

THE TREATMENT OF NARCISSISTIC INJURY IN DISSOCIATIVE IDENTITY DISORDER PATIENTS: THE CONTRIBUTIONS OF SELF PSYCHOLOGY

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ABSTRACT

Narcissistic injury is a major component of the sequelae of child abuse. The disregard of the child's basic needs disturbs the development of self-esteem and the ability to function effectively. The field of self-psychology describes the effects of narcissistic injury on children and presents therapeutic methods for use within the transference that address the consequent damage to the self. This paper will outline the theory and methodology of self-psychology and discuss its application to the treatment of narcissistic injury in Dissociative Identity Disorder (DID) patients. Peculiarities of working within the transference(s) with DID patients will be discussed.

NARCISSISTIC INJURY AND SELF-PSYCHOLOGY

Narcissistic injury is a contributing factor in many psychiatric illnesses. In adulthood, as well as in childhood, narcissistic injury affects a person's ability to maintain self-esteem and continue to function efficiently. A personal insult, a divorce, the loss of a job, an illness, and even the process of aging—all can affect self-esteem in that they all contradict our deeply held notions that we are lovable and competent. These injuries affect the functioning of the self, which has the task of supporting a person's efforts to achieve personal goals, partly through maintaining enough self-esteem to achieve those goals. Narcissistic injuries weaken the self, depleting its capacity to maintain self-esteem (Kohut, 1971, 1984).

Narcissistic injury is a major component of the trauma sustained during child physical or sexual abuse. The sense that one is lovable and competent is devastated by the overwhelming physical and emotional trauma involved in abuse incidents. For children, who are dependent on an empathically-attuned environment for the satisfaction of their most basic physical and emotional needs, it is the blatant lack of

empathic attunement (the complete disregard of the child's needs) both on the part of the perpetrator as well as on the part of the hoped-for protectors, that constitutes the narcissistic injury.

The field of psychoanalytic self-psychology has attempted to understand the effects of narcissistic injury on young children and has developed therapeutic methods that address the consequent damage to the self (Kohut, 1971; Kohut & Wolf, 1978; Kohut, 1984; Baker & Baker, 1987; Stolorow, Bandchaft, & Atwood, 1987; Wolf, 1988; Bacal 1990; Lichtenberg, Lachmann, & Fossage, 1992). Self-psychology was developed by Heinz Kohut in response to his experience in treating narcissistic personality disorders and in reaction to the psychoanalytic thinking of the time. His work represents a divergence from classical psychoanalytic theory. He focused on pre-Oedipal development. He removed the classical structural concepts of ego, id, and superego from their central position as organizers of behavior and replaced them with the concepts of self and selfobject. He also de-emphasized the role of conflict in the development of psychopathology. Kohut believed the need to maintain selfobject relatedness throughout the life span to be paramount (Kohut, 1971; Bacal, 1990, Baker & Baker, 1987).

The concepts of self and selfobject are fundamental to self-psychology. In general, self psychologists view the self as the superordinate organizing function of a person's experience and the primary source of motivation which empowers and guides the person in pursuit of his or her goals. A *selfobject* is any relationship that functions to enhance the sense of self (Kohut, 1971; Kohut & Wolf, 1978; Kohut, 1984; Baker & Baker, 1987; Stolorow, Bandchaft, & Atwood, 1987; Wolf, 1988; Bacal 1990; Lichtenberg, Lachmann, & Fossage, 1992).

In infancy, the mothering ones provide the selfobject functions, which include attunement to affect states, validation of subjective experience, affect containment, and tension regulation and soothing. As a child matures, he/she takes on some of his/her selfobject functioning, finds a wider range of selfobjects in the everyday world, and decreases in his/her own selfobject needs. Although adults continue to need selfobject experiences, the needed experiences are less intense and more varied than those of growing children. (Baker & Baker, 1987; Bacal, 1990)

Selfobject functioning can be illustrated by the following vignette:

Suppose your three-year-old boy ties a towel around his neck, thinking that he is Superman, climbs up onto the sofa and jumps off as if he could fly, bumping his head on the coffee table. Responding to his cries, you say "Oh, you have a boo-boo! It hurts! It'll get better soon. Let's put some ice on it. You wanted to fly like Superman, but nobody can really fly, not Mommy or Daddy. Only birds and planes can fly. But isn't it nice that you can run so fast."

The selfobject functions illustrated by the vignette fall into three categories that correspond to major selfobject transferences: the mirroring functions, the idealizing functions and the twinship functions. The mirroring functions were expressed in the statements, "Oh, you have a boo-boo!," "It hurts!," and "Isn't it nice that you can run so fast!" and mirrored the child's subjective sense of pain, as well as his age-appropriate grandiosity. The idealizing functions were expressed in the statements, "It'll get better soon," "Let's put some ice on it!," and "Nobody can really fly." They provided soothing and showed that the caretaker could be relied upon to know what was happening and what needed to be done. The twinship functions were involved both in the sharing of the overall experience and in sharing the human condition of not being able to fly (Stolorow, 1991; Tandler, 1992).

In childhood, the ability to maintain the functioning of the self and to support the maturation of the self requires the presence of an optimally responsive caretaker who will provide sufficient selfobject functions as illustrated by the vignette. Socarides and Stolorow (1984) proposed that the presence of attuned selfobjects are crucial to the integration of affect and cognition in early life. According to self-psychologists, psychopathology ensues primarily from the narcissistic injury sustained as a result of repeated empathic failure within the caretaker-infant relationship, a failure that inhibits the maturation of the self.

The consequences of repeated empathic failure include: fixation of selfobject needs on the immature forms of those needs, the reliance on archaic attempts to gratify selfobject needs, the sequestering of the needs and the affects associated with them, the development of the defense mechanisms of repression and disavowal, and narcissistic rage (Kohut, 1971; Kohut, 1984; Baker & Baker, 1987; Stolorow, Bandchaft, & Atwood, 1987; Wolf, 1988; Lichtenberg, Lachmann, & Fosshage, 1992).

Our dissociative patients are overloaded with narcissistic injury and empathic failure. It is debilitating enough for a child not to receive empathic responses in his struggle to endure the ordinary bumps and bruises of everyday life, but for our patients the narcissistic injury associated with inadequate caretaking is heaped on the narcissistic injury asso-

ciated with severe trauma. They are exposed to extreme levels of narcissistic injury, and the consequences for the development of the self are enormous. Indeed, Dissociative Identity Disorder (DID) can be seen as a method to preserve the self from the annihilation caused by traumatic levels of narcissistic injury. The defensive development of multiple selves protects the whole self from experiencing the trauma in a way that would be devastating (Tandler, 1992).

Self psychologists argue that once compromised, psychological health is achieved through the restoration of self-object development. This is accomplished through careful work within the therapeutic dyad with the patient's selfobject needs and selfobject transferences. This work is thought to occur in two stages: the "stage of understanding" and the "stage of explaining." The stage of understanding involves the therapist's acceptance and empathic understanding of the patient's experience, including the understanding of the defensive maneuvers and byproducts of former empathic misattunement. Self-psychologists claim that this paves the way for the stage of explaining in which the therapist offers empathic reconstructive interpretations of the archaic self-object transferences and of the traumas in the early selfobject environment that have impeded selfobject development (Ornstein & Ornstein, 1985). Effective transference interpretation is thought to modify existing structure within the self and reanimate stalled development (Kohut, 1971; Ornstein & Ornstein, 1985).

It is important to note that self-psychologists pay particular attention to transference disruptions and the contribution that the interpretation of these disruptions makes to structuralization and growth. Stolorow (1991) points out that ruptures in transference ties, whether caused by a real lapse in empathic attunement on the part of the therapist or by a misperception of the level of empathic attunement on the part of the patient, replicate the empathic failure that is the source of the psychopathology and constitute retraumatizations of the patient. The failure in attunement, both in childhood and in the therapy, tends to happen at two levels 1) The object fails to understand and respond appropriately to the ongoing psychic needs or states of the child, 2) The object fails to understand and respond to the distress that the first failure causes. The pain from such selfobject failures tends to be defensively sequestered in order to preserve the bond with the object and to reduce the inner conflict between the selfobject needs and the need to preserve that bond (Stolorow, 1991).

The recognition, understanding and interpretation of both levels of empathic failure within the therapy has a number of beneficial effects on the patient. This complicated process: 1) enables the patient to have a mastery experience in which a broken tie is mended, 2) increases the patient's confidence that selfobject needs will be received well, 3) prevents the further sequestering of affect, and most importantly, 4) allows for the expression of formerly sequestered

painful affect in a situation where it will be processed and integrated into the self (Socarides & Stolorow, 1984). Self-psychologists propose that this kind of understanding and interpretation revives development and increases structuralization. When selfobject functioning matures sufficiently and the self is stronger, the patient is more capable of solving problems and attaining goals (Kohut, 1971; Terman, 1988).

In summary, the provision of selfobject functions, the interpretation of selfobject needs, and the interpretation of disruptions in the selfobject transferences strengthen the self in its role as an effective organizer of experience. Repeated doses of understanding and interpretation of selfobject needs, transferences, and transference disruptions build and strengthen the self structure through mini-integrations of affect and cognition within the transference relationship. The additional structure, built through these mini-integrations, can pave the way for the abreactive work and the integration of the affect and cognition more directly related to the trauma (Tendler, 1992).

This strengthening process is an effective adjunct in the treatment of DID patients. Kluft (1993b) proposes that, because of the depleted, demoralized, and vulnerable condition of most DID patients entering therapy, it is advisable to spend considerable time on ego-strengthening in the early stages of therapy. Kluft (1993b) also endorses the use of self-psychological interventions that involve empathy, mirroring, and idealizations to encourage confidence and provide hope, that will motivate the DID patient to continue in the therapy. Therefore, through work with the selfobject transferences, self-psychological interventions build and strengthen the narcissistically injured, DID patient's self, a valuable component to the overall process of therapy, especially in the early stages.

SELF PSYCHOLOGY AND DID PATIENTS

Whatever our theoretical orientations, as therapists, we all serve selfobject functions for our DID patients. The specific mirroring functions we provide include accepting the alters, appreciating the patient's struggle to function, and investing in the patient's growth. Our idealizing functions include understanding did enough to guide the therapy appropriately, for example through pacing and teaching self-control strategies.

As selfobjects in the patient's life we may be one of the few people serving these functions. Hopefully our patients have had at least a few real selfobjects in their lives, providing some mirroring, idealizing, and twinship functions, but we may be the first ones who accept the patient's account of the abuse and understand the consequent dissociation well enough to provide the specific functions just listed (Tendler, 1992).

Self-psychology also involves work at the level of transference interpretation and with transference disruptions.

(Ornstein & Ornstein, 1985) Self psychologists do not supply all of the requested selfobject functions. In part, this is owing to the fact that patients will often request more than a therapist can provide. Even in the absence of such extreme requests it is common therapeutic practice among self psychologists to dose out selfobject functions so that there remains sufficient ungratified selfobject transference material to allow for interpretation. Kohut (1971) termed this practice "optimal frustration"; more recent self psychologists prefer the term "optimal responsiveness" (Bacal, 1985; Terman, 1988), recognizing that their patients have already been extremely frustrated with respect to their selfobject needs. Whatever the term used to describe the press within the transference to achieve the satisfaction of unmet selfobject needs, the therapist and patient explore them and understand their function in the patient's life. They clarify the defenses against them, and, most important to our work with DID, clarify their origins in trauma. A case example will be used to illustrate clinical work with the selfobject needs and transferences of a DID patient.

CASE ILLUSTRATION

Sallie is one of my patients who shows clear evidence of having selfobject transferences towards me. Sallie's predominant transference is best characterized as a mirror transference. Sallie is actually mirror hungry. She comes in each session with a tale to tell from her daily life. The tale can describe either a positive or negative experience. And the tale must be heard and understood by me.

For a while, I sat, listened, and reflected. More recently, I have offered transference interpretations about her mirroring needs, such as: "It's really important that I hear just the way it went for you." "You seem intent on my hearing about every part of this experience, like you want to be really sure I understand you." "It's really important for you to show me all your accomplishments, the things you're really proud of, like you want me to be just as proud of them. I'll bet you desperately wanted that from your parents, too."

The narcissistic injury that Sallie experienced, during the severe physical abuse doled out she endured from her father, is distributed across three parts, called Creative Sallie, Sad Sallie, and the Fruitbats. Creative Sallie tends to be grandiose and presents herself for admiration and applause. She performs publicly and is actually good at what she does. One of her goals is to contribute to society, especially in her role as a teacher, and to be remembered after she is dead. The Fruitbats hamper Sallie's expressiveness. As we see them, they are representations of the parents' punitiveness. They serve to protect Sallie from exhibiting the kind of behavior that the parents used as excuses for severe beatings. Sad Sallie is a depleted and hurt child alter who hid from the parents and who tends to hide from me.

At the beginning of therapy, the Fruitbats held sway over

the rest of the personality, criticizing Sallie at every turn and preventing her from achieving many of her goals. Over the course of therapy, the Fruitbats have subsided somewhat and have allowed Creative Sallie to emerge more frequently. I believe this has been the result of a feeling of safety within the transference engendered by my offering myself as a self-object to all of the parts, accepting them, mirroring them, and interpreting their functions in a positive light. It became safe for Sallie's childish grandiosity (which was age-appropriate at some time in her life and which is now held by Creative Sallie and channeled into her activities) to emerge in spite of the trauma and in spite of the Fruitbats. The Fruitbats have learned enough about Creative Sallie and about their external reality to accept Creative Sallie's efforts as less threatening.

It is not yet safe enough for Sad Sallie to emerge and participate fully in the therapy. Creative Sallie's demands for mirroring occupy time and prevent the therapy focusing on Sad Sallie and on the Fruitbats. It feels as if once Creative Sallie emerged, she has not wanted to give up center stage. She recognizes being afraid of the Fruitbats and of Sad Sallie, and she probably is afraid of me as well. She may be engaged in a tireless test of the safety of the therapy, and I have been commenting on this process.

Fortunately, in one recent session, I failed the test. This presented us with an opportunity to experience and analyze a disruption in the transference. Early in the session Sallie discussed a conflict she was having with a colleague in which her feelings were being hurt. Her description was made increasingly vivid by her use of a loud voice and by her dramatically playing out what had happened. I did not interpret anything at this time, although I keenly felt her narcissistically-charged need to have me see the hurt she experienced and to be on her side. Instead, I told her that her voice was getting very loud and might overwhelm our best efforts at soundproofing the office. I told her that the people in the waiting room may be hearing what she was saying. In this I was not being directly empathic or understanding of her experience with her colleague. I was providing her with information about the reality constraints or boundaries of our situation.

My comment triggered a switch to Sad Sallie, who cried and said that, like her parents, I was stifling her and she didn't think that I would do that. I recognized the impact of my words on her with a very simple statement: "That really affected you!" I sat with her as she cried, and I said that I knew that she was sadly disappointed in me and maybe scared, too. I worked with Sad Sallie, accessing her memories of her mother criticizing her incessantly and of her father beating her harder when she tried to explain herself. And then I said that there were indeed some aspects of the situation that resembled the times when her parents stifled her and that she may be disappointed in me for resembling her parents in some way and that we needed to understand how she felt then and now.

My acceptance of Sad Sallie's experience of being stifled in the transference seemed to be appreciated. She seemed to feel that the break in the therapeutic alliance had been mended, as she said "At least we can talk about it." And we did that. Recognizing that what had been experienced in the session had many meanings, we went on to explore the possible functions of the "booming voice."

In my response to the transference disruption and to the emergence of Sad Sallie, I recognized Sallie's distress, demonstrated my willingness to understand her experience, and provided her with a little bit of structure for understanding her past and present. Whatever else was going on, my discussion of soundproofing represented a disappointment in the transference expectation that I would be 100% accepting. It resulted in a transference disruption that proved to be a reenactment of a former trauma. However, my response to the patient refrained from reenacting the second level of trauma, the parents' failure to respond to Sallie's distress. I thus avoided the additional injury that would have increased her need to sequester Sad Sallie's feelings. Instead I helped Sad Sallie process her response to my behavior, allowing her to integrate within the transference relationship the cognitive and emotional aspects of the transference disruption that paralleled the original trauma (Tendler, 1992).

It is my belief that the processing of Sallie's experience of the transference disruption in this particular way helped her to restructure her self to include the information made available in the transference experience about herself and about me. Kohut (1971) would argue that a "transmuting internalization" had occurred and that Sad Sallie had incorporated this experience of me into her self structure. Socarides and Stolorow (1987) propose that, at all stages of the life cycle, selfobjects are needed for the integration and internalization of affect and cognition. In this instance, Sallie's affect and cognition was about me and I served as the empathic selfobject that enabled to internalize this affective/cognitive experience, resulting in an increase in her self structure. I believe that this increase in self-structure, as small as it was, enabled her to tolerate more easily the further exploration of troublesome emotional issues.

TRANSFERENCE IN DID PATIENTS: A SELF-PSYCHOLOGICAL PERSPECTIVE

There are a number of special considerations that deserve our attention as we explore the application of self-psychology theory and method to the treatment of DID. The goal remains the same as in non-DID patients: to increase the structuralization of the self through selfobject functioning, the interpretation of selfobject transferences, and the interpretation of transference disruptions. The question remains as to how this work plays out in the therapy of DID.

Multiple Transferences/Multiple Interventions

Wilbur (1988, 1984) discussed the presence of multiple transferences emanating from alters with different needs and styles of relating. She recognized a needy transference, a hostile transference, and a sexualized transference and noted how difficult it is to be attuned empathically to all the various feelings that these transferences produce. It requires a good deal of flexibility on the part of the therapist to understand and interpret as the transference material shifts from moment to moment in the therapy session. The therapist must also struggle to contain the shifting countertransference responses to these multiple and contradictory transferences.

Thinking of the contradictory transferences in terms of selfobject transferences provides some grounding in the underlying selfobject needs that these transferences may attempt to express and may even help the therapist to work more effectively with his or her countertransference issues. Seeing the hostile and the sexualized transferences as derivatives of (needy) selfobject transferences can be very helpful in discerning the needs for idealizing or mirroring that they may represent (Kohut, 1971; Baker & Baker, 1987; Tandler, 1992).

Another issue that arises in working with the transferences of DID patients is whether at any one time to work with an alter, the system, or the person as a whole. The patient needs attunement at all levels, because he or she experiences herself at the different levels at different times. In being empathically attuned to the patient, the therapist will have a clearer understanding of the level at which the patient is currently operating and will thus have a clearer understanding of the level at which to respond.

One difficulty in handling all of these transferences is that they are not exhibited in any predictable manner. Frequent switching between alters can result in constantly shifting transference themes. In addition, one must not assume that only one alter is in charge at a time. DID patients often present with an alter who is being influenced by another alter or even with whole constellations of alters at once. This makes identifying and responding to the transferences exceedingly difficult.

From the foregoing review of self-psychological theory and technique, it may seem that the recommendation is to be with the patient wherever he or she is at the moment. Kohutian theory supports the practice of remaining what is called "experience near" (Baker, 1992) and recommends that full fledged genetic interpretations, which tend to include large pieces of new information, be left for the later stages of therapy (Stolorow, 1991; Ornstein & Ornstein, 1985). Self-psychologists tend to think that being experience near is less threatening for the patient and allows the patient to do the major part of the therapy work herself, thus building a sense of mastery and self-esteem. Insights that come from the patient are seen to be more vital than insights provided by the therapist (Baker & Baker, 1987).

Remaining experience near offers distinct advantages in formulating interpretations for DID patients. First, it minimizes the difficulties that are inherent in interpreting to alters who are missing huge chunks of information about their lives. Second, by adjusting the level of cognitive complexity of the interpretation to match the level of cognitive development of the alters that are present, the therapist can be more assured of being understood. Interpretations run the gamut of cognitive complexity (Basch, 1985; Stolorow, 1991). They range from mere sounds such as sighs or laughs, to vague indicators of something happening (such as "I can see a change in your face" or "Something important is happening now"), to simplistic summaries of the patient's process (such as "When I said that, you began to look more frightened"), to full interpretations (such as "When you reacted to me like that, I was wondering if it didn't feel like you were with your mother, so frightened that she was going to hurt you again, that you felt like you had to get away"). All of these statements can be informative and can contribute to the patient's sense of being understood. Different levels of interpretation are appropriate for different alters and for different stages of therapy. Remaining experience near can aid the therapist in making the most effective choice that will enhance the functioning of the self system.

However, there are times in the therapy of DID when remaining experience near is not to the patient's advantage. Such situations include times when the patient is feeling overwhelmed or is in physical danger and a more active stance must be taken by the therapist to promote safety. They also include times when important material is beyond the reach of the alters who are presently engaged in the therapy and who may be unable to formulate insights by themselves because of lack of information or the inability to process the information. Included, as well, are times when certain alters are hiding from the therapist or are hiding other alters, and times when the patient is suffering from cognitive distortions that are in need of immediate correction. At these times it may be more useful to confront the patient with information that she is missing or is not using efficiently. In doing so, the therapist is taking an educational stance and may, indeed, be serving needed idealizing functions for the patient (Tandler, 1994).

EFFECTS OF POST-TRAUMATIC PROCESSING ON TRANSFERENCE WORK

A special consideration in our work with transference in DID patients is that our patients are different from classically defined analytic patients. The nature of this difference is at least two-fold. First, in the DID patient there exists no unified, consistent observing ego with which to form a classically defined working alliance and within which the transference can be thoroughly analyzed (Kluft, 1993a, 1993b).

Second, because of the post-traumatic nature of all men-

tal functioning in DID patients, the "as-if" quality is lost from the transference (Kluft, 1993a). Encumbered by such dissociative/hypnotic symptoms as time distortion and absorption, DID patients tend to live the transference instead of being able to examine it. Their experience of the therapist as an object from the past is on a real and concrete level, very much like a flashback experience, and without the perspective that non-post-traumatic thinking provides. Consequently the therapist can expect considerable transference acting out instead of transference understanding or insight (Kluft, 1993a).

An example of this comes from my work with a patient I will call Jane. She recently informed me that she had taken a thorough inventory of the contents of my car, and had followed me from my office to my home. I considered this an intolerable boundary violation and let her know that. In addition, we went on to discuss the parallels between this kind of boundary violation, that she had acted out, and the ones that she had been subjected to in her traumatic past. In this situation, by intruding into my personal "territory," Jane had acted out the role of the perpetrator, placing me in the role of the victim. In addition, by telling me about her behavior, she placed me in the role of the possible punisher/perpetrator and herself in the role of the victim. By telling me, she was testing the extent to which I would assume those roles.

As with our other patients, our DID patients need to translate their actions into words and need to understand the function and source of their behavior. Empathic understanding and interpretation is directed to the need or problem for which the acting-out is the perceived solution or to the historical situation for which the behavior is the reenactment. When the need (or problem) is empathically understood, the alters acting on that need tend to become less narcissistically wedded to the archaic solution and, consequently, are more likely to find alternate solutions to the need's satisfaction. Similarly, once understood, alters become less wedded to the reenactment of the abuse, and become more able to both understand the function of the reenactment and to choose alternative ways of reacting.

Jane is increasingly able to recognize the reenactment of the alters' need to see what they could get away with, and their need to have some kind of power over me. To her credit, Jane has enough ego-strength and perspective to be able to make use of both here-and-now and there-and-then interpretations of her behavior. She has also grown in her ability to identify and discuss similar impulses prior to acting them out in such an overt way.

Another effect of the dissociative processing tends to be the involvement in trance logic, a kind of thinking that increases the patient's tolerance of illogic. This kind of thinking can result in part-for-whole distortions that can promote, for example, generalized attitudes and feelings that are expressed in the transference material. Trance logic in the form of black or white thinking and the ability to give equal credence

to contradictory perceptions allows for the existence of intense, contradictory transferences (Fine, 1990; Loewenstein, 1993).

Fine (1990, 1991) offers various interventions to remedy the post-traumatic/cognitive distortions that plague the DID patient's life, both in and out of therapy. These interventions include teaching an experimental approach to the testing of long-standing beliefs, temporary blending of alters so that they can experience different points of view, and the establishment of cognitive dissonance within alters to enhance their ability to assimilate new data.

Kluft (1994) maintains that it is useful for the therapist to adopt an educational stance and to employ it throughout the therapy. Patients need to learn the difference between the now and the then, and at every turn it is important to teach the patient that difference. Working within the transference, it is useful to help the patient to identify the triggers that set off traumatic expectations and/or flashbacks. Once triggers are identified they can be detoxified by thoroughly categorizing the similarities and differences between the current stimulus and the stimuli associated directly with the abuse experience (Loewenstein, 1993; Kluft, 1994).

TRAUMATIC TRANSFERENCE

One thing that is consistent in DID patients is the presence of traumatic transferences (Loewenstein, 1993). DID patients constantly expect to be traumatized. They are extremely sensitive to stimuli in their environment that signal danger. Triggering stimuli can run the gamut from obvious to subtle and patients seem to have layers upon layers of traumatic expectations.

Traumatic transference can also occur as a flashback to some former abuse experience. The patient can experience the therapist as if he/she were, indeed, the perpetrator and then can respond in her customary fashion, feeling anger or terror, retreating, and dissociating. In the dissociated state, the patient might even superimpose the image of the perpetrator onto the therapist, as in a visual memory of a traumatic event. Reorienting efforts, often involving hypnotic interventions, can be used to return the patient to the here and now experience of being with the real therapist in his or her office (Kluft, 1994).

Some rather complex traumatic expectations include worrying about whether the therapist has the patient's interests at heart or whether he will exploit the patient for his own narcissistic gratification, as did the perpetrator(s). Some patients consider it traumatic if the therapist fails to agree fully with the patient. Having a different view of a situation can be seen by the patient as an intrusion of an unwanted reality. Since the original abuse was too traumatic to process as a whole and dissociation was used to isolate aspects of the experience, patients tend to see the therapist's efforts to reduce the dissociation slowly as traumatic. Also, because patients have usually been instructed to keep their abuse secret, the

therapist's investment in telling can be construed as traumatic. Poorly timed interpretations can also be seen as a traumatic intrusion into the patient's current mental processing.

The empathic attunement of the therapist to fluctuations in the patient's traumatic transference can provide significant information to both members of the therapeutic dyad. Careful attunement and understanding can illuminate which traumatic expectation (or dynamic) is in the patient's experience at the moment. Empathic interpretation adds information about the here-and-now reality of the therapeutic relationship to be assimilated into the patient's schemata of the therapist and of the therapy.

The disappointment of traumatic expectations is an excellent source of information for the patient about here-and-now reality. Repeated acknowledgement and empathic interpretation of the disruptions in the traumatic transference slowly mitigates the patient's tenacity to traumatic expectations by building a new history of benign interpersonal experiences in the here-and-now. The therapist, as an empathic selfobject represents a powerful contradiction to the patient's traumatic expectations.

Perhaps more importantly, empathic attunement illuminates the patient's current level of functioning within the transference, so that the therapist can adjust the pace of therapy more efficiently and adjust the timing and content of interpretations, as well. The adjustments that a therapist makes to the moment by moment changes in the patient's experience of the therapy and of the therapist is felt by the patient as a valuable selfobject experience that counteracts a host of narcissistically, injurious, non-empathic, interpersonal experiences from the past.

However, selfobject functioning, itself, can serve as a trigger for traumatic transference. Providing even ordinary levels of selfobject attunement may be felt by some of the patient's alters as unwanted closeness. Even though other alters may be yearning for more closeness from the therapist, some alters may experience the empathic attunement as an indication that some sort of abuse or punishment will follow. This expectation may have been formed by the sequential patterning of closeness and abuse in the past, by the use of the child's need for closeness as a lure into the abuse situation, or by the fusion of the feelings of closeness with the feelings of hurt and pain associated with the abuse. In this case, empathic attunement includes the understanding of the potentially traumatizing effect of empathic closeness on the patient.

CONCLUDING REMARKS

In summary, working with the multiple selfobject transferences requires extreme flexibility and empathic attunement at many levels. However it offers a method of strengthening the self and represents an effective adjunct in the therapy of DID. I have also described, here, some of the special consid-

erations that the therapist must weigh as he or she is attempting to apply the methods of psychoanalytic self-psychology, (that have proven useful in the treatment of other cases involving narcissistic injury) to the treatment of DID. These methods are seen as ways of providing opportunities for strengthening the self through work within the transference relationship so that the exploration and integration of memories of the original trauma can proceed more smoothly. ■

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