "intentionally repressed" (Breuer & Freud, 2001, p. 10). Freud later stated that 'intentionally' did not mean consciously. As they explored the subject of absent memories further, they became

> convinced that *the splitting of consciousness which is so striking in the well-known classical cases under the form of 'double conscious' is present to a rudimentary degree in every hysteria, and that a tendency to such a dissociation, and with it the emergence of abnormal states of consciousness … is the basic phenomenon of this neurosis* (Breuer & Freud, 2001, p. 12).

In 1893 Freud and Breuer believed that "in repression, the mind is split into areas of consciousness and unconsciousness; in dissociation, consciousness itself is split, so that what is known in one state of consciousness is not known in another" (Mollon, 2000, p. 194). They certainly initially agreed with Janet's remarkable findings on this subject (Breuer & Freud, 1893/2001).

The following year Freud noted that there was a difference of opinion over the splitting of consciousness. Janet's view, according to Freud, was that it was due to "an innate weakness of the capacity for psychical synthesis, on the narrowness of the

'field of consciousness' [which he thought was] evidence of the degeneracy of hysterical individuals" (Freud, 1894, p. 46). Freud however believed that "*the splitting of the content of consciousness is the result of an act of will*" (Freud, 1894, p. 46), or as a result of a failed reaction to trauma. With obsessional neurosis and phobias he wrote that it was as a consequence of needing to suppress an idea or feeling which was too distressing to think about, such as in sexual sensations (Freud, 1894).

Between 1895-1897, Freud concluded that CSA was the primary cause of the development of neurosis. In 1896, writing about thirteen cases, he described all of them as having experienced "grave sexual injuries; some of them were positively revolting" (Freud, 1896, p. 164). Having originally assumed that the assaults were at the hands of fathers, teachers or nannies, he now discovers abuse at the hands of older siblings, who had themselves experienced some form of molestation where their "libido was prematurely aroused" (1896, p. 165). The result being that it led to a re-enactment of the experience with a younger sibling, in a shift from victim to perpetrator. His experiences match what I discovered at the charity, with CSA far more widespread and shocking than I had previously imagined it to be. Freud was exploring why some children forgot these sexual traumas and others didn't. My initial experience was that not all those who forgot the sexual trauma had DID, but the way they eventually recalled what had happened to them was entirely different between those with DID and those who appeared not to. Those who appeared not to manifest parts seemed able to recall the most thorough and intimate details of what they had repressed through the use of EMDR, whilst those with a more recognisable presentation of DID struggled to get more than mere fragments of memories that they couldn't place in their narrative. Like Freud, I have also questioned why this is. Freud's ideas around his 'seduction theory' involve the repression of pleasure gained, self-reproach, and guilt which are subsequently transformed into neurotic symptoms (Freud, 1896), although, like Janet, I don't think these theories fully answer the question.

Janet (2019) described Freud's theories around 'childhood sexual mishaps' as too simplistic. He noted that critics had begun to question "why Freud saw sex wherever he looked" (Janet, 2019, p. 620) and Freud went on to abandon his seduction theory in favour of childhood sexual phantasies. In 1924 he added a footnote to the 1896 paper, 'Further remarks on the neuro-psychoses of defence', noting his error on his original theories on this subject. The modifications of his theories came at a time when there was also much suspicion related to hypnosis and whether female patients were acting (Sinason, 2011). In a letter to Karl Abraham in 1907, writing on the subject of why children forget sexual trauma he said that "children keep silent when they have experienced a pleasure gain" (Freud, 1907, p. 2). Whilst my experience with working with CSA has shown that children experience either unwanted early arousal or sexual inhibition as a consequence, I feel that the internalisation of the bad object, in particularly shame and guilt, makes more sense than the repression of sexual pleasure, even though that may be highly confusing for them. This is especially so when reinforced by the perpetrator saying to them at the point of orgasm "See, you did want it" which may be followed by telling them that they're disgusting and a whore, and that they were the one who encouraged them to do what they did. Further threats may follow along the lines that if they tell anyone mummy will be hurt, or that they will be killed. Typical responses within the child's

mind might be, 'it's not daddy's fault, it's not daddy's fault', 'mummy is a good mummy', 'it's not happening to me but to that other child', reinforcing fragmentation.

CSA is uncomfortable and has always had a powerful impact upon society, including professionals who may prefer to find an alternative answer as Freud did in the abandonment of his own early theories on the subject. Interestingly, we see a similar pattern in many churches where the focus is only on teaching about a good God and not on the opposite evil, Satan. If we do not equip people to see that both extremes exist then how can they learn to stand in the face of evil? Denial is a coping mechanism adopted by many, in various forms, in the face of things we don't want to know or see.

The client with the sense that they have repressed something surrounding a possible traumatic event/s which they feel unable to recover leads me to wonder about other circumstances that are equally painful and defended against, but not the CSA that they may imagine took place. Freud talked about the repression of unconscious wishes, and I wonder whether this may include the repression of longing to be loved, to feel safe, contained and held. The repression of something that wasn't ever there that should have been, which I will explore further with Balint and Winnicott.

Freud was moving further away from the idea that the trauma from CSA and sexual mishaps were the sole cause of dissociation, developing instead his theory of neurosis based upon infantile wishes and phantasies and the Oedipus complex. In his paper on 'The ego and the id' he writes that when the ego's object-identifications become "too numerous and incompatible with one another. . . [it may cause] a disruption of the ego in consequence of the different identifications becoming cut off from one another by resistances" (Freud, 1923, p. 30). Describing multiple personality he suggests it may be possible that "the different identifications seize hold of consciousness in turn" (Freud, 1923, pp. 31).

Janet contended that certain hysterical symptoms can be related to 'subconscious fixed ideas' surrounding a traumatic event, believing that split parts of the personality had their origin in that traumatic event (Ellenberger, 1970). He believed that modification and transformation of the memory would cause the symptom to disappear (Janet, 2019). He described the process of modification as 'substitution' (Ellenberger, 1970), which sounds very similar to the more natural processing and reworking that occurs through EMDR resource development and installation (Shapiro, 2018), which is briefly illustrated later.

Janet seemed to be the first to formulate a theory for DID. The concept of such splitting with its origins in traumatic events however began to disappear from analytical thinking. Freud's growing emphasis on repression was a major contributory factor, which led to distancing himself further from Janet, and from Breuer's hypnoid states.

Alongside this was the growing tension between Janet and Freud over who was the real originator of various theories. Freud's increasing anger and frustration led him to state that "psychoanalysis is completely independent of Janet's discoveries, just as in its content it diverges from them and goes far beyond them" (Freud, 1925, p. 31). Janet also seems to be growing more critical of Freud in his own writing (Janet, 2019). Further confusion arose from Bleuler over his description of schizophrenia. In 1908 Bleuler gave a conference in which he put forward schizophrenia (meaning split mind) for the first time. A few days later, Jung presented at a conference where he described dissociation as a splitting of the self. He suggested that as both dementia

præcox and dissociation involve splitting, "the concept of dissociation seems to blend into the concept of Schizophrenia" (Jung, unpublished, as cited in Moskowitz & Heim, 2019, p. 57). Bleuler described dissociation as a splitting off of the unconscious into complexes that can become secondary personalities that take over control from the original personality (Bleuler, 1905/1918, as cited in Moskowitz & Heim, 2019).

An unfortunate link was therefore formed between psychosis and dissociation originating from Bleuler and Jung. Bleuler described schizophrenia as different 'psychic complexes' that can take over executive control at any one time (Bleuler, 1911, as cited in Moskowitz & Heim, 2019), with Jung writing that there was no difference between a complex and a fragmentary personality, with complexes described as "splinter psyches" (Jung, 1934/1960, as cited in Moskowitz & Heim, 2019, p. 59). Prince, who was also familiar with working with multiple personalities, recognised the confusion arising between dissociation and splitting and adopted the term "disintegrated" to describe divisions within the personality and switching between alternate personalities (Prince, 1908, as cited in Middleton, Dorahy & Moskowitz, 2019, p. 39). Freud also moved away from the word dissociation, preferring 'splitting' (Freud, 1893/2001) to describe dissociative processes. The vast majority of psychoanalytic writers have followed him in this (Howell, 2019).

This confusion between schizophrenia and DID may have caused a number of cases of DID over the years to have been misunderstood and misdiagnosed. In fact, when Breuer wrote about Anna O. he described her as suffering from two different states of consciousness. He wrote, "the patient was split into two personalities of which one was mentally normal and the other insane" (Breuer, 1893/2001, p. 45). Although Anna had a great number of somatic and hysterical symptoms, it was proven that the second personality was re-enacting everything accurately from events that had taken place the previous year. She could not have fragmented only the previous year though based on our understanding of this being an early developmental pattern, so I wonder if the part re-enacting events from the previous year was in executive control during those events and continued to replay them.

Whilst research has shown a link between psychosis and trauma related experiences in both schizophrenia and BPD (Moskowitz & Montirosso, 2019), as with DID, I believe it's best looked at differently. Mollon notes that Janet's theories around trauma, multiple personality, and dissociation are consistent with thinking today (Mollon, 2000), and I was surprised to see how well they aligned with my own work using EMDR to access and rescript the memories alongside an attachment theory and trauma-based approach. I also find Fairbairn's object-relations perspective makes a lot of sense of the process that takes place when a child is trying to find a way to survive when she cannot depend on those she needs to trust. Fairbairn takes the extensive work of Freud and Janet a step further to develop his own theories. He clearly had an interest in multiple personality as he wrote his medical thesis on this subject.

Fairbairn, along with several others, noticed that repression didn't adequately explain the phenomena they were encountering in their work. He began to investigate Janet's thinking about dissociation, alongside Freud's theories on repression and infantile wishes, developing his theory on endospychic structure (Fairbairn, 1952/1994). He describes repression as

> a defensive reaction on the part of the ego, not primarily against intolerably unpleasant memories (as in Freud's earlier view), or against intolerably guilty impulses (as in Freud's later view), but against internalized objects which appear intolerably bad to the ego (Fairbairn, 1952/1994, p. 164).

He felt that the repression of bad objects also made more sense of Freud's 'repetition compulsion' theory (p. 166), saying it was less about the unconscious repetition and enactment of traumatic scenarios, and more of "being haunted by bad objects against the return of which all defences have broken down, and from which there is no longer any escape (except in death)" (Fairbairn, 1952/1994, p. 166).

The compulsive repetitive nature of the client's search for what happened to them led me to thinking about Balint's 'basic fault' theory, which he describes as repeatedly returning to "a fault that must be put right" (Balint, 1992, p. 21). This, not only in terms of something lost that needs to be found, such as the lost narrative and sense of secure attachment, but also in terms of alters that remain stuck in the past, re-enacting past trauma.

These powerful feelings of loss are felt as something that has been missing for their entire life. Such a powerful part of the DID experience is that this sense of something missing invades every part of who they are, impacting every detail of daily life including their interactions with others. Balint's description of his basic fault theory fits well with this DID experience

He suggests that the method an individual uses to cope with the original trauma influences all further development beyond that point. He describes how the patient is drawn to search for that missing 'something' throughout life, as if it could be met in the present, but that they're never able to attain it (Balint, 1992). My understanding of this is that they are searching for something that doesn't 'fit' anymore as an adult because it is an early childhood longing which they're still experiencing.

If the individual perceives this deep sense of having been failed and let down, which repeats in all future relationships, they will bring this into the therapeutic relationship from the outset. Whilst this stems from the original trauma and the sense that nobody noticed or came to their rescue, such as a teacher or other relatives not seeing or, worse, turning a blind eye, it may not be a trauma as such that they can put a finger on. Winnicott said that it's easier "to remember trauma than to remember nothing happening when it might have happened" (Winnicott, 1974, p. 106) and this links with the severe deprivation experienced by the clients I'm focusing on in this paper, and with my hypothesis. Each repetition of being let down, even if misperceived, retraumatises the client, which I will illustrate.

I questioned whether an instinctive drive to uncover the truth of what happened was also related to an unconscious search for a united sense of self, and integration (Bromberg, 1996), which includes the longing for secure attachment. If there has never been an experience of secure attachment, then how would they remember something they have never consciously known — unless it's unconsciously known?

Balint's basic fault theory is not only in line with Winnicott's notion of searching for something that never happened that should have, but shows the link between incoherent attachment and incoherent narratives. Without either, the individual is left to find security and comfort within their own body, or within a part of it (Holmes, 2001).

Linking trauma and attachment theories in my understanding of DID brings me also to thinking about 'the search for the secure base' (Holmes, 2001) and how this links to the search for what happened. Holmes describes the connection between mother and child as forming a solid ground for "the narrative self (who I tell myself I am); contingency is linked to the sense of a coherent and unitary self. Both, too, may form a basis for the beginnings of the sense of an inner world" (Holmes, 2001, p. 69).

When considering the question of what happened in terms of an instinctive attachment behaviour, I noticed an interesting similarity between both attachment and mourning behaviours. Bowlby describes how the bereaved person yearns and searches for the lost loved figure as if they have been seized by the urge to find their lost loved one, which they're not always conscious of doing (Bowlby, 2005). Bowlby's description of the unconscious compulsive search for the lost loved one and incoherent attachment patterns again helps me link the incoherent narrative with the lack of sense of self. Therefore, the question around what happened could be a defensive thought process against searching for an integrated sense of self, because with that comes the knowledge of both shame and hate.

When secure attachment is missing, alongside having to live in the face of chronic severe trauma, then the only way to survive is to dissociate. As Putnam describes it, it is "the escape when there is no escape" (Bromberg, 1994, p. 520). Bromberg goes on to describe dissociation as a normal process and one that is necessary for normal healthy development. He says that it is not the same as fragmentation but could be a defence against it and says that everyone begins life with a multitude of self-states before they develop an integrated and coherent sense of self (Bromberg, 1994).

The DID learnt survival mechanism simultaneously however places the individual into a more isolated, vulnerable position. My experience has been that without the insight of an integrated adult mind, an alter can place the individual back into the hands of danger, either with the original perpetrator, or to re-enact the behaviour with other unsafe individuals. This causes the younger alters to believe that the abuse is still happening in the present.

Freud describes the compulsion to repeat the trauma in every relationship and situation within the patient's life (Freud, 1914). He describes the method for interpreting the repetitions within the transference until the memories are re-awakened and resistance overcome. When working with a DID client, however, there can sometimes be a great sense of urgency and pressure to determine whether what the client is reporting is in the present or due to powerful flashbacks. It can be incredibly hard for all concerned to know whether what is being presented is a real and current danger when the client presents covered in bruises and needle marks, and saying that they think they've been raped, but without any recollection of how they came to be where they were and in that state. The emotion and fear felt by the client is real and its extremely hard not to get drawn into the re-enactment and not to believe what you see before you. As far as the parts are concerned, regardless of how the bruises were obtained, they are reliving what happened in the present moment so the fear and the trauma is *as if* it was the original rape and they need the adult self to show them that they are safe and the danger is in the past, (if indeed it is) with the help of the therapist.

Fairbairn provides a helpful way of thinking about an 'internal saboteur' with object relations theory (Fairbairn, 1952/1994), which I will illustrate below with Carly*.

The child growing up within a dysfunctional environment needs to keep their objects good in order to survive. The internal saboteur's aggression "towards the libidinal ego is based on the latter's cathexis of the exciting object and its own cathexis of the rejecting object; and it is thus a reflection of the original ambivalence of the individual towards his libidinal objects" (Fairbairn, 1952/1994, p. 171). He describes how the child uses all her aggression to repress her libidinal needs using the internal saboteur and suggests that this is what Freud's theories of the super ego are based upon (Fairbairn, 1952/1994).

There continues to be doubt and controversy surrounding the subject of DID. Sinason has worked tirelessly and written extensively on the subject to raise awareness of the connection between trauma and attachment in individuals who have suffered severe chronic child abuse. Together with Silver, she writes, "Dissociation, like all psychiatric symptoms including psychosis, is part of the human condition" (Sinason & Silver, 2019, p. 420), adding that dissociation is a "response to terror. . . when the predator is breathing on one's neck" (Sinason & Silver, 2019, p. 420). My area of research is not a new idea, but I have chosen to focus particularly on something that I noticed and interested me in my own clients, and to make sense of it in terms of psychodynamic theories related to DID.

Main Argument

Barbara* and Jack* both gave their written consent for their stories to be used for this paper. I have not included personal details that would identify them and have changed their names and some details for confidentiality purposes. I did not approach Carly* due to it being some time after contact ended and not wanting to destabilise her, and have therefore kept information to a minimum. Barbara and Jack were both in psychodynamic psychotherapy and group therapy with me, as well as EMDR, whilst Carly attended our day programme while I was still a trainee psychotherapist.

An internal saboteur: Carly

Carly was introduced to child prostitution and SRA at a very early age. She split off her hate and terror into other personalities in order to carry on as if everything was normal. She internalised the bad object, as well as the parents who never saw what she was being exposed to so were unable to rescue. She chose to protect her parents and herself by adopting their apparent love for this other relative, despite the horrific abuse being inflicted upon her. Therefore her own feelings had to be disowned due to the unbearable conflict that would otherwise cause. In Fairbairn's words, she had to split both the parents and the abusive relative into two in order for the ego to deal with the internalisation of bad objects: "a *satisfying* ('good') object and an *unsatisfying* ('bad') object" (Fairbairn, 1994, p. 172) and then in order to control the bad objects, she had to internalise them to remove them from her external reality. This offers a sense of greater control over the internal objects. Each bad object can then be split into "*(a)* an exciting object, and *(b)* a rejecting object" (Fairbairn, 1994, p. 172)

To illustrate how an 'internal saboteur' (Fairbairn, 1952/1994) may function, this is how it manifested for Carly. There would be physical evidence of having been stamped on, burnt, and beaten, and of sexual violence. A large team of people, including the police, mental health team, Social Services, the GP, friends and family,

as well as ourselves, were all involved in investigating whether the alleged abuse was ongoing or if it was self-harming behaviour associated with flashbacks.

Eventually, through gaining the trust of Carly's many alters, I discovered that a teenage personality was working as a prostitute and inviting men to the house for sex on a regular basis. This young teenage alter did not have the ability to protect herself when she found herself caught up in sadomasochism and drugs but believed that this was what she had to do. The other younger personalities believed that they were still being abused by the original SRA group and were terrified by what was happening. The teenage prostitute personality appeared to be re-enacting the abuse in a way that felt as if she had some control and choice. She had awareness that it was hurting the rest of the system but took some form of pleasure in what she was doing whilst compelled to keep her activities secret, which was a repetition from the original threats to hurt or kill her pets or hurt mummy if she told anyone.

Freud (1896), writes about the survivor-turned-perpetrator older sibling, and Grand (1997) discusses the destruction of linkages between self-states in her paper on incest, dissociation and memory loss. She is writing about the relationship between the abused and the survivor/perpetrator, but I want to consider the internalisation of both abused and survivor/perpetrator within Carly. Her prostitute part continues to inflict abuse not only upon the other parts but also upon the host personality. She leaves her payment, wads of money, by the side of the bed for Carly to find, as if paying her for the use of the body. She has greater control over her internal objects as survivor-turned-perpetrator, while being the direct cause of perceived abuse for the rest of the system, and shame and horror for the host personality who keeps the piles of cash a secret from everyone involved.

It's not just the distressing details that are split off and un-known but multiple levels of conscious awareness are split across the various emotional states (Mollon, 2011). This means that the intensity of the emotion held by each alter is so powerfully single-minded, such as a pure, raw anger or intense sadness, that can feel unbearable to the client as they come into conscious awareness. Each alter only knows its own specific function or role, as with Carly (Bromberg, 1996).

The unrelenting trauma necessary to cause such severe dissociation was evident also in the lives of Jack and Barbara. Both grew up in abject poverty, acutely neglected and unloved, in an atmosphere of violence and cruelty. The only way to survive was to dissociate and create multiple personalities to hold what was happening to them so that they could continue to function. Sometimes there can be a vague awareness of each other (Steele, 2011), but such 'co-conscious' (Clarke & Finnegan, 2011) awareness isn't always the case.

Many DID clients have a sense of something that they may not be able to find words for, suggesting that the trauma was preverbal (Richardson, 2011). These vague snippets may appear in the form of flashbacks, driving the client to search for meaning whilst simultaneously pushing knowing away at every step forward and repeating the learnt pattern of dissociation. Sometimes the memories begin to surface in confusing flickers of scenes, or in the form of a body memory or other sensory flashback.

The internal world of the client will feel to be in a constant state of conflict (Hazell, 2000) when "[o]uter security [has been] purchased at the price of inner insecurity" (Fairbairn, 1994, p. 65). There is something of this conflict perfectly captured in the description of a returning retreat into dissociation; that safe unknowing

state (Hazell, 2000), existing alongside the longing for connection and an explanation: the drive to know and not-know, but more importantly, to survive.

Remembering, repeating, and working through: Barbara

Barbara was in her 40's, married, and with a young child when she came to see me with her husband. It was a year after she had experienced a violent assault by an adolescent in her workplace. Since then, she had been unable to return to work or leave the house. Neither could she wash or care for either herself or her child and would forget to eat, despite her husband leaving her prepared meals. She stayed in bed all day.

During our initial assessment she told me that she had no memory of her childhood before the age of 13 years old, which was when her parents split up and her father left. She was the youngest of three. There was little money for any of the essential basic necessities. Barbara was teased by her peers at school for being dirty and unkempt. Teachers questioned whether she was on drugs due to how thin and unhealthy she looked, rather than recognising neglect. She described her siblings as feral, with one temporarily taken away for a burglary. Her father had been in prison before she was born, before eventually leaving altogether for another woman with paranoid schizophrenia. There were frequent arguments and fights between the parents, as well as between the siblings. One was eventually diagnosed with paranoid schizophrenia herself, while another refuses to have any contact with the family, including his own children whom he put into care after his own partner left. Being abandoned by their father was clearly a significant trauma that would be repeated throughout life for each of them. This repeated in our work, particularly as a resistance to the uncomfortable feelings evoked in the transference (Freud, 1914), which was directly related to knowing and not-knowing.

Barbara wanted help for her diagnosed PTSD related to the assault but said that she did not want to talk about her childhood. She stated that she had never experienced any conscious switching between states, and there was no awareness of amnesic gaps in her present life. I didn't discuss DID with her and she later told me that she had never heard of it before. She agreed to EMDR for the treatment of her PTSD.

In one of our first sessions focusing on the details of the assault she experienced a sudden breakthrough image which frightened her. She described witnessing a young boy being violently kicked on the floor. She experienced a sense of shock and horror as the scene emerged. It felt too early in the work to consider this fragment psychodynamically with Barbara as we were very much in a gentle holding phase where I was establishing a safe environment. Instead, I explained that as images can be symbolic, we'd hold it for now until such time as we could make more sense of it. The principles of work with DID, as described by Mollon, is to assess and proceed cautiously. He repeats, "Maintain extreme caution" (Mollon, 2011, p. 120). I held this memory fragment in mind until such time as it made more sense and could be brought back.

It was however fairly near the outset of therapy when Barbara suddenly switched in the room with me. Amelia, aged 5 years old, switched in to tell me that she was very upset about having poo on her clothes and her mum and older siblings making fun of her. "Mummy says I'm disgusting," she said, clearly very upset about

not being able to do anything about it. She was still in nappies and being left in them, only to be laughed at for being dirty.

The following week Barbara reported that she had no memory of the previous week, demonstrating just how painful those thoughts and longings might be to own. She came to the session without having a shower, saying she felt hopeless and without any goal or motivation. She didn't care about herself, she said. Amelia switched in to say how much she longed to have a nice long soak in the bath, to have pink bubble bath, and her own little girl's toothbrush like Barbara's daughter. This revealed a part of her that she had had to dissociate that cared very much about being dirty and unkempt, as well as her longing to be cared for. Whilst Barbara was telling me she didn't care about herself, Amelia's distress over her lack of cleanliness proved that she did, but it had had to be repressed. This conflicting pattern between parts would reveal itself in several other situations.

In this moment Amelia revealed the internalised and split off longing for mother-daughter conversations about appropriate self-care, so needed by a little girl in order to facilitate the development of self-worth. By showing a compassionate interest in her, Barbara would hopefully develop a sense of compassion towards herself and her daughter that had been missing in her own childhood. It's important for the therapist to be able to 'stand in the spaces' until the client has the "capacity to make room at any given moment for subjective reality that is not readily containable by the self [s]he experiences as "me" at that moment" (Bromberg, 1996, p. 516). Together we talked through the meaning of Amelia's distress and her own lack of self-care and compassion. Barbara bought a child's toothbrush for Amelia showing how she was internalising a good object/mother in a split off way. She could care for Amelia but not for herself, but it was a step forwards.

It's essential to engage whichever part of the client is in the room in the moment, listening to the details of the story that each part brings (Bromberg, 1996). My experience has also shown how important it is to engage with the alter in an age-appropriate way. Filling the gaps left by an absent good object/mother enables a client, such as Barbara, to move towards taking an active part in life with an ability to experience the past, present and future for herself (Bromberg, 1996).

During our work I had the privilege of getting to know many other parts of Barbara, including a teenage protector called John, who maintained a degree of suspicion of me throughout our work.

When it became apparent that Barbara had DID, I felt that she would also benefit from group therapy to help her with relationships. When another client starved himself during my leave, she said that she couldn't imagine ever being affected like that as she had learnt not to trust anyone because "you always get hurt". I replied that "It must be hard when you trust somebody and then they leave," which led to her becoming extremely distressed and tearful. After a pause, she talked about how much she longed for her father to say he loved her and to hug her. She described feeling desperately needy, childlike, and tearful whenever she saw him, and as if something was missing inside. She had no similar longings towards her mother with whom she had severed contact, reenacting her father's departure in her own controlled way. She blamed her emotionally unstable mother for pushing him away and for the abject misery and deeper neglect they were plunged into without him, despite the fact that dad had spent time in prison earlier on in the marriage.

Despite insisting that she didn't care about me being away, she emailed me while I was on holiday to say that she urgently needed help as she was suicidal. I had to arrange for her to see a colleague in my absence. When I was available, perhaps she experienced me as the mother she didn't care about while my absence evoked the longing for her father. This feels a bit too simplistic and Balint's (1992) basic fault theory helps make better sense of it in terms of a re-awakening of something that was missing that caused a return to her basic fault position. I feel instead that this cry for help was a consequence of my absence evoking the unconscious feelings of emptiness from not having any of her basic needs met.

Barbara seemed to defend against her claims not to care by simultaneously feeling the need to defend or idolise me in group sessions when other clients expressed anger towards me. She seemed unable to work with transference interpretations as she had limited ego strength and so we couldn't look at what she might be defending against. Therapy needed to be supportive, as described by Cookson (2011). We were in a 'pre-therapy' phase, which was about establishing a safe place for relationship and communication to take place. Within this space the opposing sides of herself could be heard and "the dissociated ghosts of 'not-me' [could be] persuaded, little-by-little, to cease their haunting" (Chefetz & Bromberg, 2012, p. 166).

The rejection of mother alongside the longed-for father, both of whom caused fear, physical and emotional neglect and abandonment, had been internalised and re-enacted in how Barbara repeated the father's rejection of her mother, whilst simultaneously repeating her mother's anger and longing for her husband to return. Barbara had dissociated the longing for a mother to love and care for her, and this was held within by one of many alters. In fact, Barbara often complained that she had no feelings at all. This disorganised pattern of relating predisposes a child to dissociation. Dissociation is a development pattern of coping with trauma, "the escape when there is no escape" (Puttman, 1992, p. 104).

I have witnessed several clients re-enact birth trauma with EMDR, describing the colours and physical sensations as they pass down the birth canal. They relive it from the perspective of the baby who doesn't know what is happening, and I include it as an example of demonstrating how every memory is retained within the central nervous system, whether conscious or unconscious. We can be confident therefore that there will also be the memory of what it felt like to feel safe and securely attached while in the intrauterine state (Hazell, 2000). We can compare this with how an alter perceives something. For example, when the client is reliving their birth, they do so without the insight they have as an adult. The alter continues to relive a traumatic moment as if it's happening *now* without the insight of the adult ANP. It is my belief therefore that this isn't a delusion but a memory fragment.

The multiple parts of Barbara were repeating the loss of what never was, alongside the re-enactments from any perceived threat. Balint (1992) describes how the constant repetition takes place in present life; the search for something that can't ever meet the needs of the individual because it was needed in the past. Barbara had split off all her needs which resulted in a state of denial. There was no desire to find what was missing, which only emerged in the transference or from other parts of herself.

She seemed to recover the memories of what happened prior to the age of 13 years old easily with the help of EMDR. This process seemed much like the early hypnosis methods employed by Janet and Breuer to break through the normal defences, except the client remains in a state of conscious awareness.

Two years into her therapy, when I thought we had both developed a good understanding of her childhood, Barbara announced that she didn't know what had actually happened to cause her DID. With further questioning, I realised she hadn't retained anything of what had surfaced within our sessions, EMDR or otherwise. While she had clearly been consciously aware in the sessions, in that moment I became acutely aware of the developmental process that had been learnt at a young age to survive. She had developed a keen interest in knowing but was then immediately repressing everything that surfaced, showing she was completely unable to hold onto her traumatic narrative. Studies have shown that growing up in these types of environments have been associated with deficits in the ability to think, feel, reflect, and communicate with others, which all has an impact on memory (Schwartz, 2015). Likewise, "[d]issociation and failure to achieve an integrated sense of self inhibits the ability to think about the mental states of oneself and others in a coherent way; this is known as reflective function" (McQueen, Itzen, Kennedy, Sinason & Maxted, 2018, p. 17).

Janet had noticed a difference in the cohesiveness of the psyche, which he thought resulted from "exhaustion, altered states of consciousness, or the pressure of violent affects that accompany traumatic experiences" (Bemporad, 1989, p. 628). He described a narrowing that allows "stimuli to bypass consciousness and register in split-off subconscious layers of the mind" (Bemporad, 1989, p. 629) with the unconscious layers becoming "independent, dissociated from consciousness, and tak[ing] on an existence of their own" (Bemporad, 1989, p. 629). He described these different layers as fixed ideas existing separately from the host personality, and as they grow in strength in their separateness and individual identity, weakening the host personality, and causing further dissociation. Interestingly, Janet wrote in his autobiographical sketch that *"thought is inner language, belief becomes a special combination of language and action; memory is above all a system of recounting; emotions are regulators of action, reactions of the individual to his own actions"* (Bemporad, 1989, p. 632). His treatment centred around the deep relationship with the patient, using hypnosis to understand what had happened, and then talking through the narrative to eventually reduce the associated trauma.

Going forwards, I would check what she remembered from the previous week in each session. She not only began to remember but she also began to seek corroboration of events from some of her siblings, and to discuss our sessions with her husband. In doing this together, it showed her that I shared an interest in her story when nobody had shown an interest in her as a child. She was amazed when she discovered that her siblings provided more detail and context. Interestingly, her schizophrenic sister had a very good memory of what had happened.

We had been making progress with remembering when Barbara told me that she was afraid to walk past an internal door to her garage to use a downstairs toilet. She believed that the teenager who had assaulted her lived in her garage. She looked ashamed, as if she knew it wasn't true, but her fear meant that she couldn't go past

the garage door to the toilet in case he saw her through the window. She also said that she was afraid to flush the toilet in case it drowned out her screams.

The timing of her telling me this as she was beginning to hold onto her memories was fascinating. I suggested that maybe the garage represented all the things she wanted to lock away in the dark again, and that maybe she was frightened she'd be overwhelmed by opening the door. There was a resistance to this interpretation, perhaps because it meant acknowledging the relationship within our work together, but it nevertheless led to the uncovering and telling of another memory. Freud describes how the therapist "uncovers the resistances which are unknown to the patient; when these have been got the better of, the patient often relates the forgotten situations and connections without any difficulty" (Freud, 1914, p. 147).

Barbara remembered her childhood fear of a monster that lived in the toilet. She had locked herself in the toilet to hide from her brother, but he told her that a monster would get her in there. In a state of terror, she pleaded with him not to hurt her if she came out. This he promised, but then flushed her head down the toilet, rubbed the toilet brush all over head, and threatened to break her doll if she told.

This impossible dilemma demonstrates the internal and external conflict from which she couldn't escape. The teenager in the garage represented something of this conflict and I believe this memory surfaced to let me know how terrified her system was of opening the door to the perceived 'monster'. The memory was processed successfully with EMDR and in her rescripting of it, as in Janet's substitution, she imagined a bear on guard at the garage door. She could then walk past the garage door and use the toilet without fear. The bear seemed to represent her own internal gatekeeper which enabled her to function similarly with the frightening objects behind a door.

We explored the meaning of the boy in the garage, of whom she remained afraid for a while. A year later she was able to say he was "just a boy that was hurting and scared too." She said that she needed to let him go, as if she was the one keeping him captive in the garage, rather than him being a threat to her. I believe the boy in the garage was not just symbolic of the teenager who assaulted her, but also the brother who had bullied her mercilessly during childhood, and the trapped parts within herself. I wondered if this was not just about being able to retain a narrative, but that she was ready to integrate some of the parts of herself.

It was around this time that Barbara integrated the first part, a baby boy, which was an incredibly moving experience. Mollon describes integration similarly, "like the joyful and tearful reunion of long lost friends or relatives" (Mollon, 1996, p. 155). My experience has been that when the client and the parts are ready, this can be facilitated by an internal holding hands or embracing one another as they blend into one (Mollon, 1996). Barbara imagined holding the baby and caring for him. She imagined cleaning him and putting him in a clean nappy, clean clothes, and giving him a bottle. The baby settled to sleep in her arms, gradually blending into Barbara as she soothed him.

From here, Barbara developed a compassionate dialogue with the parts of herself, one day announcing, "It's nice being together. It's safer being together." Barbara was able to integrate more parts, which led to her returning to a fuller more normal life. She returned to full-time work, which she'd assumed would be impossible. As she developed a coherent sense of her life, she also maintained that it didn't feel

like her story. I believe this is typical when there are still split off parts of the self holding memory and affect.

Over the last two years of our work together, we moved to therapy online due to the pandemic. Barbara had known for almost a year that I was going to be moving out of the area and so our regular work in person would never resume but would continue online. She seemed accepting of this but then an email arrived from her a few days after I had moved while I was still on leave. She wrote to let me know that she wasn't going to be returning to therapy because "a nice local lady was going to help take all her pain away"! This lady was not a psychotherapist but a blind massage therapist.

The tone of her words were cold and completely lacking any emotional connection, and without expressing any gratitude towards all the progress made. This was a schizoid state and her ruthlessness concealed how enormously needy she was — an "exaggerated hunger, which makes all relationships – including the potentially therapeutic relationship – simultaneously craved for and feared" (Hazell, 2000, p. 35).

So here was a final grand piece of acting out, as described by Freud: "The patient brings out of the armoury of the past the weapons with which he defends himself against the progress of the treatment— weapons which we must wrest from him one by one" (Freud, 1914, p. 151). He talks about the necessity of treating the compulsion to repeat as "a present-day force . . . [whilst simultaneously] tracing it back to the past" (Freud, 1914, pp. 151-152).

Barbara had retained a protector part called John who believed he was essential to her system's survival. He was always on alert and seemed to switch in whenever he perceived threat. John feared that I wanted to "get rid of him like the others" and I was suspicious that he was now sabotaging the therapy because he was afraid of integration. I was also aware of the comment at the outset of therapy, that she never got attached to anybody so as not to get hurt.

We were at another repetition of this conflict. Barbara was showing me how much she had grown attached to me and how my moving away had proved too much. Now another 'local lady' would take her pain away, but she had picked a blind massage therapist who wouldn't be able to see the parts of her. She was re-enacting the loss of her father through my move by adopting the position of choosing to leave instead of being left: a shift from victim to perpetrator. I think there is further significance in the blind lady if we consider the various internal contradictions. This is perhaps more about Barbara not wanting to see how my move is making her feel, whilst letting me know that I'm unable to see how painful this is for her. She needs somebody else to take away the pain that I'm now inflicting upon her, which seems as if it was too much for her to think about. As Freud says, "[t]he greater the resistance, the more extensively will acting out (repetition) replace remembering" (Freud, 1914, p. 151).

When she ended therapy, there was an impending court case against her place of work as Barbara had been knocked unconscious and left in a pool of blood which had resulted in some permanent physical symptoms. I had often wondered whether John had taken over from Barbara and provoked the teenager during that highly volatile situation, as this would not have felt dissimilar to the environment she grew up in. It was in the ambulance when she was in a semi-conscious state that Barbara was first observed talking in a regressed child-like voice.

Barbara created a male alter who was older than her siblings in order to fight back and John is likely to have been frightened and enraged by the teenager. Looking

at the behaviour and thinking of an alter in isolation I can see how some would come to the conclusion that DID is a psychosis. An alter like John is re-enacting the original trauma in the present, sometimes in entirely non-threatening situations, for example, reacting to any passing teenager in a hoodie. This may appear delusional. If the alters are fixed in time to when the original trauma took place, as Janet (2019) believed, alongside the knowledge that paralysing fear causes dissociation, (Sinason & Silver, 2019), then isn't this different to psychosis? If the alter feels heard and can learn to trust the therapist, then it's possible to orientate them to the present and show them that the danger is now past. In the same way as Janet, Breuer and Freud found, when the source of the trauma is identified and talked through, the symptoms disappear. In the case of DID, they will either integrate or settle down, unlike psychosis.

Perpetrator alters however "tend to have a greater narcissistic investment in separateness . . . and maintain a deeper commitment to perpetrator protection and perpetrator ideology" (Schwartz, 2015, p. 3). There was no doubt John had helped Barbara survive as he was used to defending her against her siblings. These parts play an important protective role, regardless of how they may initially seem (Schwartz, 2015).

Mollon (2001) writes about the similarities between the voices in schizophrenia and those of the alters in DID. Both are meant to stay secret due to the perceived risks to the system. He describes "the DID system [a]s both psychotic (in its avoidance of reality) and narcissistic (in its avoidance of relations with external others)" (Mollon, 2011, p. 112). This is an interesting perspective when you consider how the multiple self-states all relate differently and are determined to maintain separateness to protect the system, while the ANP functioning part of the client is usually not psychotic and often relates well in my experience. Whilst they're unable to hold themselves or their past together in an integrated manner, I remain unconvinced of DID as a form of psychosis. It's interesting to compare Barbara's internal world with that of her schizophrenic sister. Her delusions centre around elaborate methods to hide from those she believes are spying on her and out to kill her. She is unable to function normally day to day. Barbara's internal world consists of multiple self-states that are stuck in the past trauma (Hazell, 2000), intent on protecting her from seeing the details of that trauma so that she can function normally day to day. The delusion in DID is that the alters remain convinced that they are still living in the past at the time of the trauma. The work is in helping each part to feel safe enough in the room to begin to tell their story, as with any other client.

Fonagy (2011) writes that "[t]he fundamental need of every infant is to find his mind, his intentional state, in the mind of the object" (Fonagy, 2011, p. 28) through which they experience containment. The complete absence of object relating upon the psychic unity is devastating (Hazell, 2000). Despite the progress made there were deep attachment wounds that Barbara was less able to know than the trauma, in keeping with both Winnicott (1974) and Balint (1992).

Fear of breakdown: Jack

Jack was a 50-year-old single man, child number 5 of 6 children, born to Irish Catholic parents. Despite having an understanding of psychodynamic thinking from previous therapy, he had made no progress. He had mentioned 'the children' within him repeatedly but this, sadly, had been ignored. Sinason describes this as a "psychically

annihilating secondary trauma" (Sinason, 2011, p. 8) for the patient who learns not to speak of the parts of themselves.

Jack's father had been an extremely violent alcoholic, and his mother had been admitted to a psychiatric hospital for two years when he about 9 years old. He did not describe violence towards his mother but extreme violence towards himself and his siblings. There was no money left for food, school dinners, clothes, shoes, birthdays or Christmases after his father spent it on drink. He expressed intense hatred for his father, and contempt for his mother for not defending them. The siblings regularly betrayed each other in order to save themselves. He suffered his first panic attack as he drove over a flyover having just disposed of some of his late father's possessions. From then on he developed a phobia of crossing bridges.

Jack hadn't worked for many years because he felt that by being on benefits the government had to pay for the poverty he grew up in and the fact that nobody noticed the violence being inflicted upon him. The problem with this was that his life offered no satisfaction and he remained in debt and depressed, trapped in his need for retribution at having been failed and not able to get any of his physical and emotional needs met.

Jack had a son from a brief affair and wanted to be involved in bringing him up. He stayed for weekends throughout his childhood, but Jack lived in fear of hurting or even killing him despite there being no evidence of him being violent.

Jack described an occasion when his father chased him from the garden upstairs to his bedroom. Jack climbed up onto his bedroom windowsill and sat there poised to jump as his father entered. Under normal circumstances his father would have beaten him senseless but, on this occasion, Jack told his father that if he came any closer he would jump out the window and then everybody would know what he was like. He was amazed when his father retreated. Jack had placed himself in the dilemma of jumping to his potential death or serious injury in preference to another beating.

I linked his phobia of bridges to this moment with the frightened child parts terrified that an angry teenage part would jump and kill them. Although we thought about this and processed the fear with EMDR, his phobia remained unchanged. My linking here was incorrect, although there was a connection with that incident. Winnicott (1974), described how phobias prevented dependence from coming easily into the transference. He explained how "dependence becomes a main feature, and then the analyst's mistakes and failures become direct causes of localized phobias and so of the outbreak of fear of breakdown" (Winnicott, 1974, p. 103). He describes the fear as "a breakdown of the establishment of the unit self" (p. 103). Winnicott's theory was that the fear of a future breakdown was a breakdown that had already happened but couldn't be remembered. Janet also described phobias as one of the symptoms of a fragmented psyche as a result of violence and trauma. He described phobia as "the expression of past horrors that come to light when the individual's everyday personality loses its capacity to suppress or deny them" (Bemporad, 1989, p. 636).

I had linked Jack's phobia of bridges to the time he threatened to jump, but letting go of his father's belongings may have been symbolic for the letting go of himself — his own psychic death years earlier, which feels more in line with Janet's views of the disintegration of the psyche. He was identifying with the internalised voice of his father, which protected him from fear (Sinason, 2011), whilst maintaining the internal conflict as the alters were now afraid of Jack. Disposing of his father's

belongings must have felt like impending doom for some alters, alongside the satisfaction it gave others. This powerful and risky throwing away was not only linked to the losing of himself to dissociation, but also the 'loss' of everything he never had. Missing the connection to his dependence on therapy and myself would later become a feature set to play out at the end.

Jack lived with this constant dichotomy of an internal terror and angry aggressor. Mollon describes how "[t]he inner child and the adult then are at war with one another, often each attempting to annihilate the other, each feeling that the other threatens their own existence" (Mollon, 1996, p. 10). Jack remained stuck from the point his father died, as the child alters similarly remained stuck. This was particularly so in not being able to think about his mother and why she might have been unable to defend them, and his longing for her. Jack longed to be heard and loved, whilst having a hatred and distrust of women — an oscillation "between the struggle for independence and the terrifying wish for extreme closeness and fantasised union" (Fonagy, 2011, p. 28) which resulted in a stuck-ness and depression. I tried to find a way in through his support of the charity so that he could experience and internalise a good object.

Thus, I encouraged Jack to take on projects at the charity. He became Client Representative to the Steering Group as well as helping with the setting up and serving at our conferences. By the time I gave him notice of my house move we had been working online for two years but his behaviour changed abruptly. He gave me notice of ending altogether on the day I confirmed my leaving date. Week after week afterwards he complained of feeling physically unwell and getting increasingly more angry. He spoke about his son in a way I'd never heard before, saying that if he couldn't accept him the way he was, "he should fuck off and leave him alone". Perhaps this was less about his son and more about me. He forgot to attend two sessions, which after 9 years of therapy was unusual, and was furious when I charged him for them. The fees became symbolic for what I was taking from him.

Instead of caring for the frightened child parts he said that the little boy should "shut the fuck up". Trying to focus on helping him with a more compassionate internal mindset during this time served only to push him into a more irrational and delusional pattern of thinking. Jack had not had a faith when he started therapy but over time he felt drawn to attend a local church that he knew was attended by a couple he liked from our steering group. Church became a safe haven for him on a Sunday, where he got involved in helping with Sunday School and the weekly toddler groups, interestingly. Whilst he was unable to care for the child parts of himself, he loved helping with the children's work at the church, although regularly complained about some of the parents. If I focused on his life at church in the therapy he was rational and enthusiastic, so I decided to focus on this rational aspect of his life with the aim of trying to strengthen this during our remaining time together.

He visited his mother during those final weeks in an attempt to discover her feelings about the violence towards him at the hands of his father before she sank further into dementia. He recorded their conversation and then surprised me by sending it to me as 'evidence'. I noticed that the recording didn't mention the violence or terror at the hands of his father, despite what he'd told me of their conversation. What was clear was that this was an elderly woman, still in complete denial, who only spoke fondly of her husband. Jack seemed incapable of appreciating what it might have been like for a mother to witness her children being so violently abused. The

visit served only to confirm that he never wanted to see her again. I think this was how he was able to tell me he never wanted to see me again for everything I was taking from him, and what I was in denial of and incapable of seeing at that point.

There was a sense of something missing from the conversation with his mother despite his 'evidence'. This needed interpreting for Jack and yet was missed due to the lack of time before he ended, and therefore I noted a repetition of another failing for him. I think the missing details of the conversation was more about the missing conversations that were never going to happen between us, and I wished I'd had time to explore this. His was running out of time with his mother who was sinking further into dementia, as he was similarly running out of time with me. He could have stayed working on-line with me but in sabotaging his own help, he was communicating something of immense importance to me.

Jack's anger needed interpreting during those final weeks with the obvious, "It sounds as if you're wanting to tell me to fuck off," instead of little Jack, or his son, or his mother. My house move left Jack with the emptiness he'd always feared. He couldn't cope with working online because he was losing so much more than that. This served as a powerful repetition of the loss of everything that had never been – something that had been painfully reinforced when his mother was admitted to hospital for two years. This was not the moment at which Jack experienced a breakdown of himself for that death had already happened. It had however been a repetition of that experience.

Jack ended therapy before I'd even moved. Had he stayed and allowed himself to work through the emptiness he feared, we could have begun to think of it as an emptiness that belonged to the past. If he could have tolerated it, we could then have continued working on filling him up (Winnicott, 1974). Again, it links to something missing that's compulsively searched for, but never attained (Balint, 1992).

Jack had a narrative for what had happened to him. He knew all the grisly details and yet there was still something missing. His constant internal battles continued, as did his phobias. What he was defending against was the emptiness caused by the lack of any "facilitating environment" (Winnicott, 1974, pp. 103).

I took Jack to supervision regularly over his 9 years of therapy, and I brought him again during the writing of this paper. I was struck again by the heart-breaking details of his childhood, particularly by the impact of how my own failings had colluded with his story. In doing so much to help rebuild his damaged and fragile ego, any ending was likely to be a repetition of the abandonment he experienced by his mother. He had had a different experience during his time in therapy, which led to the discovery of a faith and new church community. Whilst he maintains a fragmented sense of self, to find a faith is to find hope where there was none, and maybe his work with the Sunday School and toddler groups were showing how he might have capacity to one day help the child alters within himself.

EMDR and DID

Whilst this is a psychodynamic study, it feels important to briefly comment on the role of EMDR when working with DID. EMDR seems to facilitate the ability to bypass defences that prevent the client from accessing thoughts, emotions, memories, and experiences that are repressed and inaccessible and this can work well for some with DID, although others will need more resourcing. When bilateral stimulation is employed the client can begin to talk about these thoughts and experiences often with

minimal distress. Unlike hypnosis, the client retains conscious awareness of what happens, at least within the session. In the case of Anna O, Breuer described "every one of the spontaneous products of her imagination and every event which had been assimilated by the pathological part of her mind persisted as a psychical stimulus until it had been narrated in her hypnosis, after which it completely ceased to operate" (Freud, 1893, p. 32). Without conscious awareness of the narrative, and without the ability to retain that narrative, even with EMDR as in the case of DID clients, its hard to understand how hypnosis helped with this process. As I described with Barbara, the narrative that comes back with a DID client, regardless of whether they are in control or in a co-conscious state and listening in to what is said, can be immediately repressed again.

EMDR has been very helpful for my work with DID, because as Knipe (2019) describes it can very quickly "transform the disturbing feelings that are held within dysfunctionally stored traumatic memories" (Knipe, 2019, p. 3). Knipe also acknowledges the similarity between the symptoms we now recognise as part of C-PTSD and DID as those described by Janet. Knipe defines defences as "any mental action or behavioural action that has the *function of blocking the emergence of posttraumatic disturbance,* that is, preventing intrusion *from* traumatized parts of self into the "normal" part or parts of self" (Knipe, 2019, p. 12).

We know that all external stimuli enters the amygdala first, where under normal circumstances it is processed and passes over into the hippocampus. Unlike the amygdala, the hippocampus stores information in the past, and some memories will fade, others are forgotten. The amygdala stores information in the present so when it is overwhelmed with trauma that it cant process it causes flashbacks which are experienced in the present as if happening again (Shapiro, 2018). The aim of EMDR is not to recover memories specifically, but to aid in the processing of trauma and other struggles encountered in life.

I noticed in three of my clients in whom there appeared no obvious switching between parts but, during EMDR, recalled memories surrounding ritual abuse with graphic clarity, without any apparent dissociation during the process. I couldn't understand how they could have endured such horrific abuse and not be DID. With EMDR I found they were able to recall with great detail what had happened and who was involved, although some of the details may be blurred and merged with others. Despite the clarity, it may be just as hard to believe when it doesn't fit the narrative they have created for themselves.

Initially I questioned how it was possible for some to endure such abuse and not have fragmented whilst others did. I tried to look for an explanation that would make sense of this phenomenon but there wasn't anything I could find. There appeared to be no explanation for why when using EMDR all the details would surface in great detail and even more, be retained when those with obvious parts did not remember like this. There was no clear explanation as to why one would be switching and recall only fragments while the others didn't and remembered in full detail once the process was initiated with EMDR. I discussed this in a supervision session with Dr Alison Miller who suggested that it is impossible for anybody who experiences such trauma to not have DID. Her experience was that in such severe trauma there would be several parts functioning at the front who could mimic the host personality and remain hidden. Why they would choose to disclose the information suddenly with such ease and detail remains unclear. The recall did not appear to be by a part 'dumping'

the information, as some may describe, in order to frighten the host personality or because they'd had enough of holding it themselves. The part engaged in the EMDR session and the information followed a natural pattern of recall as with any other person without DID, without however revealing their existence.

The benefits of EMDR for those with DID is the possibility of more easily being able to develop a compassionate internal dialogue with the parts of themselves and move towards integration much more quickly than without EMDR as the traumas are worked through. If integration isn't something that the system is ready for or wants, then developing an internal compassionate mindset where the parts can work together as a team is the next best thing. Helping the adult host personality to love and take care of their parts within an EMDR session can help the whole system to feel that at last they can be heard and helped towards beginning to trust the therapist and host personality to take care of them. With rescripting work carried out within an EMDR session this greatly speeds up the possibility of integration as the host personality is ready to hold and know the narrative of what has happened to them.

Conclusion

Whilst I resonate with a lot of Janet's work this isn't sufficient to understand why one person remembers traumatic experiences and another does not. Whilst in the early years Freud's ideas were in fact very similar to Janet's with the difference lying in their use of language to often describe the same ideas, their thinking around repression and impulses was however where they disagreed. Freud believed that everyone exists in conflict with themselves, repressing unconscious wishes and impulses which never the less shapes actions and behaviours, which is of course true. Janet however described repressed content within different layers of consciousness and splitting of the psyche being as a result of trauma, with the outcome being one of illness (Bemporad, 1989).

The narrative behind what happened to the client is so much a part of the developing sense of self that the two are inseparable, and yet a separation has occurred. Whilst they continue to strongly defend against the trauma of knowing, there remains an ongoing sense of loss of self with agonising incoherence spread across multiple alters. These are not psychotic or repressed feelings and impulses, but the fragmented terrified experiences held by parts of the self who are pushing against knowing, whilst at the same time desperate to be known. As they come closer to conscious awareness they can push further into fragmentation like two north poles on a magnet coming into contact. When they can integrate the true narrative of their lives into who they are, then a coherent sense of self emerges.

The unconscious was previously seen as holding repressed and unwanted details, but a contemporary view is of a more "fluid temporal medium of not-knowing, of never-been-known, of not being real. Thus, whole selves disappear from "consciousness" and are like ghosts on a stage, enacting their presence, hoping to be heard and to be *not-heard* " (Grand, 1997, p. 470).

For those who have experienced some of the worst childhood traumas imaginable, they can get preoccupied with trying to remember the details of what happened as a defence to the feeling of being utterly unloved, disgusting, and forgotten by everyone. If they allow hope into conscious awareness, then they have to have a desire for life and to care about themselves and others, which they often don't. The absence of a 'facilitating environment' leads to a death of self and the

annihilation of hope (Winnicott, 1974). This then sets to repeat throughout life as a basic fault that needs to be discovered through the interpretation of those perceived failures in the present in the transference (Balint, 1992), alongside being heard and seen at last.

Fairbairn believed that the repressed content was "neither intolerably guilty impulses nor intolerably unpleasant memories, but intolerably bad internalized objects" (Fairbairn, 1952, p. 62). He goes on to consider that the repressed internalised bad objects are related to guilt over the unexpected experience of sexual gratification, but that this cannot be the whole story. In the case of the three clients described above who appeared not to be DID, all were sexually, emotionally, and physically abused by various family members and others from birth. Like all the clients described in this paper none had any sense of self-worth. Whether due to feelings of unwanted sexual pleasure or of relief when siblings were being hurt instead of themselves, or feelings of intense hatred and rage, the experiences were not just intolerable but caused them to feel enormous shame and guilt which led to the belief that they were intolerably bad (Fairbairn, 1952). All of the clients described in this paper experienced an equivalent level of trauma which included feeling trapped and extreme terror.

There was one difference however that I noticed between them and that was in their defence of the parents. The DID clients who defended their parents, believing them to be entirely innocent and that they had no idea what had happened to them, found it the hardest to recall anything. They also believed that the parents needed to be protected from knowing the full details in case they couldn't cope. Each of the clients who eventually remembered their stories had a difficult relationship with their parents and were able to hold them responsible for what had happened to them, and feel anger. Like Freud, I have otherwise found nothing to explain why one comes to know and another who wants to know, continues to defend against it and remains unknowing. I have used the stories of both Barbara and Jack specifically because having DID doesn't necessarily mean a history of CSA.

I think it is important to add here, that this doesn't mean that the parents were necessarily involved as perpetrators, but maybe more in the fact that there is something in that they didn't/couldn't/wouldn't see what was happening and therefore rendered themselves unable to rescue their children. For some reason they too appear not to know, which maybe leaves the client also unable to know. This poses the question as to why these parents did not know and whether they were also dissociative. If the parents exist in a state of unknowing and they together hold something of a shared experience does that in some way effect the outcome of remembering? Is there some form of attachment in the shared unknowing of such unbearable trauma?

When flashbacks and parts begin to break through into conscious awareness as a result of defences beginning to break down which "are proving inadequate to safeguard [them] against anxiety over a threatened release of repressed objects" (Fairbairn, 1952, p. 75) does the return of the repressed bad object get even more fiercely defended against? It seems that the ability to acknowledge that the parents abused or failed them, either by their inability to rescue or through actual involvement, is the most difficult part of the memory to come back for the client. They may know that they were sexually abused, and even details of ritual abuse that took place, many

years before they discover that the parents' actions may have facilitated what happened in some way or other.

Another DID client of mine from one of my groups presented me with the gift of a dream after years of struggling with negative transference with me and not-knowing what had happened to her. She described being in a boat with me, along with a group of other people in the dream, perhaps symbolic for her own parts rather than just the other group members. When she woke up, she described a sense of acceptance towards me, which felt like a positive internal shift. Over the preceding month she had finally begun to remember sexual abuse at the hands of her father with my colleague. She sent me an image of a hand reaching out to hold onto an ethereal mist (Fig. 1, Coffeemill, 2023). She described the mist as memories she can't quite put her finger on, and her vain attempt to hold onto something. To me, this image describes not only the futile attempt to recall her own narrative, but also the inability to know the things that didn't happen that should have happened.

So, how do we help these clients to know when they do all they can to resist knowing? Opportunities will arise in the therapeutic relationship for the dissociative experience to repeat the trauma, where it can become known and validated (Grotstein, 1992). I had an opportunity through my house move which could have been incredibly instrumental but instead there was a collusion. Both Barbara and Jack re-enacted and projected their desperate loss and sense of being failed, which I felt as something missing in my interventions. Their decision to leave gave them a sense of control and a reversal of the victim/perpetrator role, but this was a defence against their basic fault position. They left me with a sense of enormous sadness which I held for them, knowing how unbearable it was for them to know for themselves. It suggests however that our relationship had been significant and that they know somewhere within them that I had indeed stood in the spaces with them.

Psychotherapy with a DID client requires gentle containment and caregiving, communicating in an age-appropriate way to every part of the system (de Zulueta, 2011). Some of those parts hold disgust and fear that none of the other parts want to see, and the therapist needs to contain her own disgust and fear at what she hears. If the therapist can contain the hatred, horror, and pain then maybe the client can begin to bear the parts of herself and move towards metabolising their story until it can be received back (Carter, 2000). This caregiving relationship is internalised and used to form a secure internal attachment relationship (Richardson, 2011).

Hazell states that "the greatest abuse a person could therefore suffer would be the absence of relatedness" (Hazell, 2000, p. 33). Jack eventually allowed himself a small window on a Sunday within which to be with others and enjoy a rational state of mind at church. Barbara, on the other hand, moved towards a more coherent sense of self based upon acceptance and an internalised sense of self-compassion.

Despite their differences, the way they both ended therapy demonstrated the intensity of their neediness whilst also fiercely detaching themselves from it in order to prevent themselves from being hurt (Hazell, 2000).

If the therapist can bear to know, then the DID client can develop the foundation upon which they also can allow themselves to not just want to know, but to stay with knowing. To know is to accept themselves and make peace with every part of who they are and what was lost. This might be possible if they can receive back and metabolise acceptance and containment from the therapist, alongside the work of remembering in the form of transference interpretations and the discovery

and working through of the original trauma. Finally, as Chefetz suggests, "[w]e must become coherent in Relation, or we are not truly human" (Chefetz & Bromberg, 2012, p. 174)

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Fig. 1

Coffeemill. (2023, March 28). [Graceful female hand from a smoke on a black background.] *Shutterstock.* https://www.shutterstock.com/image-photo/graceful-female-hand-smoke-on-black-98997203