

A MUTUAL STORY-TELLING TECHNIQUE AS AN AID TO INTEGRATION AFTER ABREACTION IN THE TREATMENT OF MPD

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ABSTRACT

Traumatic memory differs from ordinary memory in being vividly pictorial, unintegrated with the temporal flow of events, and lacking a narrative subtext. The controlled therapeutic abreaction of such memories and their integration into the life story is a central task in the treatment of MPD. In this article, I propose a variation of a technique adapted from the child psychotherapy literature, Gardner's Mutual Story Telling Technique, as an aid to providing the missing narrative after abreactive work. In addition, the technique may be said to provide a healing function, introducing a therapeutic witness to the trauma scenes. Reconstructing a coherent narrative is claimed to have further effects on ongoing identity formation, central to the recovery process in MPD.

INTRODUCTION

Traumatic memory differs from ordinary memory in its "prenarrative" quality (Herman, 1992). It has a frozen, wordless and static aspect. Although some high percentage (60+%) of those recently studied prospectively can remember trauma or recover memories spontaneously, amnesia for abuse is associated with more severe symptoms, molestation at an earlier age, extended abuse, violent abuse, physical injury, and more perpetrators (Williams, 1993). This complex of conditions more typically characterizes the multiple personality disorder (MPD) patient. Williams further reports findings in a seventeen-year follow-up study of children brought to an emergency room. She states that inability to recall abuse was associated with a closer relationship with the perpetrator and an earlier age of abuse.

Trauma interrupts the sense of flow in life, and the construction of coherent sequencing across time which contributes to giving meaning and a sense of agency or personal control in life. Incorporating narrative approaches within psychotherapy allows for the possible reintegration of the lost

temporal dimension (White & Epston, 1990). I claim along with others (Herman, 1992; Laird, 1993; Putnam, 1990; van der Hart, Boon & Steele, 1993) that producing a coherent narrative, which includes and integrates traumata, is central to resolving the identity issues at the heart of the MPD state. The "Mutual Story Telling Technique" was introduced into the child psychiatry literature in 1971 by Dr. Richard Gardner. I have found a variation of that technique to be useful in working with MPD patients after the abreaction of traumatic memory to facilitate the construction of a coherent narrative.

APPROACHES TO TRAUMATIC MEMORY

Eliciting a story of the trauma which includes all of its missing factual, sensory, emotional, and interpretative elements is the reassembling of that which had been defensively disassembled to prevent overwhelming flooding. Interestingly, the classical methods of cure resemble the disease. In the case of combat veterans, a behavioral technique of flooding is the preferred technique. It combines evoking extreme anxiety with the safe haven of relaxation and imagery. For victims of torture, the testimony method was developed. It consists of assembling a narrative out of taped therapy sessions, with a revision of this by both the therapist and patient working together to prepare a testimony (Herman, 1990). Herman further claims "that the action of telling a story in the safety of a protected relationship can actually produce a change in the abnormal processing of the traumatic memory" (1990, p.183). Miller (1993) holds that telling the story, in the case of revealing the incest secret, is not the crucial element. Apart from a therapeutic context, such telling can exacerbate traumatic effects at worst and at best promote little healing.

van der Kolk's (1993) work on the biological aspect of the processing of traumatic memory adds a useful and necessary perspective. He asserts that "post-traumatic stress, by definition, is accompanied by memory disturbance, consisting of both amnesias and hyperamnesias. These traumatic memories are triggered by autonomic arousal, and are thought to be mediated by the amygdala which activates hyperpotentiated noradrenergic memory pathways originating in the locus coeruleus of the CNS. The limbic system, which evaluates the meaning of incoming stimuli, is highly susceptible

to stress, and its levels of appraisal can be affected by relative neurotransmitter levels" (van der Kolk, 1993, p. 173). In short, both the reception and sorting of traumatic memory is disturbed at the level of initial processing. This disturbed inputting then necessarily interferes with its retrieval and integration into accessible memory.

Kluft's recent work on the treatment of MPD has emphasized the primacy of good pacing, and the importance of structuring, with a particular emphasis on an adequate working through process after abreaction. He advocates no more than two or three out of five sessions devoted to working through (Kluft, 1993). Herman (1990) adds that the uncovering of dissociated memory is not the most challenging part of the work; and that techniques which are appropriate for discrete traumatic events may not prove sufficient for the chronic trauma to which MPD patients have ordinarily been subjected. Thus the work of reconstruction with MPD is necessarily more complicated and requires more time accorded to it.

THE ATTACHMENT FACTOR AND THE MUTUAL STORY TELLING TECHNIQUE

Barach (1993) proposed the view that MPD can be viewed as an attachment disorder, with a substrate of parental neglect providing the base on which subsequent trauma occurs. He argues that the failure of the parent to respond to signals of the child's distress leads the child to similarly detach from both internal and external signals that normally would lead to searching behavior for the parent. He states that "upon the detached state are superimposed the sequelae of active abuse" (p.117).

Given this understanding, the mutual story-telling technique is particularly fitting. In this technique, the therapist, together with the patient, retells the story of the trauma from the child's point of view after recovery of such material through abreaction. Both are actually engaged in this process. The mutual story-telling technique was documented as a technique in child psychotherapy by Gardner in 1971. Although Gardner (1986) does not claim to have invented the mutual story telling technique, he developed a method for using stories therapeutically, outlined guidelines for its use, and contributed his findings and recommendations to the psychotherapeutic literature. He proposed that the child patient be invited to tell a story within a therapy session. His assumption was that the story would contain themes central to the child's (neurotic) conflict. After listening to the story in full, the therapist would then retell the child's story with a "healthier" resolution of the conflictual material (Gardner, 1971, 1986).

In my work with MPD patients, I adopted a variation of this technique as it was originally proposed. Instead of first hearing a story in full, I alternated an approximate line by line retelling with the patient. This adaptation allows a more

mutual and interactive process, a way of proceeding in line with the current emphasis on working participatively with the patient, rather than from a hierarchical stance. The story is framed from the child's viewpoint, as if a children's story were being written in simple language which any child could understand. The form of the children's story offers both a distance from the present, along with the accessing of a time frame of speculative historical validity. This method provides a witness who knows "what happened," and by participation in co-creation affirms its status as the patient's narrative truth. This narrative potentially "validates" the patient's history in a way that the neglectful parent never provided. Normally, the parent knows what happens to the child ongoingly, and stores the child's history in a manner that can be accessed by asking. The reader should be aware that the search for narrative truth in order to help a patient toward an integrated identity is not a search for historical truth. This technique, by virtue of its highly interactive format, is designed to alter perceptions of past events toward a healthy resolution, and should be regarded as contraindicated in circumstances where the patient will have to offer testimony about his or her past in some legal proceeding. Patients should be screened for such circumstances before proceeding with this or any other technique that is designed to or has the potential to alter autobiographic memory.

CLINICAL CASE EXAMPLES

Case One

The patient is a married woman with three adolescent children. She came to treatment in her late thirties through her early forties, with a mixed presentation of rather severe affective, somatic, and cognitive symptoms characteristic of MPD. She had not been previously diagnosed as MPD, although she had been in both individual and couples therapy for extreme sexual incapacitation. She worked part-time in a small business office, and dedicated most of her time to her roles as a housewife and mother.

Phobic avoidance of sexual activity with her husband provided me an early clue to the possibility of sexual trauma. She could only have sex if she "worked up to it" and prepared herself with several glasses of wine. This helped her to be able to relax enough to tolerate penetration. She also reported strange events which occurred during sex. She hated to have any pleasure herself; she feared it as a loss of control. Sometimes she would burst into tears inexplicably after sex was concluded, and be seized by extreme sadness or anger. She was unable to talk to her husband and explain where the feelings originated or to what they related. She had rituals to deal with this state and restabilize herself. For example, she might assume a fetal position on one side, curling up to go to sleep without allowing him to touch her further.

Another clue was historical: she reported that in college when she had first begun to have sex, she would often "wake

up" to find herself in a compromising situation which had taken on sexual proportions. This state of affairs would occur without her conscious knowledge of having begun or wanting sexual activity. Such reports pointed to the historical presence of considerable dissociation. Indeed, such reports were a classic example of what Kluft (1990) has referred to as the "sitting duck syndrome."

Additionally, this patient, whom I shall call Jamie, had no memories of her father. She had rather severe amnesia for most of childhood, but it was especially dense for anything having to do with her father. She never spoke of him, and did not commemorate the anniversary of his death. It was as if she had pushed a "delete file" button on anything having to do with her father. She had only one photograph of him. Early in treatment, she said she did not want it around her, and brought it to me to hold.

As we worked, I hypothesized that she had been sexually traumatized by her father at age three. I surmised this because a child alter, her "twin" in her internal system, was said to be three years old. All of her memories of apparent trauma consisted of enacted extreme body sensations without a visual component, and were wordless. She was mute when she abreacted them. Once I handed her a clipboard and paper, and asked her to write anything she could. She wrote the words: "Get off of me. You're crushing me," and then handed it back. Always her legs would be clenched together, her eyes squeezed tight, and she would hold her breath. At the end of this sequence she repeated several self-comforting phrases over and over to herself, such as "It's all right. It'll be all right."

I began to work with stories at her request. She asked me to tell her the story of what had happened to her (and been revealed by other alters) so that she could remember. She stated that initially that the only way she could allow herself to "know" would be if she pretended it had happened to someone else.

I complied with her request, dictating a story which she recorded in her journal, with her as the three-year-old main character, calling the heroine simply "the little girl." She titled the story "My Story," an interesting foray towards ownership, despite her protestations to the contrary. She told me that she read the story over many times.

This person had a strong wish to re-dissociate traumatic material after recovering it, and she often gave in to this propensity. She would find that again she could not remember recovered material a short time after we had finished working. Writing the story in her journal where she had access to it seemed to help her to counter this tendency.

In the story quoted below, I was the sole story teller, (until near the end, as noted), with her nodding her head in encouragement as I got various details more or less correct. All material from this patient is used with her explicit permission. Her words will be italicized; my own will be in conventional type. Here is that first story:

There was a little girl who lived in a house. She felt helpless, scared and out of control. Something bad had happened to her. She didn't want to know about it or feel any of the bad feelings, so she put her feelings in a special place and made up a bunch of new feelings. These feelings became separate and distinctive parts so that the little girl didn't know about the others. But she never felt normal. She tried very hard to be accepted and loved. It wasn't easy, but she did a good job.

When she grew up, she got married. Although things were not right, she tried very hard to make them appear normal, because she was an expert at that. No one could know how "unright" things were. So she pretended. She could pretend so well that she could trick even herself."

Here I decided to stop and she spontaneously continued:

"But then her father died and something happened to her. She felt panicky and her body hurt and she always thought about dying. She fell apart into little pieces. She felt like she was being sucked into a big black pit.

Then she found someone to take her hand and pull her back out of the pit. This woman held on very tightly and would never let go, even when the little girl wanted to go quietly into the pit. She believed in her. Inside the girl's head were a lot of voices. Things got very confusing. Sometimes it felt like someone screaming inside of her head. She wanted to scream "take me away from this place!" And the woman did. The woman didn't want the "pretend" girl. She wanted the "real" girl. The real girl had a lot of anger and sadness . . .

One day she gave me her journal to read. I saw that about eleven months earlier, unbeknownst to me, and prior to what I had thought of as the first attempt at story quoted above, she had written a story of her own in her journal in the third person. It reconstructed her version of her relationship with each of her parents:

This is a story about a little girl who was special. She was very special to her father. She would always go to him when he came home from work. It was her job to keep him happy so her mother wouldn't have to, and to keep him from getting angry. Sometimes she wished the mother would take over the job. But her mother didn't seem interested and she just wanted to be left alone. She seemed sad and the little girl tried to make her happy, so she kept the job without complaining. It seemed like the least she could do to keep peace. She loved when they smiled and laughed and when they were together with her. But it was a hard

job because they didn't come together much. And the little girl spent a lot of time alone with the mother and a lot of time alone with the father. There were special times alone with the father.

Here the entry trails off; apparently a memory was triggered. A few random words appear like "scared, sick, aroused" . . . and then a somatic memory seemed to intrude and she wrote the phrase, "Can't breathe, can't move."

In comparing these two stories, it might be noted that the therapist taking the lead in telling a story seemed to provide a structure of greater safety, which contained the further stimulation of potential flooding. Her own story might lead in directions she would not have chosen and could not foresee.

About six months later in treatment, after I told the first (sequential) story with her, we got to telling her story mutually. I started with a line-by-line alternation, and took more lines if I wanted to develop an idea. I would pause when I wanted her to pick up, sometimes in mid sentence. I developed the notion that in the telling we could incorporate what we knew at that time about her processing of the events, and her defenses, as well as the events themselves. I used the opportunity to bring various aspects of resistance to her attention as well. Contrast the following rendition with the earlier version:

Once upon a time there was a little girl. She was about three years old and she had blonde hair and she was very happy. She lived in a little girl's world and she didn't know anything bad could happen. Then one day she disappeared. It looked like she was still there, but for her the world had totally changed. She had a bad surprise and life was never the same. Inside, her world was very, very scary and she had to figure out ways to protect herself. She found out that when this bad thing happened, she could leave with her twin and go away from her body so that she wouldn't be there when it happened.

But there was more to it than that. She made up rules to protect herself. She vowed she would never again be truly happy. She didn't want anyone to know this so she made up a part of herself that would look happy and would put on a happy face. *Nobody was allowed to know about the bad thing or each other.* And the person that was not allowed to know the most was the little girl herself. She kept herself from knowing by never putting the bad thing into words. But the bad thing played a trick on her. It kept showing up as pain in her body, and she was afraid . . . of life itself. She could never relax and enjoy life for very long. How she longed to be like everyone else, but that was against the first and most important rule: "Never be happy because that's when

something bad happens."

And all this was a secret and no one ever knew. Mainly because it could never be put into words. It stayed as an overall scared feeling taking up space in her body. And for many years she hid in this way. *Until the pain became so great that she thought she would lose her mind.* Luckily then something good happened. *Somebody found her* and the challenge of finding her was a test that had to be passed—just like the princes in fairy tales have to figure out riddles or pass certain tests before they get the love of the princess. The test that had to be passed was *that she would never leave the little girl and that she would find her if she disappeared and that she would keep her safe.* And she had to do all this without the little girl telling her in words. She had to figure it out and she had to be right and she had to follow the rule of silence by not telling her more than the little girl could know. The only passing grade was an A+. Nothing else would do for the little girl.

And the little girl desperately wanted her to get an A+ so she could get out of her prison. The little girl helped her from time to time, but all this had to be done without making the little girl disappear, which she was very good at doing.

The little girl started to trust the woman and she tried very hard to remember the bad thing, but she also obeyed the rule not to remember. She lived like this for many years inside a grown woman's body because there was another rule that she could never grow up until she remembered. *Living inside, dark and deep, she did not like anyone to call on her directly; but on the other hand, she was more scared if the others forgot she was there. She was always scared on the inside and kept Jamie from doing things.* She hoped someone would get her out without breaking the rules because she did not know a way to get out herself. This brings the story up to the present. How the story will end will depend on *if the little girl gets brave enough and lets someone help her grow up.* Some of her grew up anyway and she learned many things. Now to finish growing up she may need to learn many other things.

When she had finished I asked her the moral of the story. She added several ending statements:

A child will do what it must to survive and be safe.

As an adult, one must reach beyond the safe barriers to be in a place of true freedom.

To be truly alive one must feel the touch of another human being.

To complete the exercise and introduce a broader ther-

apeutic agenda, I then asked her to use her journal to allow each of the major alters to react to the story in their own way. My aim was to promote more co-consciousness among the various parts of the mind. In her formulation of her alter's responses, I noticed the degree of responsibility she was willing to take, and how much she wanted to pass on to me.

She continued with the following entries:

Once you let the Little One out, I won't be able to control her. She will be out of my control. You wanted her out. Now you've got her. Don't ask me to be taking over. I work alone, it's been a hard job all these years. See how you like it. Signed: The One In Control.

I am the Little One. I am the little girl. I am glad someone is telling my story. Otherwise, I wouldn't exist. Please don't let me disappear again. It's scary and lonely inside. Please keep telling my story. Signed: The Little One

I think the little girl is a survivor, and surprisingly she has a lot of love inside her. But I think she needs a lot of love and comfort to feel safe. I would like to love and comfort her, but how do you start to love someone you've hated all these years? Maybe that's another rule; treat her mean and she'll go away and you won't have to deal with her. She is like a fatal illness to me. Just thinking about it brings on terror. How can I make her feel safe when I'm paralyzed with fear. That's why the One in Control is the only one who can deal with her. Unfortunately she has no feelings, so she can't really love or comfort her. I'm getting confused now so I can't think about that anymore. Signed: Jamie (the host personality)

Case Two

The second patient is a single, bi-racial woman of thirty-one. She is employed as a technician in an allied health field, and is quite motivated in treatment. She has the goal of returning to school and earning a graduate degree. She had presumably been abused at age three also. She dated the abuse herself and had some clear but fragmented memories from that time which emerged in treatment.

This patient, whom I'll call Laura, was back in treatment for the second time. She did not know of the sexual abuse consciously when she returned to therapy, nor had we dealt with it explicitly during the first course of therapy. Now she complained of a vague feeling that something was holding her back, that life was not progressing as it should. Along with this perception she had body sensations of discomfort and periodic overeating which she called stuffing herself to numb any feeling. Her relationships with men were devoid of mutuality. Either one partner or the other was in the role of the exploiter. Often there were periods of sexual promiscuity without any feeling attached. She had never had a serious or long-term relationship with a man.

Early in treatment Laura brought in a painting she "just had to buy" to show me. It consisted of several faces at different angles, pointing in different directions. She said this painting "spoke to her" and she just had to have it. She also wore jewelry pins which were a depiction of several masks. I began to suspect MPD and administered a DES. Her score was 46.5. I presented her with the possibility that she was MPD, and we began to work on detailing her internal system.

We began exploratory hypnosis with vague metaphoric frames which would allow for the possible discovery and retrieval of memory. For example in one early exploration, Laura found herself walking down a hallway with many closed doors. Behind one such door, she reported hearing a little girl wailing, and she went in to comfort her. This was her first meeting with a child alter named Angel. Angel revealed the abuse to her. Laura, too, cried at what she heard and afterwards she asked if she could bring Angel up with her to keep her safe and continue to comfort her. Angel came, accompanied by Bobby (a male protector), and these two were the first to be integrated after the working through of this memory.

Other memory fragments then emerged. These consisted of more specific scenes involving her father and herself at around the age of three to four. In these fragments there was vivid sensory detail: smells, color, and body sensations. She reported the visual viewpoint of a child in a face down position where she remembered her father approaching her from behind with digital penetration of her vagina. This memory was followed by intense pelvic pain.

This patient also requested help after an abreaction, and asked me directly to "do something" to help her retain and use what she had recovered. I took the opportunity of mutual story-telling for this end, but also highlighted current elements in treatment. In contrast to the first patient, one can notice how much more responsibility this person takes in the formulation of the story. Afterward she took the initiative to work with her story herself, making a tape which she used to listen and further associate to what she had heard. Here is her story:

Once upon a time there was a little girl named Laura. Sweet, innocent, wanting to be loved. She had a Mommy and a Daddy, and she was the daughter. Her Daddy was very, very bad. The bad things he did included going out to bars and not coming home, fighting with her Mommy, and more. The worst thing he did was in Laura's bedroom. But that was a secret for many, many years.

As Laura got older, she became more unhappy. She tried to be happy. She tried to talk smart and be like all the other kids, but inside she was sad. She kept trying to hurt herself to save herself. A lot of the time she wasn't even there. Very early, from the time she was three years old when the bad thing happened, she learned

the trick of going away. She could do it when things got too much, and sometimes it just happened to her without her doing anything at all. This is what she used to survive. She ran and pretended, as children do, that nothing bad had happened.

Then Laura got to be older and older until on the outside she looked like a grownup, but on the inside . . . *Little Laura was still sad and crying. Big Laura was confused and couldn't understand the voices she heard and the crying that kept getting louder.* When she wanted to act like a grown-up and have boyfriends, and try to love them, it got even worse.

So she ended up at Dr. G, and there they tried to make sense of all that had happened. It was tough and seemed like it was taking forever, but Big Laura did see many changes. And Little Laura was able to come out and tell her memories of a Raggedy Anne doll thrown in a corner, of a red bathrobe that belonged to Daddy, of the smells in her bedroom, and of the pain as the bad thing happened. She felt so confused, not knowing what to do or who to trust. After all, look what her daddy had done.

She wanted to put him on trial with a judge and a jury to accuse and convict him. And she made up the trial scene where she could imagine anything she wanted. But every time she went to finish the job there was a problem. There was an empty space whenever she tried to confront her father with what she knew. She felt he would laugh at her, pretending nothing had happened at all. So she chose to stay silent.

But something in her didn't want to go through with the scene and bring it to its ending. She was afraid . . . *that if she did that, all would be lost.* So she kept quiet. She would lose the only father she ever knew, and it would be like not even having a father at all.

But her body kept reminding her of what he'd done. No matter what she did to pretend, it still happened. She couldn't deny the truth of the pain in her body, even if she tried. *She found herself repeatedly stuck in between feeling better and not feeling at all. She knew that someday she would have to say to the father inside her all the things she had kept silent all these years. She would have to tell him how much he hurt her, ruined her trust in other men who she might like to love. How ashamed he made her feel of being a girl, and having a girl's body, that men could do such things to and get away with doing them. This did not seem fair to Big/Little Laura. Besides, he never got to know all it cost her. This too was not fair. She desperately wanted him to pay a price. She had paid too much.*

But he was dead. He couldn't hear her. The real father was dead. The father in the trial room

was very much alive in her mind's eye. *How would she adequately punish him for his crimes? How could she set the record straight if she kept backing away each time she entered the trial room? Each place was set; the characters in their places.*

Each time she went to do this, Laura's habit of going away kept playing its old tricks on her. If the body pain was there, the feelings would go away. Or if the story was there, the feelings would go away. Of if the story was there of the memory, the body sensations might disappear. Big Laura cried tears of frustration at not being able to command her own body, thoughts, and feelings at the same time. When Big Laura viewed the scene of Little Laura, she never got the total sense of being there. A part of her remained Little Laura . . . *not wanting to see, hear, smell, remember what had happened.*

Yet the body kept telling her something had happened. Her therapist helped her understand that when she remembered as Little Laura, her memory would naturally include the very same thing she had done not to feel, not to know, not to experience the total horror of those early moments that spread into years. Years of crying, torment, disgust, even hating herself, instead of him, for what he had done. She carried the burden. She never told her mother, her brother, her grandmother, or anyone else in the family. *She felt no one would believe her. How could she explain? It was all so mixed up anyway. She wouldn't make sense. People would try to deny, but that wouldn't erase what her body felt.*

Her mind would become more confused if she told those who wouldn't believe her. But first she had to tell herself before she could set the record straight. In many ways she's still trying to tell herself, because it's not an easy job like telling a story in one straight line. *At least there's not a bunch of characters there anymore. It's just Big Laura and Little Laura and her father.*

The more the story gets told, the more simple life becomes. And this story we are telling right now is a part of making life as simple and clear as possible. So Laura will continue to tell the story until the story can be told in full, and Laura can fully stand together with her very own story. The End.

After we had completed the mutual story, Laura reflected that different information about various elements of the abuse were held by different alters, so that no one could get the whole picture. She later told me that it was only with the mutual story-telling technique that she, as Laura, knew the whole story for the first time,

In the second case example, the interesting aspect which emerged for further work had to do with the patient's resistance around the point where the abreactive work repeat-

edly had bogged down. In listening to the taped replay, the patient found herself focused on the phrase "all will be lost." She recalled that this was a phrase that her father had used recurrently to get her and other family members to keep various quasi-secrets. These usually had to do with some pretense about himself in which he was engaged, like that he had more education, money, or social standing than he actually could claim. There was a family-wide collusion around these pretenses into which Laura had been inducted. She had repeated this family pattern unthinkingly until the moment when she heard this phrase suddenly as a different observer. She could now begin to question just what in fact would be lost by her telling the truth.

NARRATIVE, COHERENCE, AND IDENTITY

Autobiographical memory is the starting place for engaging in many varieties of social exchange, from the most casual question of "Where are you from?" with which strangers approach each other, to the most intimate exchange of lovers: "Have you ever felt like this before?" From its bits of data, we assemble an image of ourselves for the other, and we constitute an identity. In this context, imagine now the situation of traumatized patients with gaping holes in their memories of their life. Even the most insignificant exchange can land in one of these holes and provoke massive anxiety. Little wonder that we encounter such social isolation in our patients, as if they are abiding by the adage of "discretion being the better part of valor!"

Putnam (1990) writes that, "The reconstitution of the self through the recovery and chronological sequencing of missing autobiographical memories can play an important role in the therapeutic process (p.126)." Laird (1993) adds what we know so well from our patients, that, "Often words are not said internally because parts of one's experience, the self-story, are inaccessible to the self . . . the *dissociative unsaid* . . . because they are unthinkable and unspeakable (p.258)." Herman (1990) reminds us once again of our role in bearing witness, making it possible for the patient to bear a reality that cannot be borne in isolation. She writes that, "By our presence, we enable our patients to tell what has happened to them and to make sense out of the unspeakable events of the past (p.291)."

Linde (1993) writing on the phenomena of the life story notes that psychotherapy and the life story, a conversational form, have considerable overlap. Almost all systems of therapy permit patients to recount significant stories. She also notes that recent hermeneutic approaches view the life story as being more a vehicle of interpretation than of facts. The therapist and the patient then have the possibility of constructing a new, more successful life history, if indeed it is interpretation which is the more crucial element.

However we construct our stories, we do so within a social coherence system which provides parameters to guide our

efforts. Linde (1993) defines coherence systems as a "more global cultural device for structuring experience into socially sharable narrative" (p. 163). She further notes that "a coherence system is a system of beliefs derived from some expert system, but used by someone with no corresponding expertise or credentials" (1993, p.163). An example here would be psychoanalysis, which is an expert system imputing causal power to childhood events in explaining the adult personality. This attribution system comes to be seen as common sense, which everybody knows, is taken as a given, and does not need further explanation or justification. In its terms then, we may account for our behavior in retrospect when we tell life stories.

Two principles of the life story and its management in conversation are the demonstration of agency and continuity. Agency is demonstrated when we show that our life choices flow from our character and are a result of our considered choice, rather than an accident. Similarly, we must manage any apparent discontinuity of autobiographical sequence such that we posit an underlying connection which accounts for the discontinuity, again showing that we are in charge of our life. Not to do so consigns one to a lesser identity.

MPD patients cannot qualify their life story in these ordinary social terms. It helped that the Feminist movement, through the early vehicle of consciousness-raising groups, enabled women to speak. In the exposure of woman and child abuse which followed from that speaking, a narrative was produced of woman and child as victim. Having the narrative available has provided a social climate enabling other women to speak further of what was formerly unspeakable. But the narrative of abuse and the identity of victim was not one which offered a sense of agency or being in charge of what had happened in life.

The formulation of the victim-narrative was accordingly transformed into the survivor-narrative, an identity with considerably more dignity. This shift was accomplished in part by popular self-help books like *The Courage to Heal* (Bass & Davis, 1988) which directly promoted the distinction Survivor, rather than Victim. The recently published *Fire With Fire* (Wolf, 1993) a popular book on the women's movement, argues as its central premise that the victim role was a very poor political identity, which hurt the momentum of the movement and must now be cast aside. These books and others like them, as well as the method I describe in this paper, document the attempted shift from a less powerful to a more powerful and approved identity with a sense of agency. However, as noted earlier, it is crucial to bear in mind that the narrative that empowers the survivor and promotes healing may not be identical to historical reality. Memory is a complex reconstruction process, not a pristine record of the past. Therapy inevitably has the potential to contaminate memory with post-event materials and influences. The reader can see from the examples that the mutual story-telling technique in this context is used to enable the patient to tell her

story, and not to create a completely novel narrative with encouraged and constructed "historical" events. Nonetheless, all cautions appropriate to work with recovered memories should be born in mind.

SUMMARY

This paper has extended narrative approaches to psychotherapy to the treatment of MPD. I have argued that given the characterization of traumatic memory as "wordless, static, and frozen," story-telling techniques after abreaction of such memories allow several important restorative functions to take place:

- 1) The therapist bears witness to the patient's experience, ending the isolation and secrecy in which the trauma has existed, and rendering the recast experience a social one.
- 2) A narrative subtext is created, making the memory available for future accessing and conversations.
- 3) New identity formation is facilitated out of the story being told in a transformative vein, allowing the shift from a victim identity to one of being a survivor. A sense of agency may also be engendered by participation in the creation of the story together with the therapist. That the story as told remains open at the ending emphasizes the ongoing role we have in shaping our life stories as our understanding unfolds. Additionally, the mutuality of the story-telling technique affords a customization of elements that the therapist would bring to the patient's attention for focus or review. It can contain a summation of "what we know up until now," and emphasize current elements of resistance or suggest where more work is needed. After the story is completed, journal writing or listening to tapes of the story may be used to extend its possible therapeutic mileage. Two case examples have been provided to illustrate these points. ■

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