WORKING WITH DISSOCIATIVE IDENTITY DISORDER IN STAVANGER, NORWAY

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ABSTRACT

The article gives a short review of how knowledge and competence on dissociative disorders have developed in Stavanger, Norway. The main part of the article describes two patients with dissociative disorders. The first of these cases describes a middle-aged female patient with a long psychiatric history with different psychiatric diagnoses. She was the first among our patients to get the MPD diagnosis in 1992. The other case presents a young man diagnosed with DDNOS during his first stay in the psychiatric department in 1993. The diagnosis later on was changed to MPD. Their treatments within the Norwegian mental health system are illustrated.

INTRODUCTION

Interest in the role of trauma in psychopathology has grown in Norway since the 1980s. Well-known psychiatrists have, for many years, researched the symptoms found in the concentration camps in the second world war, and described the KZ (concentration camp) syndrome (Eitinger, 1964). The Alexander Kielland disaster in 1980, in which an oil-rig that housed many oil workers overturned, killing over 100 people, also alerted Norwegian psychiatrists and psychologists to the importance of research in traumatology. Finally, the extent and importance of childhood trauma and incest became more widely known in the 1980s. In spite of this, nothing was written about dissociative disorders in the Norwegian professional medical and psychological journals before the 1990s, although the *DSM-III* (American Psychiatric Association, 1980), which described them in detail, was widely used in Norway over this period of time.

A group of clinicians at the psychiatric hospital in the County of Rogaland (RPS), which is situated in Stavanger, were intrigued by inpatients diagnosed as psychotic or schizophrenic who did not present typical clinical symptoms and who did not respond to antipsychotic medication. By searching the literature and databases, important and clarifying articles were found, suggesting the possibility that some of these patients might be dissociative. Specialists from Holland (Onno van der Hart, Ph.D., Suzette Boon, Ph.D., and Nel Draijer, Ph.D.) and the United States (Richard Loewenstein, M.D., Bessel Van Der Kolk, M.D., and Glen Gabbard, M.D.) were contacted. Through participation in ISSD conferences, their knowledge and understanding of traumatized patients grew.

When the Stavanger group published their first article (Boe, Knudsen, & Haslerud, 1993) in the *Norwegian Medical Journal* on "Multiple personality, also a Norwegian phenomenon?" the journal's editor regarded this as very controversial and added a critical commentary in which it was claimed that multiple personality disorder (MPD) was iatrogenic and that the MPD diagnosis was superfluous (Goetestam, 1993).

The Dissociative Experiences Scale (DES) of Bernstein and Putnam (1986) was translated into Swedish in 1992 by Ulla Karilampi, then a Swedish student of psychology, and into Norwegian in 1993 by Tor Boe, Jan Haslerud, and Helge Knudsen. The Structured Clinical Interview for the Diagnosis of *DSM-IV* Dissociative Disorders SCID-D, devised by Marlene Steinberg, M.D. (Steinberg, Rounsaville, & Cicchetti, 1990), was translated into Norwegian by the Stavanger group, and used in the first study of the frequency of dissociative disorders in a Norwegian inpatient clinic (Knudsen, Draijer, Haslerud, Boe, & Boon, 1995).

When Onno van der Hart, Ph.D., visited Stavanger, Henk Otten, M.D., a Dutch physician who had specialized in psychiatry in Stavanger, was asked to come from the Norwegian Lappland as a translator. He became interested in dissociative disorders and qualified as a hypnotherapist after studying in Holland. Otten returned to Stavanger and is active in the dissociation group, teaching hypnotherapy and discussing the treatment of patients with a dissociative identity disorder (DID) diagnosis. The Lappland group, including Henk Otten, M.D., and Karl Y. Dale, Psy.D., has also translated the Dissociation Questionnaire (DIS-Q) (Vanderlinden, Van Dyck, Vandereycken, Vertommen, & Verkes 1993). Recently, the Dutch Somatoform Dissociation Questionnaire (SDQ-20) (Nijenhuis, 1997) has been translated by Françoise Stoerseth and colleagues in Stavanger, and research on somatic dissociation has started.

Trond Diseth, a child psychiatrist at the National Hospital in Oslo (Rikshospitalet) has translated and introduced the Adolescent Dissociative Experiences Scale (A-DES) developed by Armstrong, Putnam, and Carlson in 1993 (Armstrong, Putnam, & Carlson, 1997).

In Stavanger, we are now in contact with professionals throughout Norway. Lars Weisæth and specialists from Holland and the United States have held lectures here (Richard Loewenstein, M.D., in 1995; Bessel van der Kolk, M.D., and Glen Gabbard, M.D., in 1996). The Stavanger group has been actively lecturing in Norway on dissociative disorders, self-mutilation and the use of the SCID-D. The Psychiatric Educational Fund in Stavanger produced a booklet on DID and dissociative disorders in 1993 that has sold thousands of copies throughout Norway. They have also produced and distributed a video of an interview with Onno van der Hart, Ph.D., on multiple personality disorder in 1993.

Interest in dissociative disorders is growing in Norway and we are receiving more and more requests for information from colleagues in other parts of the country. There is still a saying among our more skeptical colleagues, however, that "the DID seems to be a strange US and Stavanger phenomenon, because nobody else in the country seems to find any of these patients." In 1995, a group of skeptical colleagues at our clinic invited Professor H. Merskey, a member of the False Memory Syndrome Foundation advisory board, to give a speech on "The production of Multiple Personality Disorder" without managing to diminish the still growing interest and engagement in the field of dissociation among the local clinicians.

In Stavanger, a well-established research and study group has been doing diagnostic and therapeutic work on inpatients and outpatients with dissociative disorders.The following two cases will serve to illustrate some of this work.

CASE ONE
(CONTRIBUTED BY T.S. LANGFELDT, PSY.D.)

A year ago, I was asked to take over the therapy of a 48-year-old woman, Mrs. A, who had the diagnosis of DID. She had been hospitalized for eight years and was about to leave the hospital to live in an apartment in a health service centre. She had initially been diagnosed as schizophrenic but later was understood to have dissociative identity disorder.

Mrs. A had told the staff about hearing voices from the first day of her hospitalization, but the voices had been interpreted as a psychotic symptom. When she told the staff that she was going to be punished by one of the voices, they protected her. When she actually began to hurt herself, the staff stopped her. It became very difficult to prevent self-inflicted skin burns.

Mrs. A has a history of severe abuse from her mother and sexual abuse from her father extending from her early life through adolescence to adulthood. She escaped by moving to another country when she was 20 years old. She married and had two children. Mrs. A was an only child and was kept isolated from friends. She was constantly afraid and was in constant pain due to the iron-burns and cigarette-burns inflicted on her by her mother. She never took off her clothes at school and nobody knew about her suffering. She cannot remember any single moment of happiness with her mother, but in spite of regular sexual abuse, she has some good feelings for her father. She remembers her first dissociative episode when she was seven years old. She felt that a girl some years older took control of her body in situations of extreme loneliness. New alters came along as she grew older, when she was in situations that aroused extreme anxiety. She has suffered from severe amnesia and still has hours and days that just disappear. She believes that there are alters that she does not know of, which take control from time to time. As of today, 92 alters have been identified. Some have names, others are named by their function ("the filter") or characteristics (the Homosexual).

Mrs. A says that she shifts identities very fast in almost any situation that is threatening or that provokes anxiety. She is afraid of taking the bus from the hospital to her new flat. She is afraid that the bus driver will take her away some place and hurt her. One of her alters called Boris takes over in this situation. He is an irritating, hostile, and strong person. Mrs. A feels ashamed and embarrassed about him but she manages to take the bus. There may also be situations where there is a fight "inside of her" about what to do, say or mean, and this fight makes her feel confused and very depressed.

Building a Relationship

Mrs. A was very afraid of me in the beginning. Once, she walked out of the office. She has asked me several times in a serious/humorous way if I was sent by her mother to spy on her, and has suggested that I had microphones in my office. After we established some degree of relatedness she gave me a set of drawings that was a representation of her life story. We used some of the drawings as a starting point in our relationship, thus finding a way of communication that reflected the understanding she wanted to convey. Of course, she tested me in the beginning of treatment. I tried very hard to understand the total loneliness, pain, and grief that she had suffered from her childhood through her adult life, and as an adult, and how she had managed to survive.

Building a Relationship With Her Other Alters

Slowly, I came to meet the other alters. She told me that some of them were noisy and laughing and that she would be punished if she told me about the abuse and about her alters. It was especially Boris who insisted that everybody is a potential abuser, and that Mrs. A should never trust anyone. Mrs. A had to listen to him as long as he was the one who was the most helpful in everyday life and protected her

from real danger. In addition, she was very disturbed by thoughts that she was a nasty person who deserved all the punishment she had endured as a child. It was Boris who never had doubted her innocence; he was therefore very important to her. Boris was also very shy and afraid and refused to talk directly to me. He agreed to talk to me through Mrs. A. I told him about my respect for him, about never doubting Mrs. A's innocence, and his lifelong struggle to keep her away from potential danger. Mrs. A told me that he accepted my view and that he would be present in the therapy sessions without laughing or quarreling. Mrs. A also had one female identity called Mona who was most often present in daily life in the hospital. She was a likeable, obedient and nice woman. She was always present in dialogues with the doctors and nurses when discussing medication. Only in short periods had Mrs. A been herself, mostly with her primary nurse, whom she had known for seven years. She also trusted me enough to be herself in my presence. She felt relaxed being herself and did not want to leave my office. She wanted a part of her to stay there constantly and she asked humorously if an alter could sit on a chair in my office all week. We both knew that this was a cognitive way of her making an emotional link to a place where she felt well. She told me about a personality named Jens who was a homosexual and who was in love with a male patient. She often found herself outside his door, feeling foolish and ashamed. She could feel an enormous struggle inside herself when this happened, and she could also imagine the excitement Jens felt.

Discussing the Alters' Way of Helping Her in Daily Life

By describing the different alters and how they behaved, we were able to start planning how they could help her in given situations. Once, she wanted to visit her mother, whom she had not seen for eight years and who was in an old people's home. She was really afraid of losing control, fearful that her aggressive alter would do something violent. We discussed which and how many alters could help control and support the aggressive alter so that he would not do anything brutal. We also discussed the possibility of the aggressive alter "staying at home," but she decided that she wanted all the alters to come along. She made arrangements within her system as to who would protect the aggressive alter. She visited her mother and no harm was done. Feeling so much aggression was so frightening that Mrs. A felt she had to "keep her feelings in separate boxes." This prevented her from feeling that she was a whole person and depressed her.

Dealing With Aggression

Mrs. A was becoming more and more worried by the aggressive feelings. She had never been violent in any way, but she often felt she might lose control and hurt somebody. She had injured herself seriously some years before by burning and cutting herself, and had starved herself for days. She became afraid of herself because she felt such a strong inner pressure of anger.We discussed the many different ways of expressing aggressive feelings in a positive way. She was very good at drawing and she had written a lot of poems. We also decided to try music therapy. She was very afraid of making any form of noise because she had always been punished when she made noise as a child. Mrs. A was willing to try playing drums, and we started working on sounds as a way of expressing emotions, including aggression. We are still not sure if this is helping her. She remains very afraid, and she often sees the piano which the music therapist is playing as a whale with big teeth that can eat us all. The main thing is that she manages to hold on to herself in these exciting ten minute music sessions, together with two other people, an accomplishment that makes her very proud. She continues to be very afraid of her aggressive feelings, and she has lately started to talk more specifically about feeling aggressive when she was a child, and when she looked after her children. She is afraid that she might have hurt her children in some way when they were young.

Working With "Black Holes"

Mrs. A was suffering from severe amnesia. She lost a few hours every day, and often whole days at a time. The nurses said she would behave differently and often change the name on the door of her room. She was behaving well and the nurses could talk to her. Despite her concerns, she was never aggressive. She always became frightened when she realized that she had been "away." She believed that there were one or more other alters other than the 92 that she knew to be present and this scared her. She was afraid that these alters knew of more traumatic events than she was aware of, and she believed that the reason they were unknown was that she could not bear more pain by acquiring their knowledge. She is now afraid that she has been aggressive to somebody. It became clear that there was one alter (the Philosopher) with very religious and philosophic interests who knew of these other persons. She would not tell about them unless Mrs. A was ready. The Philosopher started to write letters to me about God and Creation and about the meaning of life and about life and death.

As of today we do not know what the Philosopher knows. But we believe we can use the Philosopher to lead us to the unknown alters when time is right and Mrs. A feels safe enough.

Using Hypnosis in Treatment

Mrs. A was very willing to try hypnosis in order to get into contact with the alters she did not know. She entered into a state of relaxation very easily. She also managed to find a safe place to concentrate. The other alters also found safe places. When all the alters were safe, it became possible to get in contact with an alter who had travelled to another city some weeks earlier. The alter could talk about the trip

and why he did not want Mrs. A to know about it. After the hypnosis, Mrs. A felt very strange and empty. She said that she had been in the safe place all the time and did not know anything about the alter that had been talking to me. As we have only just begun with this promising method, we do not know if it can be used to recall more of her traumatic experiences. We are aware of concerns that have been raised about the veracity of recalled material, but this is not a focus of this report.

Nightmares and Dreams

Mrs. A had a lot of nightmares and dreams. In one repetitive dream she was standing with many adults in a circle around her. The adults wore dark cloths. She was crying. She needed some help to see if she was pregnant, but nobody responded. She used to wake up feeling very lonely and afraid, and could not go to sleep again. It was clear that none of the other alters knew of this dream. We decided to look at the dream again as if it were a movie. I asked her to see if all the people were in dark clothes. She could see two women who had dresses with flowers on. I asked her to focus on the women and look for any signs of contact. Mrs. A then said that when one of the women turned around, it was her school teacher. She then asked me if I thought that the school teacher would have helped her if she had known about the abuse, and I said that I thought she would have tried. The next week she told me that she had had the same dream, but that the school teacher this time had turned around and given her a gift. The gift was a therapist. She did not have the dream again. I think this dream was about hope. Today Mrs. A says she knows more about being herself in relation to other people. She trusts some people in the hospital. Her goal is to remain herself in relationships to other people outside the hospital and to get in contact with the alters she does not know of. She is interested in the world outside and she wants to know her son and daughter better. She is hoping for a better life, but gets ironic about the matter of managing her life better, and says it is a bit late to start living at the age of forty-eight!

CASE TWO
(CONTRIBUTED BY I. HOVE, PSY.D.)

I work as a psychologist in an outpatient clinic for psychiatric patients who abuse drugs (dual diagnosis patients). This clinic is a part of Rogaland Psychiatric Hospital (RPS). I started working with John in September of 1992. He later told me he had tried psychiatric treatment twice before, but he was treated by male therapists. He was afraid of men and had dropped out of treatment.

Background

When he was a week old, John was placed in an orphanage because his mother did not want him. He visited his mother on weekends, but does not remember how often. He was physically abused by her, and was abused both physically and sexually by her different male partners and other visitors.

When he was nine years old he moved from the orphanage to live with his mother and a stepfather. This came as a shock for which he was not prepared. He asked to move back to his former home where he felt safe, but this was refused.

From then on he had nightmares. He started stealing, smoking, and drinking. Later he started using illicit drugs. The family moved a lot, and he attended five different schools. John was a good pupil before moving back to his mother, but after the move he started having behavior problems . He was sent to a special school and later to a treatment-collective for young drug addicts. He was there twice, the last time voluntarily. There he met a girl with whom he lived for several years; they had two daughters together. They both used drugs most of this time. Shortly before he came to treatment she had thrown him out. John had been violent towards her on several occasions, once seriously. He was later convicted for this.

The Diagnostic Process

When we started treatment John admitted that he was not in touch with his feelings and was often misunderstood by others. He complained about loss of control over his thoughts, and that he heard a voice in his head that told him what to say and do. He had amnestic periods and he cut himself. He was violent without provocation and used amphetamines to regain control. He had no recollection of his violent acts. He wanted to kill his mother, and he told me about these wishes without visible feelings of guilt. He told me that it felt as if another person controlled him when he was violent, and he had no way of stopping it. He also told me he was lucky never to have killed anybody. He described how he in a way left his body when he was abused, and we discussed the possibility that the same thing happened when he was violent, since he had amnesia for the violent acts. He had explained his forgetting of his violent acts as due to his drug abuse, although he often had been totally sober when the act actually happened.

Some months later, he admitted having "out of the body" experiences every day. He often felt invaded by another person and observed himself from the outside.

In March of 1993, he came to an appointment and told me he was not John. He said he was "the other person." He heard more voices and they were aggressive. He was afraid he would hurt somebody and felt out of control. He saw images like a film before his eyes, in which he killed people. I hospitalized him on a voluntary basis and gave him a diagnosis of dissociative disorder not otherwise specified (DDNOS). He stayed in the hospital for two weeks. After the hospitalization period he was unstable in his contact with me for several months. He used drugs heavily and I made strenuous efforts to keep in touch with him.

On December 24, 1993, he was hospitalized again. He was confused but not psychotic. He said he had walked around for a week without sleep, food or drugs. He did not know where he had been or what had happened. He talked about a servant who told him what to do. He said that he was to be sacrificed on Christmas Eve, and was waiting for instructions. He was terrified. The diagnosis of multiple personality disorder (MPD) was made over the following three to four weeks. It became clear that he had at least two alters.

Throughout this process John and I had discussed his condition openly. I had told him that the symptoms could be either psychotic or dissociative. From the start I actually believed they were a dissociative phenomena, but I knew little about these myself at that time. I explained to him some of the dynamics of dissociation, and he confirmed that much of this was familiar to him. He has seemed relieved by my explanations and was really surprised that a diagnosis existed that included his symptoms. At the same time this also frightened him. I could see how anxious he was when he revealed his symptoms to me. I felt I was being tested a long time before he was able to trust me. I have not promised him that I will not make mistakes, but I have promised I will always be able to tell him why I do what I do. I also have been very conscious about being totally honest with him and never use even the smallest white lie. I think he would detect such lies before I had finished talking.

Early Stages in the Treatment Process

The diagnosis was confirmed during the first four weeks of hospitalization. He had nightmares every night. These nightmares appeared to be spontaneous abreactions which were extremely frightening. He told me about the content of some of them.

Over the next six weeks he self-mutilated frequently. He needed to see blood. We regarded him as suicidal and the people around him were afraid. Twice he cut himself so deeply that he needed surgery to repair his wounds.

Our strategy has been consistent to make him responsible for his own safety. John had to ask for help if he felt he was losing control. He could have someone in his room or outside of his room when he felt the need. He left the hospital several times. We were concerned and afraid he would kill himself, but we permitted him to go. Instead of battling for control, I tried to negotiate and make agreements with him about his safety when he wanted to leave. We worked with control, and I tried to make alliances with the angry alters. At this time I did not know how many alters I was relating to. We also talked about my safety, and he took the responsibility for addressing this. I suggested several different means of increasing safety, such as having an extra person present in our sessions. I let him decide whether that was necessary. He thought it over and found out that his dangerous alters were not dangerous to me.

The period of self-mutilation culminated in a very dramatic episode in which he came to my office drunk after having cut his arm. He brought the knife with him, and several different alters came forward and were angry. After an intense internal struggle he stabbed the knife in my table. He did not threaten me in this episode, but I was frightened he would hurt me or himself. The next day he had total amnesia for what had happened. I asked for an alter who could give me information. The next session I met the one I had asked for. He told me he was "the boss," and he revealed to me a system of eight alters. I introduced a communicative system of finger signals for communicating with alters and made a contract with the system against violence toward himself or others. This contract was renewed in every session for the next seven weeks. Usually there was no negotiation about this; he told me that the alters often discussed this arrangement before the sessions. When he revealed the system, the nightmares stopped for a while.

We had sessions twice a week; during this period they lasted up to two hours. In the sessions that followed the Boss telling me about the system, I realized that he had also informed the other alters about the system and amnestic gaps were filled.

The Alters

The Angel, created between two and three years of age, was abused until the body was seven years old. The Quiet One (age seven) took over this role after age seven. Together with the Support (age nine) they help the Boss (age 13) to keep order. The Boss is literally the boss – he is the strongest alter. He gave me and the other alters the information about the system. The Innocent (age nine) and the Support (age nine) have been present much of the time. They are both socialized and easy to relate to. The Innocent belongs to the "angry" side and helps the others to be aggressive when necessary. The Wild One (age 11) is a protector of the body, and he can be dangerous to others. He reacts to real threats from outside and to flashbacks, which often resulting in unprovoked violence. The Hotheaded One (age 12) is a persecutor. He is responsible for the self-mutilation and has a need to see blood. He can also be dangerous to others. Satan (age 12) is the leader of the aggressive alters. He is the most powerful of these, but has a hard time controlling the Hotheaded and the Wild Ones. Usually he lets the others come forward to do what he wants them to do, but sometimes he has to do "the jobs" himself. Satan competes with the Boss for control. John (age 31) is the host person. In the beginning he knew nothing about the others.

John and the aggressive alters are drug addicts, while the others are not. The Innocent likes alcohol, and prefers sweet liquors. The Wild One uses alcohol and amphetamines. The Hotheaded One uses cannabis, heroin, and benzodiazepines. Satan uses everything available, including LSD. John prefers amphetamines.

During three sessions, I met the Innocent. This was

allowed due to a compromise between the Boss and Satan. They both listened to what happened in the sessions and informed the other alters about what they found appropriate. I always had in mind that the other alters may hear what I said to whichever alter was out, and I was careful to talk in positive ways about all the alters, including the aggressive one, claiming that every one had had an important role in the survival of trauma, and that every one will also be important in the future. I explained to him that the alters together have the qualities he normally would have developed in one person, if he had not experienced all the tremendous trauma that caused his dissociation.

I told John I would like to meet the alters directly. In response to this, I met all the other alters except the Angel during the following sessions, a new one in every session. We started with the angry ones, and Satan decided the succession: the Wild One, the Hotheaded One, and Satan. They were all suspicious, angry, and frightened and accused me of creating chaos in the system. I negotiated hard with every alter and managed to make a contract about cooperation with the rest of the system. Satan told me he was very angry with me, but he had accepted an agreement not to hurt me.

In the next sessions I met the Quiet One, the Support and at last the Boss again. The same arrangements were made with them. The Boss decided I did not need to talk directly to the Angel, and we agreed he would inform the Angel about what was going on.

I suggested the Boss and Satan could try to cooperate instead of fight each other. I advised that they could try to use their strength together to protect the other alters and the body, and create a leader team. The following days they tried to do so, and the system had several positive experiences of this kind. This was not easy for them; they were suspicious of each other and often managed to cooperate only for short periods of time.

The Following Years

Later another system of five alters appeared. These knew nothing about the others. In addition to these, another two were revealed later, one at a time. One of these is female. Most of the time since September, 1992, we have usually worked intensively twice a week, but have met less frequently in some periods. At times, John is tired of therapy and wants to escape from it. He has been hospitalized a number of times in the last years, but these are shorter admissions, at times when the anxiety is too unbearable and the alters are afraid and aggressive. Our relationship is very strong and I regard this alliance as an extremely important factor in the therapeutic process. John is also very dependent on me, and my summer vacation is a problem every year. He also has had problems in the course of shorter absences. Contrary to my usual practice, I have sent him postcards, which he has appreciated. During the last three years I also have taught him a hypnotic technique he can use during my absences. John has described safe places where he liked to stay when he was small, and we have "placed" the small alters in safe places and told them not to have the experience of time passing. In addition to his safe places, I have described different fantasy pictures of pleasant surroundings which he can use. This has been useful to him. He has had the experience of the small alters remaining safe and untroubled by my absence.

We also have worked out an organization of his alters, in which all four alters have executive responsibility in addition to John. They have an internal arrangement of responsibility and power, and they relieve each other in order to make sure every one of them has enough control, but also has the opportunity to rest. These leaders are responsible for the comfort of the other alters. This cooperation model works well most of the time. However, when John is exposed to external stress which especially triggers flashbacks of early trauma, the system is not strong enough.

John has refused to work towards integration. He does not believe that is possible and does not want to work directly with his traumatic experiences. He wants to forget the trauma, but he knows this is impossible. In difficult periods he has terrible nightmares or no sleep at all, and he wanders around outside or listens to music in order not to hear all the voices in his head.

During the therapeutic process he obviously has dissociated a lot. He often reveals that he does not remember his sessions. For a long period of time I recorded the sessions, and he kept the tapes so that he could listen to what we had talked about afterwards, and he found this helpful.

I have also recorded three different tapes with hypnotic suggestions about relaxation and fantasies about a pleasant and safe place, which he can use whenever he likes. The tapes have been very useful for him. He listens to the tapes every night during difficult periods, and tells me that this calms him down.

The contracts about violence against himself or others have been repeated through the whole therapeutic process, but are made for longer and longer intervals. He has not self-mutilated since we made that agreement, and he has admitted that this contract has prevented him from using violence both against himself and others in stressful circumstances.

On one occasion I was afraid of him. Early in the treatment process I came back from vacation and met a little (probably psychotic) two- to three-year-old alter which I had never met before. The alter was terrified and aggressive. He did not know me and had not been forward since the body was at that age. I interpreted this among other things as a punishment against me for having been away. I completed this session with two male nurses present. The next time I talked to John, I was really angry with him for having risked destroying our relationship. He admitted the system knew what happened, apologized, and promised never to behave like this again. He never has.

During these years John has been hospitalized several times on a general psychiatric ward. He also has spent nearly a year in a special section of our hospital where drug addicts with psychiatric problems are treated, and was in the rehabilitation department for a few months. I have been his therapist throughout all these stays in hospital, and I visit him wherever he is, in addition to his coming to my office. In the past year, he has lived alone in an apartment outside town. He is socially totally isolated, but he is not using drugs. He manages the apartment quite well, although this varies with his condition. He eats when he is hungry, about once a day, but he has learned to make sure he always has food available.

He is visited by a psychiatric nurse once every two weeks. This contact is also very important. I feel a need to include more persons in his life in order to make him less dependent on me. He has no contact with his own family. His biological father died many years ago, and his mother died recently. He had not talked to her for a couple of years prior to her death, and did not want to attend the funeral. He has no contact with his daughters now. They live in another town. He has tried to establish contact with them in the course of treatment, but he has problems with keeping telephone appointments. He has realized that he must concentrate on himself.

He manages his own finances. Sometimes he has spent money without remembering how, or he has lost money on the way home, or has taken a taxi and not remembered afterwards. This happens less frequently now, and I think he uses a lot of energy in order to manage keeping order. He has a stable income from disability benefits.

My wish for him is that he could live in a house together with two or three other psychiatric patients, where each of them has their own part of the house, in addition to a living room and kitchen where they can be together. John needs contact with other people, but most of the time he is not able to approach others. Ideally, social contact should be easily available for him. He can not live together with other patients with a drug problem. This would be too risky.

In such a house psychiatric staff would be needed to look after the patients every day or every other day depending on their condition.

It would also be helpful if John had an opportunity to work on the days he feels able to do so.

The therapy will continue, with different content and goals depending on his condition and wishes. He is not ready to finish the therapy, but I doubt we will get much further as long as he refuses to work toward integration. Stabilization and higher quality of life have been the key words in our work the last year of treatment.

CONCLUDING REMARKS

To work with dissociative identity disorder patients is a challenge in many ways. First it is important to know the symptoms in order to make the correct diagnosis.

Building a therapeutic alliance is also crucial for these patients (Kluft, 1996). As they have a history of betrayal and abuse, absolute honesty and reliability from the therapist is essential. As long as the basic relationship is established, one can use fantasy techniques and try different interventions. One of the first important tasks is to create structure and control where this is needed.

It is important to avoid a struggle over power. The patient will always win this kind of struggle, which may accelerate self-mutilation. The patient should have as much power and responsibility for him or herself as possible. These patients are survivors, and it is important not to be overwhelmed by their helplessness and regression. Staff members can easily find themselves doing things for these patients which they find hard to admit afterwards. Another pitfall is to be so fascinated by the exotic symptoms that the investigation of the symptoms becomes the dominant goal, instead of focusing on therapy. This kind of approach may lead to even more fragmentation.

Our experience with communicating directly with the alters is positive. It is also important to remember when talking to the patient that all the alters may be listening to what the therapist says. In building relations with the patient and the alters it can be wise to talk in positive ways to the patient about all the alters, including the persecutors, and show an understanding of their roles and functions in the survival of trauma. ■

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