The Therapist's Experience of Disbelief in Working with Dissociative Identity Disorder

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written about by another person (except where explicitly defined in the acknowledgements), nor material which, to a substantial extent, has been submitted for award of any other degree or diploma of a universality or other institution of higher learning.

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Abstract

Disbelief of patients with Dissociative Identity Disorder remains a common, yet relatively unexplored phenomenon within psychotherapeutic literature. In treating DID, therapists and healthcare professionals alike are subject to strong unconscious forces that make both diagnosis and treatment of DID difficult for the practitioner. In this dissertation the writer's own process with both clinical literature and patient work is explored, as part of a hermeneutic literature review into the nature of disbelief of DID. The therapist's countertransference is seen as pivotal to conceptualising disbelief, as a 'to be expected' part of treatment.

Disbelief is examined through the lenses of the *imperative to not-know* and the *difficulty with the multilateral self*. The *imperative to not-know* is explored as a defensive process, that acts to prevent knowing, though an investment in -K, resulting from the patient's need for early life survival (Bion,1962). The therapist's *difficulty with the multilateral self* is then examined as a protective response based on the degree of dissociation that occurs in DID, as well as the reliance on a unitary model of self.

Qualities that enhance the practitioner's ability to treat DID with such difficult, evasive, and overwhelming dynamics are explored, including the development of negative capability and an ability to maintain the complexities, by entering into uncertainty and not-knowing. The therapist's ability to 'stand in these spaces' is seen as central to restoring linking and K in effective DID treatment (Bromberg, 1996; Bion, 1962). An interdisciplinary cross pollination of ideas is sought, in order that an ongoing fruitful engagement regarding countertransference, disbelief, and DID can be of benefit to the patient.

Chapter One

Introduction

This research project is a hermeneutic inquiry into psychoanalytic literature that examines the therapist's experience of countertransference in treating Dissociative Identity Disorder (DID). The intention of this research is to focus on literature that examines the phenomenon of disbelief located in the clinician's countertransference experience and therefore the implications for diagnosis and treatment in psychotherapy practice.

Background to This Question

My interest in the phenomenon of disbelief that surrounds the diagnosis of Dissociative Identity Disorder (DID), began two years ago when I undertook a clinical placement at a Community Mental Health Centre. I was struck by healthcare professionals disregard for 'DID' as a 'real' diagnosis, and the discomfort described by clinicians in having DID cases. The narrative that DID may have been created by previous clinicians or that it may not even exist at all, was observable in clinical discussions, despite its Diagnostic and Statistical Manual (DSM) classification. Working with this client group myself, I began to notice a parallel of disbelief in my own countertransference, and a curiosity regarding who or what was not being believed began.

Given the psychotherapy framework and training I am engaged in, my instinct was to understand this phenomenon as evolving out of the dynamic between myself and the patient, specifically within the context of transference and countertransference, the patient's history, and resulting intra-psychic defence mechanisms. I began to wonder how disbelief fitted into the discourse surrounding DID patients, and the literature I

encountered appeared to echo this split between proponents of a socially constructed iatrogenic[1] aetiology of the disorder, and a psychotherapeutic perspective.

I conducted a mini literature review at this point (unpublished) in which I discovered that while both positions acknowledge trauma to be a significant feature of DID patients' history, only psychotherapists placed a significant emphasis on trauma within the aetiology as being pathogenic. I continued then to consider what the relationship between trauma, disbelief and countertransference in DID might be. I wondered what effects this had on patients and how the responsible clinician understands and accounts for their own experiences of disbelief. I also wondered, ultimately, how this then both effects and guides their treatment approaches. In response to DID patient presentations I observed a frequent splitting of the team into varying degrees of belief, and noticed how this was echoed in my countertransference and my own varying self-parts, that both believe and do not believe.

Dissociative Identity Disorder

The diagnosis of Dissociative Identity Disorder, formerly referred to as Multiple Personality Disorder is a diagnosis recognised by the Diagnostic and Statistical Manual of Mental Disorders DSM-V (American Psychiatric Association, 2013). The diagnosis is characterised by the existence of at least "two or more distinct personalities" (p. 292) described "in some cultures as an experience of possession" (p. 292). It is also a diagnostic criterion that the person must experience significant amnesia and gaps in memory. As a disorder it interrupts the daily functioning of the individual and therefore impedes their ability to engage in social, educational or work life.

[1] Iatrogenic is defined as a diagnostic or medical treatment that inadvertently induces a condition or disease ("Medical dictionary," n.d.). The social constructivist model builds upon this iatrogenic notion, and is based on the conclusion that DID has an iatrogenic origin, that may also be impacted by books, films and social influences by which the patient is hypnotically affected.

DID results from a prolonged exposure to recurring traumatic events and is a particularly creative defensive mechanism that allows for the splitting off of different parts of the personality that may represent younger, demonised or idealised aspects of the self that have varying awareness of the traumatic events and history of the patient. Chefetz (2000) points to the defensive function of DID to separate out experience and knowledge associated with traumatic events, expressed as an adaptive and protective strategy to manage the debilitating, overwhelming and adverse effects caused by the terror of usually early and severe trauma.

I would agree with Chefetz (2000) that there is a defensive adaptability to not-know that can include separating affect from knowledge and the forgetting of personal history, and it is this not-knowing for the patient in the form of dissociation and disavowal that can become echoed in the therapist's countertransference as disbelief.

I noticed in myself a baffling and often bewildering sense of incredulity in moments with patients who recalled disturbing experiences like they were reporting casually on the weather outside. At other times the recollection of self-knowledge felt as if both the patient and I were staring at a jigsaw puzzle, not imagining that any of these pieces could ever fit together. As Chefetz (2000) states, the countertransference of disbelief to trauma functions to cover knowledge of abuse, when the therapist is unable to withstand overwhelming feelings of anxiety and helplessness that knowledge of abuse can engender.

Countertransference

Freud's (1910/1952) conception of countertransference was as an obstacle that was necessary for the analyst to overcome through personal analysis. It was considered a hindrance arising out of the patient's unconscious feelings that obscured the therapist's 'objective' viewpoint.

In my understanding the evolution of this concept can be attributed to a wide array of influences including Klein and her followers, as well as the representatives of humanistic and interpersonal psychoanalytic schools. It would appear that the culmination of this thinking resulted in three seminal papers by Winnicott (1949), Heimann (1950), and Little (1951) that defined countertransference as an understanding of the therapist's feelings towards the patient, which have clinical value and importance in understanding both the patient's conscious and unconscious communications.

Heimann (1950) in particular describes all of the therapist's feelings towards the patient as countertransference being of clinical significance. In this defining break from tradition she notes the therapists' experience of countertransference to be a product of the patient's creation, and as a deeply felt sense of rapport, the therapists' most significant tool in accessing and understanding the patient's unconscious.

I would add to this view the work of the ‘relational turn’ in psychoanalysis, and the impact that the therapist's own history has in what is seen as the creation of an analytic third, or a convergence of both the therapist's and patient's personal history in understanding the phenomenon of countertransference (Aron, 1996).

More specifically, Gorkin (1987) discusses two categories of countertransference significant to work with DID of 'objective' and 'subjective' countertransference. 'Objective' being a generalisable experience of what other therapists may experience with the same patient and 'subjective,' what is evoked more specifically in the therapist based on their own history and internal world. In my experience, while both forms of transference take place, the experience of 'disbelief' which is common to work with DID patients belongs more commonly to the category of 'objective' countertransference, which shall be the subject of this dissertation.

Countertransference in trauma theory is defined by Wilson and Lindy (1994) as occurring along a continuum between over identification with the client, and a

distancing detachment. These 'to be expected' forms of transference to trauma are further understood according to Wilson and Lindy by subjective or more generalisable countertransference categories as described by Gorkin (1987). Given the high likelihood in trauma work of aspects of the trauma story being replayed in the therapeutic relationship, these framings help to further define and recognise countertransference and its relationship to disbelief.

Dissociative processes underlying disbelief in the countertransference are closely connected to the experience of severe and overwhelming trauma (Putman, 1989). According to Kluft (1984) they allow the traumatised patient to separate themselves from overwhelming affect, and to retain certain degrees of functionality. Countertransference in DID can therefore involve feeling many of the feelings associated with the patient's own trauma and early life experience that the patient may be dissociated from. In locating disbelief Kluft (1984) cites the necessary retreat of confused and bewildered therapists to the sanctuary of scepticism.

Hegeman (2010) states disbelief is the most common countertransference to abuse and changes in identity, such as those experienced in DID. I would agree, as Hegeman suggests, that it is relative to the human condition to feel unnerved and experience disbelief when faced with the fragmentation of our concept of a unitary self. Experientially this can feel like an assault to our basic understanding of who we are, and a fundamental challenge to our conception of the nature of our own being. It is this anxiety or disbelief experienced in the countertransference that I propose is of central importance in framing DID and the beginning point of my research question. I will focus therefore on what disbelief signifies for the therapist and the patient alike, and how we can better understand these in order to improve work with DID patients.

Beginning My Research

In my initial literature review on the controversy between the iatrogenic (social constructivist) model and the psychoanalytic perspective, I became interested in what role countertransference had to play in understanding DID. Disbelief in particular appeared to be a significant part of my own experience with DID patients, as well as a common feature of trauma work. In understanding more about disbelief and DID, the backdrop of trauma theory felt like an important landscape to navigate.

The denial of childhood sexual abuse has a history as Howell (2011) describes of a phobia that exists within the general population of knowing about abuse, despite evidence and growing awareness that child abuse is disturbingly common place. The denial of child abuse has a well-documented history (see DeMause, 1997), but a full discussion of this is beyond the scope of this dissertation; however, the denial of DID exists within a similar history of incredulity. Goodwin (1985) points to the historical precedent of disbelief of DID, as rooted in the explicit teaching of psychiatry students that DID did not exist, that female sexual abuse did not take place, and that patients were either malingering or attention-seeking, due to being hypnotised by misguided and ignorant psychotherapists.

While the phenomenon of disbelief sits within a similar history to the denial of childhood abuse, the denial of DID has been less examined. The intention of this dissertation therefore is to examine from a psychotherapeutic perspective what the literature can tell us about disbelief, countertransference, and DID. Given my psychotherapy training it has felt important to both acknowledge the lens of this investigation, and to add to the field from this particular perspective.

Cultural Context

While a comprehensive investigation of the cultural framing of DID is beyond the scope of this dissertation, it feels important to acknowledge the inherent biases of research that takes place within a Western cultural context and to acknowledge as Hegeman (2010) suggests, that the prevalence of disbelief of DID in Western culture is caught up with the notion of a highly boundaried idea of self. It has been significant in conducting this research for me to consider what it means to both diagnose and to pathologise, and to pay particular attention to the Western cultural practice for pathologising DID self states, where in other cultures these are likely to take on a different narrative such as spirit possession.

In saying that, it is also important to acknowledge more broadly that given what we know about the aetiology of DID, there could likely be dangers in taking a culturally relativist position, given what might be covered over, and therefore at stake in not pathologising, including the potential to collude with a misuse of power. It is significant to remember the potential for culturally relativist thinking to lead to practices such as 'culturally sanctioned' abuse (female genital mutilation, for example), and an abdication of our responsibility to universal human rights, and an ethos of decency and respect. It has felt important therefore to hold in mind the dialectic between culture and universality, as dynamic and unfolding with each unique situation, while keeping in mind more generalisable truths in my wider thinking around this topic.

Chapter Summary

In this chapter I have discussed my rationale for undertaking this research, as well as my orientation and psychotherapy lens that I locate myself within. I have described the background to the research question, as well as defining Dissociative Identity Disorder, disbelief, and countertransference as key elements of my research.

Structure of this Dissertation

In chapter two I will discuss my hermeneutic methodology and qualitative research method. I will outline key processes as well as obstacles that I encountered as part of the research process. In chapter three I will provide further context for my research process, and arrival at key themes. In chapter four and five I discuss the outcomes of this literature review. Firstly, I will discuss the *imperative to not-know* and secondly, the difficulty with the notion of a *multilateral self*, and how these relate to disbelief encountered in working with this client group. Chapter six is a discussion of this study's findings, and what the implications for clinicians working with DID might be, as well as the wider field of psychotherapy practice. I also include in this final chapter a summary of the strengths, limitations, and implications of this study for further research.

Chapter Two

Methodology and Method

Hermeneutics. Hermeneutics is a mode of inquiry into both knowledge and understanding that is derived from Heidegger's (1962) notion of ontology, which emphasises our enmeshment within our context. Gadamer (1977) describes Heidegger's ontology as the basis of contemporary hermeneutics and as a form of interpretation and understanding that is deeply seated within, and reflective of the nature of our subjective experience.

Philosophy. I have used an interpretive hermeneutic research methodology for this dissertation. The work of Grondin (1997), Zimmermann (2015), and Gadamer, (1977), underlie my understanding of this methodology for undertaking research.

According to Grondin (1997), hermeneutics places the writer within the context of their environment and history. Hermeneutics centralises the interpretive and subjective nature of research and puts into question accepted epistemological viewpoints. Hermeneutics is further defined by Zimmermann (2015) as examining the way knowledge is understood and the paradigms of understanding that we live within. Research that is hermeneutically oriented parallels psychoanalysis in its grounding in and examining of the mechanisms of meaning making that occur between the text and interpreter, or patient and therapist. In this way, Zimmermann suggests, hermeneutics can become an expanding interplay between knowledge and understanding based on intuitive insight.

It is likely therefore that a hermeneutic examination that acknowledges my own bias and psychoanalytic orientation will be a fruitful approach for an interpretive literary investigation. As Gadamer (1977) writes, hermeneutics is a continuing dialogue between reader and writer that seeks understanding inherently tied to the context of the

reader, which, as a methodology, mirrors the delicate ground of both psychotherapy and trauma work. I intend therefore to utilise a hermeneutic methodology to frame a critically robust, yet reflective approach to understanding DID.

Understanding through hermeneutic interpretation

I propose a hermeneutic methodology for this research project parallels what Davies (1996b) emphasises as psychoanalysis' interpretive model of exploring subjective truths. Davies (1996b) has described how in psychotherapy the exploration and remembering of historical trauma underpinning DID presentations is best understood through a hermeneutic lens. Davies (1996) suggests that this interpretive approach to disorders with trauma aetiologies allows the survivor's process of understanding to take centre stage as part of the therapy process. In this model, the narrative of the survivor is privileged over the attempt to isolate objective truths. This runs parallel with a hermeneutic model for psychotherapy research. It is evident then, as Kluft (1992) suggests, that hermeneutic approaches to trauma are deeply steeped within the field of trauma work, and naturally align to a hermeneutic method of research. It is what Boell and Cecez-Kecmanovic (2014) describe as an approach to research that seeks to engage in constructing a continuously developing understanding of knowledge, rather than objective truths.

My intention in this research is to utilise my own psychotherapeutic propensities to reflect on the literature, and gain interpretive insights, in order to expand on knowledge regarding DID within a psychoanalytic framework, with a particular emphasis on the therapist's experience or countertransference. Research that is hermeneutically orientated parallels psychoanalysis in its grounding in and examining of the mechanisms of meaning making that occur between the patient and the therapist. Hermeneutic research, like psychotherapy, is also open, reflective, and scrutinising of

its own process, and it will be an important part of this research to consider the ways in which underlying constructs and processes impact on research outcomes.

Subjectivity, countertransference, and hermeneutics

The emphasis of my research question is on the phenomenological and subjective experience of the therapist when thinking about, and being with, DID patients. Subjectivity, particularly the therapist/researcher's interpretive stance, is at the heart of this research investigation into how we reach clinical conclusions, and treatment considerations regarding DID. A hermeneutic methodology, as Schwandt (1994) suggests, centres on the notion of the self's subjectivity, and who one is in a state of becoming, defined as ontology not methodology: meaning results from the nature of our being. Subjectivity as a framework allows the researcher to fully immerse themselves in all the parts of their experience that inform the process of interpretation, drawing a direct parallel to the exploration of subjectivity (countertransference) in psychotherapy work with DID.

Hermeneutic Process

Identification of texts. Initially I was interested in a systematic method of researching using the search terms "Dissociative Identity Disorder" AND "Dissociative Identity Disorder AND countertransference" along with "scepticism OR Dissociative Identity Disorder" AND "Disbelief OR Dissociative Identity Disorder". I searched relevant databases including known sources of peer reviewed journals (AUT Library, pep-web.org, Google Scholar), however, I found that the texts that I located did not address the core of the research question regarding the therapist's experience, or have much reference to disbelief and countertransference in DID. However, the process I undertook, produced a large amount of potential literature that allowed me to

distil a range of texts, which enabled me to then engage with a more organic process of "snowballing and citation tracking," (Boell & Cecez-Kecmanovic, 2014, p. 269) where I located texts that led me to more relevant literature that I felt resonated more deeply with the heart of my research topic. I included material that discussed the relationship between the therapist and patient, with further inclusion criteria focusing on trauma and disbelief. This "snowballing and citation tracking" process felt more in keeping with the aims of a hermeneutic literature review, which is to locate a small number of texts pertinent to the research question, allowing for an in depth reading and reflection on selected material (Boell & Cecez-Kecmanovic, 2010). In order to generate insight and new information the researcher must use their own subjectivity to guide them in sourcing and locating relevant material. While I decided to distance myself at this point from a structured search process, this felt in keeping with how McWillams (2011) describes psychoanalysis to be a difficult discipline to research empirically, because of the value it attributes to the complexity of each situation and person.

The second phase of my search then became a more unstructured process whereby inclusion and exclusion criteria became defined by my subjective resonance with each text. The hermeneutic process requires an in-depth reading of literature, which organically leads to further relevant literature, and by following this method I was embracing Boell and Cecez-Kecmanovic's (2014) organic and intuitive method of refining material. An acknowledgement of my background, culture, bias toward psychoanalysis and personal experience with this topic is therefore highly relevant in how I made decisions and which texts I was drawn to. I noted a tendency towards psychoanalytic writers including theorists such as Bion and Bromberg as well as Chefetz and Howell, based on their expertise in psychoanalysis and DID. I also found my experience with the research question and my own sense of having felt disbelief in

the countertransference with DID patients fuelled my desire to explore my own phenomenological experiences with texts.

In defining what would be used as 'text' I included my own countertransference in working with clients, as well as ‘countertransference’ to the literature I found. In including my own responses, I felt I was able to more fully engage in a hermeneutic process and bring in all the aspects of experience that were impacting on my interpretation of the literature.

Reading, re-reading, and re-thinking

The next phase of my process encompassed what Boell and Cecez-Kecmanovic (2010) describe as the hermeneutic circle, a method where moving between the individual parts and the larger whole facilitates a process of gaining deeper insight into selected literature through a reading and re-reading of material pertinent to the topic. According to Boell and Cecez-Kecmanovic (2010), this method requires an in-depth reading of literature, which organically leads to further relevant literature, including texts that I happened upon or were recommended to me. I carefully tracked my initial impressions of texts, writing down my thoughts and responses, and noted the development of ideas upon re-reading texts that I had felt naturally drawn to, and that had remained of interest to me. It felt like an important part of this process was to become at times lost in the material, engaged in a continuous period of writing, not knowing if I would emerge with themes or a clarity of insight. Trusting in the hermeneutic process is what Smythe and Spence (2012) describe as the activity of waiting, and giving over the immediacy of needing to know. Insight, I found, trickles down through the edges of what is visible, but remains obscured, and it is through this continuous commitment to letting go, that the fruition of a dialectic between seeking and waiting is able to take place.

A hermeneutics of letting go felt like it had particular relevance for my topic given the focus of the research question on the therapist's experience, and what Bion (1962) describes as the significance of the unknown, unknowable, and unthinkable in psychoanalytic work. In a parallel to therapeutic work with DID clients, what is unknown or unthinkable remains outside of conscious awareness, and rather than a view of 'the whole', the personality is split into parts. Psychoanalytic work with DID clients therefore mirrors the hermeneutic process of going between the parts and the whole, through a process of gaining gradual insight, where creativity, and what Winnicott (1971) refers to as play, expand the researcher's ability to arrive at subjective truths.

Organising Thoughts and Emerging from Within

A common countertransference experience in my work with DID patients is an absence of a cohesive narrative, and the feeling that the ability to put things together is just out of reach. I feel that this experience is analogous to the hermeneutic circle of reading and writing, and struggling, not knowing when or how thoughts will become organised. As Smythe and Spence (2012) write, there is "no logical, linear process that moves from start to finish" (p. 21). Finding threads and weaving thoughts together in order to write, became a journey of emerging rather than finishing or polishing off a final product. My experience of knowing or insight, as a felt experience, is what eventually began to emerge from the murky water, as a sense of conviction formed from following tangential threads to what felt like natural endings. The revelation of the therapist comes from what Bromberg (2006) describes as that which "takes place not through thinking, 'If I do this correctly that will happen' but rather, through an ineffable coming together of two minds in an unpredictable way." (p.147).

I felt that a point of completion was about to be reached when both time constraints, and as Levy and Ellis (2006) suggest, new material that I came across appeared to pertain to familiar themes, authors, ideas and conclusions. I also reached a point in the process where I could see new areas of research branching off from my current view point, and a sense that the solidification of where I was currently at needed to take form, through a synthesis of my current knowledge, interpretation and understanding. I felt that trusting in my own judgment, as I had been doing all along, was therefore an appropriate indicator of when to stop, and that I had developed an understanding, and perspective on how the therapist's experience of disbelief was functioning in DID.

Actualisation of the Research Process

In my current position looking forward, I feel that the integrity of my commitment to this research process, having been both a significant inward as well as outward endeavour, will be demonstrated by my commitment to the dissemination of my clinical findings, in order that an engagement with a wide, and multidisciplinary clinical audience remains at the heart of this research.

Chapter Summary

In this chapter I have discussed how a philosophy of hermeneutics underlies my research method and methodology. I have described how hermeneutics both builds from and highlights the researcher's subjectivity. I have outlined how this particular philosophical lens is a complementary match given my psychotherapeutic orientation, as well as my chosen DID subject matter. I have also reflected on the hermeneutic circle and the process of engaging with literature that I have undertaken in order to gain insight into this research topic. I have discussed the challenges and gains of deepening

into an interpretive, intuitive, and reflective research method, as well as briefly discussing the wider intentions of this research process going forward.

Chapter Three

Diving in and Wading Through

Initially I had the expectation that if I reflected on the therapist's experience of disbelief regarding DID, a distinct narrative would develop, which would allow me to make sense of the broad variety of intrapsychic and interpsychic perspectives on DID within the literature. However, as I stared at pages and pages of handwritten notes one evening, what felt like a dense fog descended upon my immediate area of vision, and I had difficulty in making any thematic links within the material. As I continued to read I seemed to be digging an increasingly deeper and darker trench. Looking at my notes and books sprawled out in a semi-circle around my work space, I was reminded of a recent group revelry session while presenting a DID client. The song 'The Wondrous Boat Ride' (Bricusse & Newley, 1971) from *Willy Wonka and the Chocolate Factory* (Stuart, 1971) arose in the group's response to the patient. This feeling of being lost and directionless in the material with a building sense of urgency enveloped me, like a shapeless fear. I felt this to be a direct parallel to my experience of working with DID patients and the literature I was attempting to make sense of: hazy and spiralling without direction.

> Round the world and home again
> That's the sailor's way
> Faster faster, faster faster
> There's no earthly way of knowing
> Which direction we are going
> There's no knowing where we're rowing
> Or which way the river's flowing
> Is it raining, is it snowing
> Is a hurricane a-blowing
> Not a speck of light is showing
> So the danger must be growing
> Are the fires of Hell a-glowing
> Is the grisly reaper mowing
> Yes, the danger must be growing
> For the rowers keep on rowing
> And they're certainly not showing
> Any signs that they are slowing

(Bricusse & Newley, 1971, track 9).

Going back to my method to understand this experience, Smythe and Spence (2012) provided me with the guidance to have faith in my process, outlining how "understanding spirals, grows, becomes confused, gains clarity, holds contradictions, and recognizes paradox" (p. 19). Smythe and Spence's description of embracing the vicissitudes of the process, including confusion and doubt felt like it provided me with the necessary fortitude to stay in the experience as outlined by my method. Their description of an act of grace, as opening up to and allowing the coming of a new thought through full immersion in the hermeneutic process, was significant to embracing an "interplay of seeking and waiting, of writing and pondering, of knowing and doubting" (Smythe & Spence, 2012, p. 20). It was through this submission or allowing that something began to loosen, and my inability to think and its familiarity to working with DID became apparent. It was at this point I felt directed back to Bion's (1959) *Attacks on Linking*. Bion's (1959) description of intrapsychic processes that serve to defensively sever links between subject and object, or knowing and not-knowing, felt particularly apt to both the countertransference in working with DID patients, and my countertransference to becoming immersed in the literature.

Emerging Through the Fog

In exploring this inability to think when confronted by the material, a closer reading of Bion's (1959) understanding of psychotic processes drew my attention to the mechanisms through which parts of our experience can remain unknown to us, and how in the countertransference this attack on linking can be experienced as an attack on the therapist's ability to think. This particular idea of Bion's struck me as significant to both my own experience and the ways in which disbelief was described in the material I was reading. The therapist's experience of the phenomenon of disbelief encompassed a felt sense that from a psychoanalytic perspective there was a severing of the link between the widely accepted aetiology of DID (Putman,1989, 1991; Howell, 2011) of severe, and ongoing early traumatic experiences, and the resulting disbelief of its presentation.

I felt mindful of the ways in which disbelief was described in the literature as both an identification with the persecutor and a reenactment of the initial denial of the experience itself (Hegeman, 2010). It felt however that there was a deep-seated anxiety in these responses that struck me as a vehement *need to not-know* that captured my attention, persisting as a felt sense throughout my reading of the material. While initially dismissing this thought as too broad, and fearful of settling on any one idea as more pertinent than any other too soon, I found that this particular thematic link stuck with me, in a way that was hard to shake. As I went back to the literature, re-reading and re-thinking, in a sense re-tracing my original steps, I found myself coming back to my own experience of disbelief in relation to DID, a not-knowing necessitated by an instinct of something more disturbing than my conscious mind could hold.

Departing and Arriving

Hegeman (2010) suggests that even those well attuned to the significance of dissociative mechanisms remain susceptible to an experience of disbelief that lurks at

the peripheral of our awareness. I found in my experience of tracking what I thought to be my resoluteness to believe in the reality of DID that I felt surprised, that despite my best efforts it was as Hegeman suggests; there existed within me a deep-seated resistance, that I had remained relatively unaware of.

In reflecting further on this '*need not to know*', I became aware of this resistance in myself as a potentially important discomfort to know more about, in order to focus on my understanding of the therapist's experience of disbelief in relation to DID. Going back to the literature at this point, Orgad's (2014) discussion of Bion's notion of -K as an enactment of not-knowing that takes places within the family system, focused my attention more directly on the interpsychic and intrapsychic effects of not-knowing. Throughout my reading there had continued to be an emphasis on the therapist's and patient's experience as both a interpsychic and intrapsychic experience, however, what continued to impress upon me was the therapeutic paradigms that defined the way these phenomena were understood. More specifically the 'unified notion of self' that 'believing' in DID seemed to fundamentally disturb in the therapist's experience, identified by Hegeman (2010) as something deeply disturbing without accompanying words.

I decided therefore that there were two significant parts to this experience of disbelief for therapists that were of central of importance for me in understanding and working with DID. The imperative to not-know and the experience of a multilateral self. Both of these ideas helped me in focusing in on what stood out about my own experience in working with DID, and provided thematic links that allowed me to think more clearly as I continued to navigate my way through the material.

Chapter Summary

In this chapter I have discussed in detail my experience with the literature as a process of reflective contemplation and struggle. I have described how embracing a hermeneutic method facilitated my ability to 'be in the experience', in order to make links between my own experience with DID patients and my research topic. I have attempted to demonstrate how trusting in the process led to a progression of insights and clarity regarding thematic resonances and organising principles which then began to emerge from the data. I feel that in fully embracing a hermeneutic circle of moving between the parts and the whole, that a unique marrying of my own propensities and experiences with the literature has given the space for my selected themes to evolve.

I continue in the next chapters to utilise these concepts to articulate an understanding of the therapist's experience of disbelief in working with DID. The following chapters offer a detailed consideration of the imperative to not-know and an exploration of the multilateral self as they correspond to my interpretations of the data.

Chapter Four

Disbelief to Survive and Surviving Disbelief – The Imperative to Not-Know

I found that in researching the therapist's experience of working with Dissociative Identity Disorder, that DID appeared to engender in the clinician more than a simple feeling of disbelief, but what I came to think of as an *imperative to not-know*. This imperative appeared to have a degree of force, and vigour, that felt in its immediacy much larger than what could be explained simply. I felt this first hand as a jarring and pointed experience of lightning-fast indignation. In drawing on my own reverie with both the literature and patients, I set out to understand this imperative to not-know to gain insight regarding my own work with DID.

As Galton (2008) states, "it is widely agreed that a diagnosis of DID is prima facie evidence of early trauma" (p. 181) and yet somehow, the link between the diagnosis and the countertransference response of disbelief, has gone largely unexplored in the clinical literature. Instead, as Kluft (1993) remarks, countertransference responses of disbelief become mistakenly enveloped by unexamined scepticism. In setting out to understand the nature of the therapist's disbelief in relation to DID, and how this becomes expressed or covered by an imperative to not-know, I needed to consider the intrapsychic as well as interpsychic factors at play, to understand what becomes activated in the therapist, to ultimately understand more about working with this client group.

Goodwin (1985) highlights the overtly protective functions of the clinician's disbelief. She draws a parallel between de-realisation as a defensive strategy employed by the patient, and disbelief as an endeavour to create distance from terrifying realities utilised by the clinician. This position is in agreement with Galton (2008) who argues that when working with this client group the therapist is likely to face into overwhelming helplessness and anxiety and will attempt to manage this through a

questioning of the disorder. This protective adaptability struck me as having dissociative qualities, similar to those employed by the patient to distance themselves from overwhelming aspects of historical trauma, where dissociation is used to keep knowledge separate to experience, in order to support their ability to continue to function.

Through my own work with DID patients I have considered how a parallel between my own disbelief and the patient's became shaped by an internal split within myself, as the need to not-know appeared to buffer me from something devastating: a level of dread that I would rather not have to bare. I noticed this similar buffering in my countertransference to the literature. When re-reading Chefetz (2000) on the subject of traumatic memory loss of the primary personality in DID, I observed how I could rationally understand the defensive function of the mind to split off and dissociate from overwhelming trauma, yet, I continued to notice that another part of my mind, while considerably turned down, persisted to doubt, question and disbelieve. I wondered to what degree disbelief protected me from what it could mean for me to fully comprehend the degree of devastation that must necessitate the complete fragmentation of the self that occurs in DID.

The concept of protection in itself denotes safety from imposing harm, and is also central to an imperative to not-know or not see. As Britton (1994) so aptly describes, the 'blindness of the seeing eye' (Freud, 1924/1953) is a defensive measure which is directed internally as well as externally. Hegeman (2010) describes this as a knowing and not-knowing that is hard to shake, as she describes still having feelings of doubt after many years of working with this client group. In utilising my own countertransference to the literature I found, I could track a niggling sense of disease as I read the following example of a clinician's impressions of a DID client:

> The psychiatric crisis nurses who interviewed her did not believe the patient was really upset or in pain, or that she had overdosed, but admitted her to a psychiatric hospital when blood levels of the sedatives she had ingested were found to be elevated. Staff in the hospital did not believe that she had multiple personality. They diagnosed her as having a borderline personality with a factious syndrome. The gynaecologist, who after several years had come to believe that the sadistic sexual abuse she had described had really taken place, believed the patient was experiencing remembered pain (her father had repeatedly manipulated her cervix with an ice pick). However, ultra sound revealed multiple cysts on both ovaries... (Goodwin, 1985, p. 3)

As I read this, I became aware of what I have come to think of as a 'partition' my mind erected to act as a filter to protect me from horrific information. It was not until several minutes after I finished reading the above, that the phrase "her father had repeatedly manipulated her cervix with an ice pick" re-entered my mind with the full force of comprehension, my body winced, and I felt stunned at having not made this link sooner. In continuing to consider this phenomenon, I turned to Bion (1959), who discusses the ways in which an attack on linking occurs, when the link cannot be contained within the mind of the subject. I had, it could be said, in this instance lost the ability to 'think' with the rational function of my mind, and the meaning had escaped me. This experience echoed for me my own clinical work and the experience of unthinkable thoughts, similar to what Bion (1959) describes as the attack made to object links by the psychotic part of the personality in patient work, which in my countertransference I experienced as a mystifying blankness and incomprehension.

Subjectivity, Anxiety and Truth

In attempting to understand such seemingly overwhelming countertransference, Bion (1970) guides us in situations where 'not-knowing' permeates our experience to remain open and tolerant of what can feel uncomfortable. Bion (1970) refers to this as a 'negative capability', a term used by Keats (1899) to denote the quality to withstand anxiety, confusion and not-knowing. I found myself considering how in my responses

to both the literature and patients, I had been challenged to develop a similar state of tolerance. I wondered if in addition to my own personal attributes, that this may in part be a reflection of the DID patient's own underlying and destabilising sense of not-knowing, that activated a part of me which yearned to alleviate this anxiety though 'knowing', which in my clinical work had become a search for a tangible 'truth'. I noticed how this phantasy of knowing likely functioned to shut down something that might otherwise feel too unbearable, and how my desire to be alleviated by 'the facts' regarding the patient's history, in one instance, had no basis in finding a hermeneutic truth for their reality.

I considered then that the quest by the therapist for objective truth or historical accuracy is in itself problematic, and within a psychotherapeutic context I would even question its relevance to the therapeutic task. As Galton (2008) describes, our task is to tolerate not-knowing and to help our patients to do the same. It is not to investigate the patient or to put as much emphasis on the historical truth as may be required in a court of law, it is instead to find a form of truth that is therapeutic and, as Bromberg (2009) describes, 'accurate', in that it is meaningful for the patient. Conversely, this may simultaneously involve holding the possibility of a truth that is unbearable and therefore unable to be known about by the patient, which the therapist may come to both know and not-know. This could be thought of as a type of holding that Winnicott (1960) refers to, of holding the other in mind, by holding a wondering or a knowing that may otherwise be too overwhelming.

This form of truth I believe evolves out of what McWilliams (2011) refers to as experience near work, and an approach that privileges the survivor's own narrative through a process of holding both knowing and not-knowing. While I observed that there has traditionally been an emphasis placed on objective and imperial truth within the therapeutic dyad (see Hanly, 1990, & Schafer, 1979), Davies (1996) points to the

importance of a subjectively held truth as an approach that privileges the patient's own trauma narrative in confronting challenging realities. Psychotherapy in this form is not an archaeological dig to find an objective reality, but a project undertaken to assist the patient in finding meaning and comprehension regarding their own 'knowing'.

In my own patient work, anxiety and a difficulty with not-knowing has on several occasions resulted in a phantasy of discharging intense affect at the expense of the patient, involving a desire to speak a truth that may be premature or too confronting. There is a particular truth-seeking character who in my reverie takes the form of a town crier ringing a deafening bell, who walks throughout the streets speaking an abrasive truth that is too painful to be known. In trauma, this character may be opposed by 'the denier' character that manifests as its own distinct personality in DID presentations. This personality in my experience may have the characteristics of a mafia hit-man or what Rosenfeld (1971) describes as an omnipotent and powerful part of the self, geared towards withdrawal into a delusion of complete self-sufficiency. This 'personality' in DID, as Howell (2011) suggests, is tasked with mounting a full-throttle assault on truth at all costs, which De Massi (2012) describes as the psychotic part of the personality corrosively acting out against more health orientated parts. This 'hit-man,' who is responsible for an assault on truth, and a proponent of -K, is experienced as the imperative to not-know within the family system (Bion, 1962).

Bromberg's (2009) conception of truth as a subjective phenomenon within "the context of an ongoing dialectic with the intersubjective phenomenon of accuracy" (p. 347), suggests truth is an agreement reached between the analytic pair that takes into account an 'ongoing dialectic' regarding what is found to be accurate. I wondered however if too great an emphasis is placed on the unique nature of each therapeutic dyad's truth that more generalisable aspects of the therapist's experience might be lost, such as objective countertransference experiences of disbelief. Furthermore, the

importance of a synthesising universality could be lost through too great a concentration on subjectivity and intersubjectivity, which helps to guide practitioners on what is expected or likely to take place for the therapist. I would expand therefore on the significance of subjective truth to include what Gorkin (1987) discusses as objective countertransference elements, those responses common to particular presentations. Wilson and Lindy (1994) describe these generalisable complementary countertransferential responses to trauma as the experience generated in the therapist by the patient's ego-alien beliefs arising from unassimilated aspects of trauma and are therefore more focused on what the patient, rather than therapist, brings into the relationship.

McWilliams (2011) describes a wide range of 'to be expected' countertransference in thinking diagnostically about dissociative disorders, including a range of traumatic transferences, as well as hatred, anger, and disbelief. I think it is significant that these common countertransferences she describes echo the early life experiences of patients, given that disbelief, as Chefetz (2000) describes, is characterised by what happens when the abused child is responded to with incredulity, and disbelief becomes interjected into the narrative of the abuse. It is not difficult to make the link then, to how, as a result, the patient's own sense of doubt is solidified, and enactments by therapists and healthcare professionals take place later in life.

McWilliams (2011) and Chefetz (2000) also describe how the child may have been told very specifically that the abusive experience was not happening, did not happen, and out of necessity it became cast into the realm of fantasy, being unable to be known about or believed. It follows for me then that truth, as the subjective experience of the survivor/patient, becomes susceptible to attack from authority figures due to the potential for a collusive enactment and denial of abuse based on the patient's early life experience. This form of truth is also susceptible to the patient's attacks, given their

system's investment in not-knowing, and the potential for unconscious enactments and identifications with the aggressor.

Swimming with the Tide

I began to consider that if countertransferences to DID have unique yet generalisable components, then incorporating the likelihood of countertransference responses such as disbelief into treatment planning for this client group would be important. Yet, I also wondered in what ways not-knowing and disbelief could pose unique challenges, that could not be addressed through a simplistic invitation to practitioners to take stock of one particular countertransference experience. I thought again about Britton's (1994) discussion of the difficulty of the 'seeing eye' in seeing itself, and if something that felt so important to not-know could have a unique ability to evade being seen. I felt Britton's assessment of knowing and not-knowing as a dissociative defence to be significant in understanding how the therapist can navigate countertransferences which are unknown or at the edge of experience. I wondered if the therapist, in their encounter with disbelief, could be expected to observe an unknown known. This is the limitation that Freud (1953/1924) referred to, and Levenson (1972) more widely built on, of how does the eye see itself? (Stern, 2013). Wolstein (1972) thought that it was possible to retreat to an area within the self that is asocial and at a great enough distance to observe countertransference enactments. While this perspective or separation would be ideal, separating ourselves from our context has been generally accepted to be unrealistic in intersubjective thinking to date (see Aron ,1996). I would also argue that it is from within this position of entanglement that we are able to gain the most appreciation of experience near insight, by observing and commenting on our countertransference (from a close proximity rather than a great distance or height).

Disbelief in this case is not to be avoided, or to be observed from outside of experience, but grappled with from within, as a source of insight.

Through my ongoing consideration of how then to work with the intensity with which disbelief presents, which I have termed the *imperative to not-know*, I attempted to locate my own experience of feeling completely submerged in the countertransference. Anderson, a GP working with DID patients, describes her experience as such: "the almost constant underlying feeling is that you are joining and possibly increasing your patient's delusion, rather than helping and treating a very difficult psychological condition" (Anderson, 2008, p.208). In a direct parallel to the literature, my own experience of feeling as if I was 'doing to,' 'damaging' or 'creating' phenomena with this client group had the same "almost constant underlying feeling" Anderson refers to. The sense that something could be created where it had never existed before, along with the disbelief that accompanies this, continually captured my attention. Yet, as Kluft (1993) writes, there has never to date been a recorded case of iatrogenically created DID. How then, from a psychotherapeutic perspective, can this overwhelming feeling of power to 'do to' or power to 'create' be understood?

Distortions, Illusions, and Disintegrating

My own sense of losing reality, and the fervency with which disbelief landed in me, made me curious about the automatic and unconscious elements of my response and their power to obscure reality. In coming back to the trauma aetiology of DID, I considered van der Kolk's (2014) description of the automatic responses of the mind/body system in trauma to avoid impending danger, and how this might run in parallel to an automatic survival instinct of disbelief in DID. I wondered if I considered disbelief to be a type of flight/fight response then it was functioning to cover over what Wilson and Lindy (1994) suggest is the complementary countertransference of fear,

terror, and despair often experienced in response to trauma. This type of internal flight which is experienced by the patient as the 'escape when there is no escaping' is the flight into a dissociative not-knowing.

It felt to me that within this 'flight into not-knowing,' was an unconscious exchange between myself and my patients, containing what Bollas (2007) discusses as unthought knowns, which move in and out of conscious awareness, and have the potential to eclipse understanding. I likened this process to what Bion (1962) suggests is the attack on the alpha function, the capacity to think our thoughts, as a form of -K, that is central to managing terrifying and unbearable states. I understood this as a shutting down of the ability to know, by foreclosing on further enquiry and investing in maintaining an illusion, to avoid further disintegration.

In straddling this unconscious exchange between both knowing and not-knowing, I recalled a dream I had experienced during an initial phase of meeting with a 'new' aggressor personality of one of my patients, and experiencing a latent yet unshakable disbelief in response to this 'new person in the same body'. In the dream, I had been attacked by a faceless DID patient who I had been seeing for some years, who had attempted to kill me with some brutality. In making sense of this in both supervision and through my own journaling process, Bion's (1965) conceptualisation of dreams as the manifest content of what is unable to be thought made me consider that while consciously disbelief was likely buffering me from something terrifying and unknowable, that unconsciously, I was not able to completely escape. Bion describes how “thoughts without a thinker,” (2005, p.44) or beta elements, (those parts of experience which have been unable to be processed by cognitive mechanisms), can land within the therapist as unprocessed data (experience). I felt therefore that as Bion (1962) describes, that affect - in my case terror, fear, and panic - had been unable to be known about, and had instead manifested as dream content. I imagined that if my dream was, in

part, an act of unconscious thinking, and that as well as my own unconscious terrors, beta elements of my patient were likely being processed. There is as Bion (1962) describes a failure of interjective and projective processes in the early developmental experiences of patients, that can leave the child in a state of annihilation terror, of a "nameless dread" (p.96), that likely constitutes the degree of fragmentation and pathology seen in DID.

I felt at this time a personal sense of disintegration, of coming undone, and while I was aware that from an intersubjective perspective these experiences drew on aspects of my own personal history, I was interested in how the patient's unconscious material could provide important clinical information on how their internal system was geared towards denial and dissociation. I wondered if in dreaming with, and for my patient, I was experiencing unprocessed beta elements, but also beginning to reinstate creativity into a system that had survived on concrete rigidity by providing an alpha function (Bion, 1962). As Winnicott (1969) writes, the patient's inability to use objects results from the isolating and terrifying nature of trauma that necessitated complete self-reliance, and the patient's creation of pseudo objects or internal characters to survive in a world hostile to their needs, a system which is built in DID for the specific purpose of not-knowing and not-needing.

Dreaming Into and Out of Reality

As a part of being involved in both clinical and immersive research processes, I continued to pay close attention to my dreams and how they could assist me in further developing my understanding of disbelief. As part of my journaling process, I noted down one particular dream towards the end of my research process. In the dream, I was in a huge castle under siege. I knew somehow that the enemy was infiltrating through the sewers, and in the dream I ran around telling everyone, but as much as I tried I could

not get a single person to believe me. I felt this dream represented a shift within me from pervasive feelings of disbelief to feeling disbelieved, what Davies (1996b) refers to as the back and forth role exchange between believer and disbeliever in working with DID patients. The feeling in the dream of being under assault, in conjunction with my reality being disbelieved, illustrated to me to how unconscious exchanges and processes of reenactment were a feature of my clinical work. As Davies (1996b) summarises, this can be understood as "reenactments in the transference-countertransference of the mutual assaults and counter-assaults on reality testing that marked the patient's early relationship with her abuser and others" (p. 208).

In grappling with my own disbelief, it felt vital that I should be able to understand how reenactments of the patient's early experiences of disbelief from attachment figures could result in current experiences in therapy of reality feeling under siege, for both the therapist as well as the patient. I therefore returned to Galton's (2008) illustration of how the child's cry for help becomes extinguished by a disbelieving caregiver (who may be active or complicit in the abuse), and how very clearly in later life we see a variety of enactments of the same scenario, whereby the patient's plea for help is again ignored (often by a range of healthcare professionals).

I felt also that Galton's (2008) framing of the patient's self-disbelief as the degree of loyalty required to maintain important attachment needs, clearly highlighted the nature of what was at stake in the patient's historical need to not-know, which is perhaps a significant part of the puzzle that healthcare professionals are often missing. The life dependent nature of the attachment bond as outlined by Bowlby (1958) to create safety and security has a primal and evolutionary function that undoubtedly fuels the child's investment in this allegiance. As an outcome of this innate attachment drive, it could be considered natural for the patient to consciously or unconsciously fabricate their story, demonstrating their creativity and early life survival instinct.

I felt that viewed within this context that writers such as Merckelbach, Devillyc & Rassina (2002) who describe 'fantasy-proneness' as a characteristic common to DID presentations, would have to agree that instead of a more sinister motivation this is simply the demonstration of the necessity to survive common to all human beings. I wondered therefore what impact it would have on treatment if therapists approached fabrications through the lens of a highly evolved survival strategy, which becomes experienced in the countertransference as disbelief. It felt clear to me that the link between survival, trauma, and DID meant that an imperative to not-know can be strongly identified in the patient's own internal world, and parallels what is felt by the clinician and then unconsciously acted out against the patient.

I noticed as I read articles by authors such as Merckelbach, Devillyc & Rassina (2002) and Lilienfeld and Lynn (2003), how the iatrogenic emphasis and disbelief in the 'validity' of DID spurred a deep sense of frustration, agitation and feeling of being silenced. I felt curious about how this countertransference to the material paralleled that of DID patients when encountering disbelieving professionals. As Dell (1998) writes patients who were told they were “liars”, “totally wrong” and accused of being “phony” (p. 530). I wondered therefore how the distribution of power is conceptualised by iatrogenic writers, and how in order for the therapist to be attributed the power of pathogenesis in DID, who in the transference the therapist becomes.

I felt in this way that Lilienfeld and Lynn’s (2003) transference to psychotherapists of the role of the aggressor was an unconscious joining with, and protection of, the abuser, that once again acted out the patient's early life dynamics of disbelief. It also attributed a great deal of power to the therapist's supposed 'hypnotic' abilities, rather than the impact of a formative abusive environment, and the hypnotic powers of repeated abuse and mystification.

The Ministry of Un-Truth – Systems of Non-Thinking

Dell's (1998) description of sceptical attitudes towards DID in the public health care system resonated with my own experience of scepticism during my time in a Community Mental Health setting. Beliefs that my patients were 'making up symptoms' because of a dependency on therapy and that talking with them about their personalities would inflate or even create them, had a maddening and even fragmenting effect on me. I found myself plunged into a questioning of myself, and a bewildering sense of disbelief. Through supervision I was able to re-calibrate, reconnect with my own certainty, and to locate the majority of my confusion within the typical countertransference of my work with the patients concerned. I felt, however, an unsettling sense of bewilderment at the degree of disarray that these responses continued to engender in me, and how despite my best efforts this was difficult to shift, while both knowing and not-knowing the reality. In putting aside some time to reflect more deeply on what it felt like as a therapist to be disbelieved, I returned once again to the trauma aetiology of DID, and wondered what in this instance was being obfuscated, or managed, out of existence. Emmens (2016) writes there is a difficulty within Community Mental Health settings to remain open to enquiry, and that in place of thinking there is a pre-emptive foreclosure regarding clinical work that likely protects professionals against the anxiety and not-knowing that often accompanies work with difficult and traumatised patients. It is perhaps this environment that has the strongest investment in a culture that underpins an imperative to not-know, because as Emmens clarifies the culture of government funded mental health settings is to meet targets based on funding, without holding in mind the ways in which this systemically effects the treatment provided. On this basis, I would argue that an imperative to not-know has a socio-political function, which can be located in a wider public aversion to knowing and

not-knowing about sexual violence and child abuse, and what at both an individual and societal level we become dissociated from.

Chapter Summary

In this chapter I have discussed the imperative to not-know that exists in response to DID at both an interpsychic and intrapsychic level. I have discussed how disbelief provides a defensive shield that acts to protect both the clinician and patient, though a complex arrangement of unconscious processes. I have outlined how the imperative to not-know is both a hindrance and an asset in working with the countertransference with this client group, specifically how expressions of disbelief can provide a depth of information regarding the patient's early experiences of object relations, and how disbelief becomes interjected into the narrative of the abuse. I have also considered how countertransference in DID works, and how this involves a high proportion of unconscious processing that can have a fragmenting and disorientating effect on the therapist. An important connecting thread has also been my own experience of disbelief in relation to work with DID patients, and how this automatic, obscured and fervent nature of an imperative to not-know impacts on patient work.

Chapter Five

Multiplicity and the Space Between – The difficulty with the multilateral self

My research into the therapist's experience of disbelief in DID led me to examine the theoretical constructs that surround our understanding of this phenomenon within a psychotherapeutic context. I was particularly interested in the framing of the self, and how Bromberg's (1994) contribution to approaching this from a multilateral perspective could enhance our understanding of the fragmentation and defensive processes that take place in the development of this disorder. I was also curious about how multiplicity itself adds to a sense of primitive anxiety in the therapist, and therefore what we may be able to learn about both disbelief and the patient by continuing to explore the therapist's experience.

Hegeman (2010) describes how, "fragmentation of the unitary self makes us anxious" (p. 172), given that we have a largely unchallenged experience in our daily lives of the feeling as if there is usually just one 'I' per self. DID has, as its core, a framing of self that is deeply disturbing to the ontological considerations of what is means for 'me' to be 'me'. Couched within an existential questioning of the nature of the self, defences such as disbelief that placate the degree to which trauma is known about, do so by facing into this abyss of uncertainty regarding our basic structural integrity.

The thematic resonance of a *non-unitary self* was a theme that I found to be central to the defensive processes that surround disbelief in DID presentations. I wondered in what way an anxiety regarding a non-unitary self laid the foundations for the clinician's disbelief. Bromberg's (1996) quotation of Sturgeon where he cites that, "Multiplicity is our first characteristic; unity our second. As your parts know they are parts of you, so must you know that we are parts of humanity" (as cited in Bromberg, 1996, p. 511), impresses upon the reader a sense of an innate multiplicity. In taking

multiplicity as our starting point, dissociation of these parts of self becomes less perplexing, and our doubt and disbelief less pervasive when working with DID. If in fact, as Sturgeon suggests, this innate multiplicity is the multiplicity of humanity, and we are both one and many, we also contain within us the horror, terror, and trauma which makes DID so hard to believe.

In my work with DID I have struggled with my pre-conceptions of the self as a unitary structure, and while conceptually I have been aware of theorists such as Lampl-de Groot (1981) and Turkle (1978/1992) who have discussed the self's innate multiplicity, I have found that the phenomenological experience of being with the other who presents with a fractured self a more distinct struggle. I wondered about my sense of being lost with patients being in part a fragmenting of my own preconceptions of how reality should operate. I also wondered about the off-hand comments or slippages of healthcare professionals during my time at Community Mental Health, expressing how very deeply unsettling these types of presentations can be, and if in a parallel to the patient, there is something deeply disturbing about a fragmented self, which evolves out of trauma. I felt that my own disturbance with a multilateral self, as with disbelief, belonged in part to the category of 'objective' countertransference, as outlined by Gorkin (1987), but I also began to consider that the degree of trauma in DID likely eclipses 'knowing' or' believing' at a phenomenological level when we are confronted by the self as both one and many.

Bromberg's (1994) discussion of maturational processes that lead to the experience of a healthy illusion of continuity and coherence, made me consider how structurally central dissociation is to our core functioning. If we take multiplicity as our starting point, as both Sturgeon and Bromberg recommend, then it is the degree of separation between these parts expressed as discontinuity and dissociation that becomes what is pathological in disorders such as DID, rather than a core of multiplicity. If, as

Bromberg (1994) suggests, state changes are typical in a healthy person, and these simply go unnoticed because of their subtlety, then it is likely that dissociation is central to the functioning of the human mind. This is however not a new thought, only an overlooked one, and as Bromberg (1994) reminds us, Ferenczi's (1933/1995) early recognition of the significance of dissociative processes as pivotal to internal functioning played a significant role in his understanding of how trauma governs discrete self states that operate to protect the self from 'knowing'.

I wondered how a centralisation of dissociative processes could impact the therapy relationship if they became as central to our general thinking about the mind as repression and intrapsychic conflict are. Whilst I have been focused predominantly on the therapist's experience in DID, I have been investigating this as a means to understand what is therapeutic for the patient. Therefore, I wondered what might happen if I were to position my experiences of disbelief surrounding DID differently by placing greater emphasis on dissociation and by keeping multiplicity in mind.

Developing A Mind of My Own - Holding Multiplicity in Mind

In continuing to reflect on Bromberg's theory of mind, I considered how Hegeman (2010) suggests that the manifestation of DID is the abused child's attempts to develop their own theory of mind to try to understand ‘why this is happening to them.’ It struck me that in DID the child's attempt to understand the existential problem of 'why?', the child, and then adult, demonstrates an innate creativity that allows them to problem solve by unconsciously assigning each state, such as disbelief, a distinct character in order to cope with the otherwise annihilating effects of early-life abuse. The character of disbelief in particular appears to have a central role in underpinning dissociative processes, through the degree of separation that occurs in the mind of the abused, to be able to create 'not me' self states. In working with this client group the

therapist who becomes plagued by disbelief and condemnation, perhaps also works hard to develop their own theory of mind, of ‘why is this happening?’ when challenged by the multilateral self and the phenomenon of dissociation.

I continued to think about how understanding both our own and others’ motivations is a developmental achievement that becomes invariably compromised in trauma when we consider, as Davies (1992) writes, that mature personality organisation is based on an integration of a diversity of object experiences, which 'self' and 'other' understanding results from. Our experience of self then, as the multitude of our relationships, is defined not just by experiences themselves, but by how our experience of them is made sense of, a process which invariably becomes compromised in trauma. For the child, the development of their own mind is shaped, as Winnicott (1960) suggests, by the mother's mirroring and ability to both reflect and add to the experience of the child. In early life trauma however, this same capacity to know one's own mind becomes compromised, and instead what is mirrored back, particularly in parental abuse, is a relational understanding of the self through the eyes of the abuser. To me this understanding in DID feels central to mapping the multilateral and dissociated parts of self through what Davies (1996a) refers to as “self-object dyads” (p. 281), by utilising transference-countertransference responses of the therapist to make sense of the patient's early object relations. Davies' (1996b) sense of countertransference as a very precise tool to gage the nature of the relational wounding that took place for the patient, echoes my own sentiment of utilising countertransference responses to understand intrapsychic conflict, through the degree of dissociation and disbelief that characterises the therapist's experience.

My own experience of framing clinical work with DID from the perspective of a multilateral self, involved noticing my own internal state shifts and what they could tell me about the patient's experience. Bromberg (1994) suggests that traditionally the

therapist listens from the perspective of the unitary self that has become fragmented, rather than a multilateral self that lacks the necessary illusion of unity. In embracing this framework and model of self, I felt the fundamentals of both thinking and listening in my overall practice needed to be revisited, and in my work with DID in particular, this made more of an intuitive sense. I felt that Bromberg's (1994) invitation to centralise "a dialogue between discontinuous domains of self-meaning" (p. 533) required a form of listening where separateness was pivotal to comprehension, and how otherwise we run the risk of pre-emptively homogenising self states before fully getting to know them. While I have aligned my position with Bromberg (1996) on the primacy of the multilateral self, I feel that this is not in disagreement with both continuity and unity being developmental achievements, and fragmentation maladaptive. Instead I feel that what Bromberg (1996) points to is the danger in seeking unity defensively, that which negates the process and understanding of the need for dis-unity, and that this becomes clearer when viewed from the perspective of the starting point of the multilateral self. From this perspective, we can see how the parts and the whole are necessarily distinct and yet work together.

Metaphors, Autonomy, and Being Real

In my own practice when encountering disbelief in my countertransference I began to make sense of this also as a discontinuous state, with its own persona, attributes, and way of thinking, a state that was both separate and part of me. In doing so I found myself pondering Bromberg's (1994) framing of unity as a type of metaphor for the experience of wholeness, and Merckelbach, Devillyc and Rassina's (2002) article entitled "Alters in Dissociative Identity Disorder: Metaphors or Genuine Entities?" came to mind as the antithesis to Bromberg's position. In this article they suggest that alters in dissociative identity disorder are more analogous to metaphors, than distinct or

real 'identities'. Re-reading their article I was struck by the implication of how if we consider the different parts of self as simply metaphors belonging to a unitary self (as Merckelbach et al. do), then we lose the potential for understanding discontinuity and separateness. As Bromberg (1994) advises we have many parts that are not so easily defined, but unique realities, that comprise the whole. Furthermore, it felt that Merckelbach et al. were proposing a false dichotomy between either "metaphors or genuine entities" (p. 481), a true or false dilemma that inadvertently positioned the reader in the direction of doubt and disbelief regarding what is considered 'real', under the pretence that there is an 'either or' to be reconciled.

I felt that Merckelbach, Devillyc & Rassina's (2002) questioning of the parts of DID by asking "are they just metaphors for different emotional states or are they truly autonomous entities that are capable of wilful action?" (p. 481), speaks to this invitation to split between real and not real, true or false, rather than an inquiry into how we understand what an autonomous self part might be, and how this might be the same and also different to a metaphor. Instead, the argument of Merckelbach et al. then takes an even further split and more compartmentalised position, stating that while many articles "assume DID is connected to severe and recurrent traumatic childhood experiences" (p. 481), their article is concerned "with a different issue, namely the status of alters in DID" (p. 481) as if aetiology and symptomatology could or should be so easily separated. In writing this I can easily locate my own incredulity in response to the attitude of Merckelbach et al. that phenomena can be stripped of context; that metaphors for Merckelbach et al. are symbolic, which lessens their status as 'real', which of course calls once more into question 'reality' for DID patients, in a subtle yet undermining way. It also brings to mind Bion's (1959) attacks on linking, in separating trauma from the development of DID, and is reminiscent of an attack to the patient's own ability to have object links, between the 'good and bad breast' (Klein, 1946), that would have likely

occurred in early life, in order to manage pathogenic abuse. I feel my own incredulity in this case is a protective anger, aligned with this part of the DID patient, for whom having their reality questioned becomes a form of reenactment of the historical mystification and trauma that took place.

In considering the place of metaphor as a descriptive tool for understanding psychoanalytic processes, it is for good reason, as Sullivan (1954) writes, that self-parts can be thought of as characters, which as Klein (1946) writes, correspond to part-objects, since in the presence of trauma the capacity to know the parent as abuser, and then as carer, as is often the case in DID, is beyond the capability of the child. Sullivan's description of self-parts in DID as characters on the other hand, does not make these fragments any less 'real' in how these parts are experienced by the patient. In further responding to Merckelbach, Devillyc & Rassina (2002), it felt important to also consider how Reindesa et al.'s (2003) study of the brain activity of patients diagnosed with DID found areas of the brain associated with self-awareness and consciousness demonstrated "the existence of different regional cerebral blood flow patterns for different senses of self" (p. 2119) when different 'identities' or 'self parts' are operating. Reindesa et al. have illustrated from their findings the patient's experience of feeling like they are more than one self has a neurobiological reality. In linking together Bromberg (1994, 1996) with Merckelbach et al.'s desire for clarity about the 'reality' of DID's self states, I do not believe that Bromberg had in mind that consciousness is the experience of many separate people or selves. Rather, I think that the multilateral self, as an ontological framing, is a signifier that allows for a greater appreciation of the complexity of what it means to have a self and to be an 'I'. It is an approach above all else towards a multifaceted knowledge, not an arrival at absolute or singular truth.

Davies (1996a) reminds us that we "debate theories not facts" (p. 281), where we continually "tread at the very frontiers of what we know and understand about the

human mind" (p. 281). In understanding clinical work and the limitations of knowledge, I have found it important to remain grounded in an intuitive and felt sense of truth, approximating what Bion (1970) refers to as 'O', a type of knowing gained through experience, and an evolving truth regarding the patient and therapist. In continuing to base our understanding of knowledge and truth on experience, as Bion (1970) suggests, the multilateral self continues to make itself known, through both the patient and therapist's unconscious, which Hegeman (2010) describes as containing the forbidden and disavowed aspects of our culture and selves that engender disbelief.

From the Outside Looking In - Non-Linear Times and Broken Spaces

As a significant part of my research process, I continued to read clinical material that described the first-hand experiences of DID patients. In one example of my reading "Aahbee" describes her history:

> A part of me I'll call Geraldine survived that day. I put a different face on the girl and floated at the back of the room until it was over. Somehow we got ourselves home, with the still-broken bike and a made-up story about falling out of a tree to explain the bleeding. Night-time was never restful in our house. During junior-school years, a part of me I'll call Francine dealt with abuse by Daddy. A kind of switch flicked inside ("Aahbee," 2008, p. 95).

In reading this narrative, found in its entity in *Forensic Aspects of Dissociate Identity Disorder*, I reached a point where it became very difficult to keep on reading, and as with reading other life narratives of DID patients, something began to shut down in my mind. As I read Aahbee's description of a series of unspeakable sexual assaults that take place in addition to the sexual abuse and violence she was experiencing at home, the horror of how much a child under 10 years of age could withstand, crumbled, rather than expanded, my imagination.

In continuing to hold her story in mind, I began to consider my own discomfort and distress with regard to its dissociative features, as I do in my clinical work with

DID. I found on this occasion I continued to draw a blank as to how to construct meaning, or make sense of my own countertransference reactions, as if some other deeply disturbing process had colonised a part of my mind without my knowing. Given my ability to articulate at least an element of this experience, I conceptualised this within what Bromberg (2010) suggests is a state of *sort-of-knowing* that contains within it an element of dissociation. I felt this sort-of-knowing narrating part of myself that was able to describe what was happening, was juxtaposed with a more silent, and what I felt to be blank, part. I wondered if in this moment that the constellation of my own self parts, comprised a microcosm countertransference of what Neimeyer and Buchanan-Arvay (2004) describe as the disruption in trauma of a linear self narrative, where dissociation takes the form of an interruption between the narrator 'self' and the audience 'self' parts.

In DID, dissociated narratives, or self parts, can take the form of what Neimeyer and Buchanan-Arvay (2004), refer to as 'silent stories' where there may be a 'mute' or as “Louise” (Cross & “Louise”, 2008) describes in her horrific history of abuse, an alter that that takes the form of a 'silent witness' to un-knowable crimes. I wondered then if my experience of blankness in the countertransference to Aahbee’s story represented more than just disbelief or an attack on thinking, but a 'dead zone' that I was able to both know and not-know about. This self-part felt to me like a part of self that exists as if outside of time and space, as Aahbee (2008) describes, a part of self that is “weighted down out of sight on the bed of the lake, far away from consciousness.” (p. 87). I imagined then that this 'silent witness' in DID is a part of self that has become frozen in time, and what Neimeyer and Buchanan-Arvay describe as the result of a disruption in the narrating part of self that continually links us relationally to the past and present.

I wondered then if in clinical work with DID, that working towards cognitive representations of our uncertainty or disbelief is a developmental step of an evolving

capacity to, as Bromberg (1994) suggests, 'stand in the spaces' of the different parts of self, for both the patient and therapist. As a therapist working with DID, being able to symbolise with the patient their confusion could be thought of as a nascent ability to resolve intrapsychic conflict, and to work with the many parts of self towards a cohesive functioning of the whole. I felt this was illustrated in Aahbee's (2008) continued story:

> Many of the remaining dissociative barriers crumbled and fell, with triggers, flashbacks, and times of agonizing connection with various of my long-hidden "parts" that each held more pain than was bearable at the time. It was quite literally like falling to pieces (p. 102).

Here she describes her agonising process of recovery, in which the many parts of self are experienced with an increased ability to hold contradiction and the 'spaces between'. Yet this experientially feels "like falling to pieces," when in DID this involves coming 'face to face' with the multitude of the self.

I wondered if in dissolving these dissociative barriers there was a return to a more constant narrating part of self, or if in fact there was simply a diversity of internal voices now to be heard. I imagined that if we operate from a model of self that is decentred, that there is a continuous dialogue with both our internal as well as external world, a chorus of voices that constitutes the multitude of being, and perhaps what captured Bromberg's (1994) attention so adamantly when he quotes Sturgeon, which I shall cite again as it has also captured my attention: "Multiplicity is our first characteristic; and unity our second. As your parts know they are part of you so must you know that we are part of humanity" (as cited in Bromberg, 1996, p. 511). In both navigating from the therapist's counter-transference and operating with dissociation as a centralising principal of personality organisation, I have found that the amount of uncertainty, disbelief, and anxiety has diminished by facing into the complexity of 'the self' as a multilateral and whole being.

Chapter Summary

In this chapter I have discussed the multilateral self as a vehicle to deepen our understanding of the therapist's experience in working with DID. I have considered how a non-unitary model of self challenges our notion of what it means to have a self, and how in our work with DID this may contribute to the therapist's anxiety, doubt, and disbelief. I have examined how dissociation is pivotal to our understanding of multiplicity, and how it is the degree of separation, rather than the multilateral self that is pathological. I have discussed how developmentally disbelief can evolve as a protective mechanism for the child, which is felt in the countertransference by the therapist later in life. I have considered how 'dead states' in DID represent more than not-knowing or the patient's disbelief, but a part of the self frozen in time, which sits at the edge of what can be consciously known. I have postulated that when understanding the relational nature of early life abuse, that the framing of the multilateral self provides us with a vehicle to understand the nature of dissociation and fragmentation, through the therapist's countertransference. It has been central in this chapter to continue to reflect on my own countertransference and how it relates to both a multilateral model of mind, and disbelief.

Chapter six

Discussion

The intention of this research was to inquire into the nature of the therapist's experience in working with DID, with a particular focus on the phenomenon of disbelief as it occurs between the therapist and patient. In focusing primarily on the therapist's countertransference and the role of unconscious processes, I found intrapsychic and interpsychic functions to be central to understanding how a history of severe trauma in DID can contribute to disbelief in the practitioner. While I have discussed at times my own personal proclivities and the nature of intersubjective phenomena, I have chosen to focus on what Gorkin (1987) refers to as the more generalisable countertransference experience because I feel it has clinical utility in the development of a collective language for treatment planning. Specifically, I have focused on disbelief as a 'to be expected' aspect of countertransference when encountering DID, and how this provides significant clinical information regarding the internal world of the patient.

Outlook

Throughout this research I have claimed my psychotherapeutic vantage point, as well as my own countertransference responses, as pivotal to my experience with the literature and clinical work. At the beginning of this research I wanted to understand my own disbelief surrounding DID, as well as the culture of disbelief within our mental health system. I hope this research will be of use in broadening how disbelief is understood, and that the outcome could lead to a fruitful interdisciplinary engagement. I believe that multidisciplinary research can help practitioners, as Emmens (2016) suggests, to remain curious and open, and to keep on thinking about the experience of disbelief, despite how difficult this can be within the culture of many of our mental health institutions.

I started this research with wonder regarding what was being acted out unconsciously by well-meaning practitioners who, like myself, may have found it easier to put into practice phantasies of disbelief rather than challenge the systemic culture of –K, described by Emmens (2016) as prevalent within our mental health system. I have chosen, therefore, to focus on the experience of the therapist in order to understand the adversity that they may face, and ultimately, how this affects the patient. As a result, I have come to consider that the misdiagnosis of DID, which the International Society for the Study of Trauma and Dissociation (2011) suggests takes typically between five and 12 years to correctly diagnose, has a high probability of misdiagnosis based on practitioner disbelief of its presentation. While studies such as Dell (1998) have surveyed both clinicians' scepticism and patients' experiences of scepticism leading to misdiagnosis, a contemporary and in-depth study of the impact of disbelief appears to be an important area for further research.

Strengths and Limitations

A likely critique of this research is the lack of empirical investigation using qualitative data and observable facts. In this way, my research is not repeatable, given that the researcher's subjectivity is key to the results produced. The merits of a traditional positivist framework in particular are seen as the ability to anticipate outcomes, in order that a measure of control might be introduced to predict the behaviour of future phenomena (Ponterotto, 2005). As a research method this differs vastly from Smythe and Spence's (2012) emphasis on intuition, provocative thinking, and "letting process come" (p.14). Given that my research focuses on unconscious processes, rather than observable facts, this approach could be seen as lacking scientific validity, despite the unconscious having become a recent frontier in contemporary neuroscience for understanding the human mind (Stein, Solms & van Honk, 2006).

In light of the validity of unconscious processes within the history of psychoanalysis, I felt it important to utilise a method of investigation germane to the paradigms of understanding that the research takes place within. Psychotherapy and hermeneutics exist in a complimentary synthesis of prioritising phenomenological truth that unfolds and becomes an embodied and felt knowing. I feel it is a strength of this study that I have been able to reflect on my own subjective responses to the literature, as a type of 'countertransference' to the text, which has provided an additional layer of data through examining my own truth regarding the therapist's experience. The merits of this study for me have been to build on my subjective experience and to weave this into an understanding of the literature. It has been the recognition of the process of wrestling with, and leaning into the discomfort, that is central to linking, thinking, and continuing to develop my own subjective K (knowing) (Bion, 1962).

Growth and Synthesis

I began this research with the expectation that insight in relation to DID and disbelief would come about through an investment in the hermeneutic process that would lead to a particular 'conclusion' or insight that could provide an explanation regarding who or what was not being believed. Instead, however, I have found that through my deep immersion in the literature and subsequent period of reflection, that the activity of seeking and waiting, and remaining open, is reminiscent of the qualities that Bion (1962) suggests we bring to psychotherapy; of increasing our capacity for not-knowing, through both negative capability, and 'O', which brings us closer to the, "things in themselves" (p. 6). It became apparent during this state of immersion that rather than avoiding or transforming disbelief, engagement with the therapist's own processes was the most central tool in an active form of enquiring, knowing, and gaining insight.

In the literature I found the potential for collusive enactments with DID patients to be highly probable. While a commitment to the subjective and intersubjective nature of truth in DID work is important, those who suffer with DID exist within a universe that has been hostile to the truth in all forms, which can make holding onto K or truth, such as the patient's historical abuse, problematic. I have understood this hostility towards the truth through the lens Bion (1959) describes as an attack on linking. This has been important in contextualising the 'denier' part of the patient, that exists within the therapist, and in doing so, to locate my own truth seeking and denying characters who wish to close down and attack knowing and thinking. I feel that the image of the town crier, who bears such unwelcome yet truthful news, exists within me, as well as the denier, whose role it is to offer up a protective illusion.

Illusion as a form of protection has felt central to grappling with my own conscious and unconscious material, in what I found to be the imperative to not-know in DID. I feel now that what was likely missing in my exploration of the data was an intersection with the more brutal, hostile, and rageful elements that are invested in maintaining this illusion. The part of self in DID that can be omnipotent, and links to what Rosenfeld (1971) describes as the gang like structure of the psychotic aspect of self that works in a highly organised fashion to keep secrets as well as an omnipotent sense of ‘not-needing’ external objects. This not-needing part of the self feels connected to the attack on the therapist's reality that is central to not-knowing, but does so through unconscious anger and rage. This hostile not-needing is based on the withdrawal of the libidinal self into a state of primary narcissism that can be felt by the therapist as an empty brittle shell in place of where the patient used to be, cut off from object links: there is an inability to think that is key to maintaining a protective illusion.

Consolidation

Through this process and through my wrestle with disbelief I have come to an ever-deepening sense of humility for the creativity of the psyche and the strength of the human spirit to survive the unsurvivable. I have found the research process has changed my own ontological consideration regarding what it means to have a self and to be an I, through focusing on the multilateral self and the importance of dissociation. In reflecting on my choice of literature, I feel that the power of unconscious processes is the most significant underlying feature of my findings in understanding disbelief, and the part of the puzzle that is likely missing in other frameworks for working with DID. While this research is from a psychotherapeutic vantage point, I believe that it contains an opportunity for a cross pollination of ideas regarding both the therapist's and the patient's experience that could enable practitioners from diverse disciplines to engage in a more informed understanding of their own scepticism as well as that of their peers and the wider mental health system.

I now feel that my tolerance for ambiguity and reflective interest in my own confusion are important tools in working with disbelief independent of whether my patient suffers from DID or not. I feel that being lost with patients and embracing my own fragmenting sense of reality is a necessary endeavour in navigating from the countertransference to enter the mind of the other, which is central to the work of psychotherapy (Orange, 2011).

I have outlined in my data chapters how both the imperative to not-know and the difficulty with the non-unitary self, both pose significant challenges for the clinician working with DID. I now consider dissociation to be a central organising principle that links both the protective force of not-knowing, and the multilateral self. I see the therapist's disbelief as anchored within a dissociation from parts of themselves, as well as the parts of humanity that contain the inherited intergenerational trauma of 'the

many'. This dissociation is from both our potential to inflict terror, and those terrors contained within our own collective trauma histories. In DID these trauma histories are embodied, and when the therapist enters the mind of the other, they become distinctly difficult to believe, and are split off and disavowed: an imperative to not-know ourselves, as much as to not-know the other, takes place.

Ongoing Significance and Contribution

The relevance and originality of any study are a general consideration, especially when reviewing secondary research sources and clinical material. I feel, however, that the merits of this study do not hinge on equating primary research or newness with relevance, and that my subjective insights have been rich in their relevance for examining both the epistemological framing and the phenomenological understanding of disbelief in DID. I feel that in focusing on this specific phenomenon I have added to an area that lacks attention, perhaps because of the complexity of unconscious forces that seek to prevent 'knowing'. While these unconscious processes are so actively exemplified in DID, I feel that this research also has relevance for the general field of trauma work. I think that my particular subjective experience has significance based on my 'fresh eyes' within a Community Mental Health setting, and for practitioners like myself working with this patient group.

Broader Implications for Practice

As a result of my reading and lived experience alongside the literature, I have found it necessary to revise my own practice to encompass more of an appreciation of both multiplicity and of dissociation. In centralising dissociation and listening from the perspective of a multilateral self in my general practice, I have come to agree with Bromberg (1994) that the implications of “non-linear switches in discontinuous states of

consciousness" (p. 522) are wide reaching, and in work with non-DID patients there is great potential for exploration and wider application. I feel, however, that an appreciation of the existential crisis and the disbelief that this can engender in the therapist (and patient) is missing from Bromberg's revelations regarding the broader applications of inherent multiplicity. Even if the difficulty with the multilateral self is of a lesser degree in non-DID patients, I feel that multiplicity is likely to be as much an unconscious anxiety for the therapist, as it is for the patient when holding such discontinuous states in mind. DID, in particular, presents unique challenges to 'holding on to belief', which Bromberg (2010) suggests can best be approximated as 'sort-of-knowing,' or 'standing in the spaces', and is the cornerstone for holding multiplicity in mind.

I feel now that practice informed by the centralisation of dissociation is important to maintaining the significance of separation and discontinuity in DID work, as well as what Bromberg describes as the necessary illusion of unity. I think that the therapist's capacity to use their countertransference to enter into the unknown in order to maintain such complexities, is what Bromberg (1994) refers to as existing between dreaming and wakefulness, and an arrival at Bion's K, as a way of restoring linking. From the perspective of intersubjective theory this could be considered the creation of a third space, within which both thinking and knowing then become possible through the restoration of the capacity to dream (Bion, 1965). Further research from here would likely take the form of in-depth qualitative interviews with practitioners working with DID, followed by a detailed analysis of the transference and countertransference dynamics, with implications for treatment.

Concluding Thoughts

My intention in this research has been the exploration of the therapist's experience of disbelief in treating Dissociative Identity Disorder, as an intrapsychic and interpsychic phenomenon wider than any particular therapist and patient. While this parameter has given me a very specific area of consideration regarding DID, this has also allowed for a greater exploration of the wider unconscious processes underlying disbelief. I have found that through an exploration of my own countertransference responses to both texts and clinical work, I have been able explore how the patient's internal world can generate disbelief in the clinician. Through focusing on the experience of the therapist, I have attempted to centralise both unconscious and dissociative processes in order to understand the fervour with which disbelief manifests in what feels like *an imperative to not-know*, and the unconscious barriers to understanding the *difficulty with the multilateral self*.

Psychotherapy is distinct in its capability to understand the significance of unconscious processes, and therefore grapple with what can be obscured and evaded when the therapist's capacity to think or know is under attack. The ability to stand in the spaces between, and to delve into confusion as a source of insight underlies the cultivation of negative capability, and the therapist's endeavour to hold onto K. For therapists working with DID, this means that disbelief no longer needs to become the seedbed of patient maltreatment and of unconscious enactments, but an opportunity to understand with greater accuracy the patient's internal world. For those suffering with DID this means the opportunity for a reparative engagement in which internalising the ability to move fluidly between self-parts and maintaining the complexities becomes possible.

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