THE FIVE FORCES: WORKING WITH DISSOCIATIVE STATES

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by SHAMAI CURRIM

The purpose of this dissertation is to get me my PhD in Transpersonal Psychology and to bring consciousness forward through a further acknowledgement of the Transpersonal realm.

October 6 ,2004

Dedicated to the inherent knowledge found within each of us

and given to us by the Great Masters.

To the current Living Master Sant Rajinder Singh Ji Maharaj

"Some study to find answers

I live to find truth"

Shamai Currim

September 6, 2004

TABLE OF CONTENTS

LABELS

I've been silenced all through my life

The labels I carry I never hide

I got them through triggers

Planted in my mind

Labels are awful

Labels are sad

People use them

Thinking you're bad

But they just don't know

The pain that's inside

And the labels are the mask

Behind which you hide.

Beverley

(taken from Sinason, 2002)

PREFACE

As a creative mode of physical and non-physical communicative interaction, psychotherapy plays a multi-level role in bringing us to a greater understanding of who we are. Over lifetimes people have had the perennial question before them-"Who am I?" "and where did I come from?" While psychotherapy may not have all the answers, it can certainly help one to attain more clarity on their direct life purpose.

In this dissertation the author takes you on a voyage through the Five Forces of Psychology. While its beginnings may show presence from the earliest days of mankind, the future of psychotherapy, if we allow for natural momentum, shows great promise. Through the pondering of many talented minds, intuitive seekers, and hard, laborious, and many times unappreciated time and talent we have, today, almost as many varied forms of therapy as there are people coming into therapists offices. It is to those brave souls, the ones who have battled and come back as warriors, that this research is being presented. It is to the unsung hero, the wounded warrior that I take this time to speak. Please note, it was impossible for me to list every adjunct therapy so I had to set some guidelines. The therapies that were included in detail are those that are the well known primary psychological therapies and those which came forward in the Research section of this paper. I ask for your forgiveness if your modality is not present and I offer you the opportunity to take this work to the next step.

In this study it was difficult not only to set the boundaries for presentation, but also to know and separate the therapeutic modalities currently in successful use with today's patients who exhibit dissociative episodes. The delineation of the Five Powers set the stage for clarity and momentum and encouraged me to my goal. While I had researched and created a model of the Five Powers (see chart I) during my undergraduate studies, it was truly an act of divine innocence. It was a method for my mind to have a visual image of the steps of evolution of psychology. After completing my graduate studies I came upon Douglas Russell's paper in the Psychosynthesis Digest Vol.1 and had a déjà vu experience. Here was the presentation of the Forces that I had been examining, clearly laid out and ready for my perusal.

Dear Reader, I present to you The Five Forces: Working with Dissociative States as a guideline to working with your patients, for it is from active therapy that I have gathered the research material and it is to the world that I let it go.

May the Forces be with you…and may you prosper and grow.

WHAT IS PSYCHOTHERAPY

Psychotherapy is the treatment of psychological disorders or maladjustments by a psychological technique, as psychoanalysis, group therapy, or behavioural therapy. Psychotherapy does not include physiological interventions, such as drug therapy or electroconvulsive therapy, although it may be used in combination with such methods. Behaviour therapy aims to help the patient eliminate undesirable habits or irrational fears through the use of principles of conditioning.
www.artofwellbeing.com/glossary.html

Psychotherapy is the treatment of mental and emotional disorders using psychological methods, such as counselling.
www.effexor.com/resources/glossary.jhtml

Psychotherapy is a general term that refers to the treatment of mental disorders by intellectual and verbal means such as suggestion, analysis, and persuasion; often used in conjunction with other treatment courses like medication.
www.nacac.org/how_glossary.html

Psychotherapy is the means to a specialized formal interaction between a mental health practitioner and a client in which a therapeutic relationship is established to help to resolve symptoms of mental disorder, psychosocial stress, relationship problems and difficulties in coping in the social environment. Some specific types of psychotherapy may include, but are not limited to, psychoanalysis, family therapy, group psychotherapy, supportive treatment, gestalt therapy, experiential therapy, primal therapy, psychosocial therapy, psychodrama, behavioural therapy, and cognitive therapy.
www.hhs.state.ne.us/crl/mhcs/mental/practicedef.htm

Psychotherapy is a potpourri of treatment modalities involving in most cases an interaction between an individual and a therapist or analyst. While research results are mixed about its effectiveness, there is a large body of scientific literature that indicates positive correlation with behavioural changes and "feeling better".
www.therubins.com/geninfo/Definit.htm

Psychotherapy is the treatment of mental and emotional disorders using psychological methods such as counselling.
www.yestolife.com.au/blue_site/8/8a.htm

Psychotherapy is a technique of treating mental disorders by means of insight, persuasion, suggestion, reassurance, and instruction so that patients may see themselves and their problems more realistically and have the desire to cope with them.
nces.ed.gov/pubs2000/studenthb/glossary.asp

Psychotherapy is a therapy provided with a psychodynamic framework. The therapy may be individual, group or family therapy.
www.socialcareassoc.com/resources/glossary/p.htm

Psychotherapy is a method of treatment designed to produce a response by mental rather than physical stimulus; it includes the use of suggestion, persuasion, re-education, reassurance, and support as well as hypnosis and psychoanalysis.
www.calib.com/nccanch/pubs/usermanuals/menthlth/glossary.cfm

Psychotherapy involves meetings with a mental health nurse, psychiatrist, psychologist or other trained person for the relief of emotional, psychological and related physical symptoms of distress or dysfunction.
www.nursing.virginia.edu/centers/research/wait/psyched/glossary.html

The term **Psychotherapy** covers a variety of theories of personality development, specific techniques and therapeutic aims. For example, there are psychoanalytic therapies, behavioural therapies, and interpersonal therapies, all of which have different techniques and aims, and all of which qualify as a "psychotherapy".
www.cmhanl.ca/education/publications/dcs/glossary.html

Psychotherapy helps one look objectively at behaviour, feelings, thoughts, and problematic situations to determine more effective ways of understanding and behaving.
www.nfipa.org/terms.htm

Psychotherapy is a method of treatment using mental applications, such as hypnotherapy.
wps.prenhall.com/chet_badasch_inthealthoccu_6/0,6847,517287-,00.html

Psychotherapy is a form of therapy in which trained professional uses methods based on psychological theories to help a person with psychological problems. (p. 570)
www.mhhe.com/socscience/intro/cafe/lahey7/student/olc/chap15glossary.mhtml

Psychotherapy is a treatment in which a trained professional-a therapist-uses psychological techniques to help someone overcome psychological difficulties and disorders, resolve problems in living, or bring about personal growth psychotherapy (278.0K)
highered.mcgraw-hill.com/sites/0072494263/student_view0/chapter13/glossary.html

Psychotherapy is the treatment of emotional or behavioural problems by psychological means, often in one-to-one interviews or small groups. Modern psychoanalysis and cognitive therapies concentrate on the patient's beliefs. Other therapies, such as those within humanistic psychology, attend to the patient's emotional state or sensitivity. The distinction, however, is not clear-cut, as all these therapies involve intense exploration of the patient's conflicts, and most rely on the emotion generated in therapy as a force in the patient's recovery. In contrast, behaviour therapies derive from the view that neurosis is a matter of maladaptive conditioning and concentrate on modifying patients' behaviour.
www.rehab-finders.com/glossary.html

Psychotherapy is the branch of psychiatry concerned with psychological methods
www.cogsci.princeton.edu/cgi-bin/webwn

Psychotherapy is the treatment of mental or emotional problems by psychological means
www.cogsci.princeton.edu/cgi-bin/webwn

Psychotherapy is a set of techniques believed to cure or to help solve behavioural and other psychological problems in humans. The common part of these techniques is direct personal contact between therapist and patient, mainly in the form of talking. Due to the nature of these communications, there are significant issues of patient privacy and/or client confidentiality.

Wikipedia, the free Encyclopedia

Psychotherapy is a set of techniques believed to cure or to help solve behavioural and other psychological problems in humans. The common part of these techniques is direct personal contact between therapist and patient, mainly in the form of talking. Owing to the nature of these communications, there are significant issues of patient privacy and/or client confidentiality
wordiQ.com

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Psychotherapy is the use of psychological techniques to change behaviours, feelings, thoughts, or habits. It is generally employed to relieve symptoms of emotional or behavioural dysfunction or distress, however it is also used to help people achieve greater levels of self awareness and to actualize latent potential.

PlanetPsych.com

Psychotherapy is a highly personalized and collaborative effort, engaging a trained professional with one or more individuals who are experiencing distress and disruption in their lives. Several concepts will be useful to understand the bewildering array of services that go by the name of therapy. Most important among these are: "common elements," "theory," "technique," and "social processes."

Keith Sonnanburg, Ph.D. Insights from Psychotherapy
http://www.speakeasy.org/~keson/ezine.html

Psychotherapy: noun

1. The branch of psychiatry concerned with psychological methods.
2. The treatment of mental or emotional problems by psychological means.

(WordNet 1.7.1. Copyright 2001 Princeton University)

THE HISTORY OF PSYCHOTHERAPY/MODERN PSYCHOLOGY

The oral teachings recorded in the Upanishads, Buddhist sutras, and similar records go back thousands of years and provide evidence that mystical teachers of widely different cultures describe a way that leads to a higher level of existence.

There are records of treatment of mental distress through psychological means from the origins of civilization (priests, shamans, witch doctors). As far back as 15,000 B.C one can find, depicted on the wall of a cave in southern France, a sorcerer, his head crowned with deer's antlers. Primitive man understood himself through the heavenly bodies as well as the rhythms of waking and sleeping, and the rise and fall of emotions. Primitive cultures showed a general preoccupation with the nature and attributes of the soul. The conception of a psychic entity, or detachable soul, made sense to him. The opening lines of Homer's *Iliad* refer to the souls which, in combat, have departed to Hades and, when Achilles is visited in the nether world he is still, in a sense, the Achilles once known. Primitive psychology sees the survival of the soul after bodily death, through the view of immortality, or permanent existence. Greek philosophy referred to a ghost soul and, in the sixth and seventh centuries B.C. theorists tried to find a central substance or principle from which all else could be derived. **Democritus** looked to a mechanical explanation, Sophists saw the human experience as a meaningless flow of experiences, and **Socrates**, with his conversational, critical method confronted them both, erecting the architecture within from which Western philosophy and psychology developed. **Plato** separated the soul from the body and **Aristotle** ordered and defined the system of knowledge from which the soul and the living organism could be brought into relation. From **Copernicus** we get the belief in the natural order and laws of nature and **Gilbert**, in his study of magnetism, gave us the modern term 'experimental'. Francis **Bacon**, while not quite understanding all the theories, spread enthusiasm for empirical methods and Isaac Newton gave logical use of experimental results. **Descartes** introduced physiology and the rationale nature and saw the Pineal gland as the 'seat of the soul'.

His analysis of emotions was significant as was his conception of the machinelike nature of the reflex response. **Malebranche** also worked with the physiological definition of emotions while **Spinoza**, in his book *Ethics,* published in 1677, and way ahead of other theorists of his time, worked on a philosophy which fused the body and mind and included the memory, which brought forward the idea of unconscious motivation. In the English empire **Hobbes** began to draw a distinction between original nature and the products of experience glossing over what he saw as acquired, innate activities and reflecting more on relations to social life, bringing us closer to our understanding of motivation. David **Hume** (1711-1776) brought in the notion of causality and **Kant** (1724-1804) brought this from the external natural world into the human mind. He saw two separate domains of reality, one inside the mind, and the other completely outside. He recognized the role of time and space and included twelve categories defining quality, quantity, relation and mode. Johannes **Muller** (1801-1858) worked with the studies of sensation and perception and **Helmholtz** (1821-1894), in taking away Muller's belief in *vitalism* and embracing *mechanism,* brought theorists to the belief that no other forces, other than the common physical-chemical ones, are active within the organism. **Briquet** (1859) referred to Hysteria as a disease which modifies the whole organism and was the first to show that this included chronic physical complaints and psychological disturbances (Briquet's Syndrome or currently called somatization disorder-APA, 1994). In 1877 **Charcot** first conceptualized hysteria as a mental disease recognizing that it involved disturbances of perception and control. **Janet** (1893) stressed involvement of body and mind and saw hysteria as hereditary weakness which involved emotional and traumatic events.

Formal psychotherapy thus began to form in the eighteenth and nineteenth centuries when treatment was taken over from the clergy by rationalistic medicine and eventually became the specialty of psychiatry, which at first dealt primarily with madness. **Freud**'s psychoanalysis extended this view to include neurosis and hysteria, and psychotherapy now includes the

problems associated with existential human suffering, the traditional domain of religion, from which it historically originated.

Today, Western science is characterized by a split between the sacred and the rational. The issue involves the fact that most contemporary theorists of psychotherapy are based on a nineteenth-century physical and biological scientific model that is far too narrow to encompass human consciousness.

Human beings need meaning. Without it they suffer boredom, depression, and despair. Increasingly, psychotherapists are called on to deal with these symptoms as people confront aging and death in the context of a society that is coming to realize the possibility of its own decline and extinction. Western psychotherapy interprets the search for meaning as a function of childlike dependency wishes and fears of helplessness or, at best, a genetic disposition toward intellectual control, preserved and enhanced by natural selection, because of its survival value.

Our lives and our psychological health depend on a sense of purpose, and yet western psychotherapists, to date, have lacked a theoretical framework that provides meaning, direction, and hope. Science's vision of an orderly, mechanical, indifferent universe can provide no purpose for life. We live in a society where many people attempt to suppress despair at their purposelessness and to substitute heightened sensation for meaning. Even the pursuit of material goals may be a blind response to the urge to attain a dimly sensed reality in which purpose and meaning are facts, not fantasies.

Pain and dysfunction inevitably result from the denial or distortion of reality. A person who seeks psychotherapy may be suffering from a distortion of reality, not only at the interpersonal but also at the metaphysical level. Emotions, thoughts, impulses, images, and sensations are the contents of consciousness. We witness them, and we are aware of their existence. Likewise, the

body, the self-image, and the self-concept are all constructs that we observe, but our core sense of personal existence, the "I", is located in awareness itself, not in its content.

The distinction between awareness and content tends to be ignored in Western psychology. Most people have trouble recognizing the differences. Careful observation shows people that they can suspend their thoughts, that they can experience silence or darkness and the temporary absence of images or memory patterns that any element of mental life can disappear while awareness itself remains. Awareness is the ground of conscious life, the background or field in which all elements exist, different from thoughts, sensations, or images. One can experience the distinction simply by looking straight ahead. It is to this state that Transpersonal Psychology addresses itself.

THEORETICAL APPROACHES TO PSYCHOTHERAPY

There are a wide variety of theoretical approaches or orientations to psychotherapy. The choice of approach is usually determined by the training and experience of the therapist as well as the needs and desires of the patient. Some of the more widely used approaches are briefly described below.

Anxiety management training (AMT) can also be classified as a Cognitive-behavioural technique. It involves *Relaxation training* with a management of fear and anxiety through the systematic relaxation of the major muscle groups or the imagining of relaxing images, *Breathing retraining* which uses slow abdominal breath to help the patient relax and/or avoid hyperventilation with its unpleasant and often frightening physical symptoms, and *Assertiveness training* which teaches expression of one's wishes, opinions, and emotions appropriately and without alienating others.

(http://www.ncptsd.org/wsah_booklet/32_the_mental_health_pr.html)

Behavioural Therapy employs learning theory to effect changes in behaviour. It is usually symptom focused as opposed to working on unconscious material. Unlearning unwanted behaviours (including thoughts and feelings) and learning desired behaviours is the work of behaviour therapy. Maladaptive habits are weakened and eliminated (extinguished) and adaptive habits developed and strengthened in very small steps (successive approximations). These changes are consolidated through reinforcements (rewards, either intrinsic or extrinsic) until stable behaviour change is established. .

(Bateman, 2000; Rowan, 2001)

Cognitive Therapy seeks to alter habitual maladaptive thought patterns. Unrealistic expectations, wishful thinking, living in the past (or future) and over generalizing can all lead to disappointment and frustration. Cognitive therapy emphasizes a rational and positive world view. It has proven to be especially effective with anxiety and depression. (Bateman, 2000; Rowan, 2001)

Cognitive-Behavioural therapy (CBT) involves a modification of unrealistic assumptions, beliefs, and automatic thoughts that lead to disturbing emotions and impaired functioning. It involves *Imaginal exposure*, or the repeated verbal recounting of the traumatic memories until they no longer evoke high levels of distress and *In vivo exposure* which is the confrontation with situations that are now safe but which the person avoids because they have become associated with the trauma and trigger strong fear. Repeated exposures facilitate habituation to the feared situation.

(http://www.ncptsd.org/wsah_booklet/32_the_mental_pr.html)

Eclectic Therapy although not a formal school of thought, is the use of a combination of approaches or theoretical orientations. It is used by most therapists. There are many different blends. It is a recognition that individuals may benefit from a variety of techniques. The eclectic approach can be flexible and adaptive and avoid forcing treatment into one size fits all limitations. It is necessary that the therapist be well grounded in several of the more orthodox approaches to treatment rather than using bits and pieces through a lack of familiarity. (Bateman, 2000; Rowan, 2001)

Existential Therapy is an approach that examines some of the major issues in our existence such as the meaning of life, loneliness, mortality, and the challenge of free will. It focuses on taking responsibility for ones choices and creating our own meaning and purpose. It is especially useful with the elderly and in working on issues of death and dying. Though it emphasizes needs of the individual it usually helps patients find new meaning in their relationships. (Bateman, 2000; Rowan, 2001)

Psychoanalysis is the personality theory and psychotherapeutic approach pioneered by Sigmund Freud, the father of psychoanalysis. The approach emphasizes making the unconscious conscious and thereby giving the individual choices in life rather than being at the whim of unknown forces within themselves. Psychoanalysis frequently uses dreams and free associations (spontaneous uncensored communications) as the subject matter for treatment. . The therapist (analyst) says little but guides the patient in interpreting the meaning of the intrusion of unconscious material into everyday life. Sessions are frequent, up to five times per week, and treatment usually lasts for years. (Bateman, 2000; Rowan, 2001)

Psychodynamic Psychotherapy is the term used to describe treatment approaches based on psychoanalytic principals, but which are conducted less frequently, over a shorter duration, and allows a small amount of eclecticism. Psychodynamic therapists are more active (communicative) than psychoanalysts. (Bateman, 2000; Rowan, 2001)

Transpersonal Psychotherapy

Sutich describes transpersonally oriented therapy as "therapy directly concerned with the recognition, acceptance, and realization of ultimate states." He describes this as the

"oldest of all the therapeutic approaches." He states that "Transpersonal therapy is also concerned with the psychological processes related to the realization, or making real, of states such as 'illumination,' 'mystical union,' 'transcendence,' and 'cosmic unity.' It is also concerned with the psychological conditions or psychodynamic processes which directly or indirectly form barriers to these transpersonal realizations."
(Boorstein, 1996, P. 10)

Walsh and Vaughan remind us of the constrictions of a definition, preferring to use a definition of process in order to make room for continuing growth and evolution. They refer to *Transpersonal Experiences* as "experiences in which the sense of identity or self extends beyond (trans-) the individual or personal to encompass wider aspects of humankind, life, psyche, and cosmos," *Transpersonal Psychology* as "psychology that focuses on the study of transpersonal experiences and related phenomena." (i.e. cause, effect and correlates; disciplines and practices inspired by them), and *Transpersonal Psychotherapy* as "therapy informed by a transpersonal perspective which recognizes the value and validity of transpersonal experiences and development." (Boorstein, 1996, P. 17). Walsh and Vaughan use a transpersonal paradigm model of the psyche which includes the dimensions of consciousness (defences and obstacles distorted by input from reality and fantasy in accordance with needs as well as height potential), conditioning (tyranny of the mind, detachment), personality (less centrality to personality which may involve disidentification rather than modification), and identification (intrapsychic, identity beyond the individual ego/personality).

Rowan (1993) tells us that the Transpersonal is not the extrapersonal, is not the same as the right brain, is not New Age, and is not a religion. He sees the transpersonal as everyday life, which includes inner voices, intuition, creativity, and peak experiences. Brant Cortright (1997) gives us the following basic assumptions:

1. Our essential nature is spiritual
2. Consciousness is multidimensional
3. Human beings have valid urges toward spiritual seeking, expressed as a search for wholeness through deepening individual, social, and transcendent awareness.

Boorstein (1996) reminds us that the transpersonal approach involves an enhanced awareness with perceptions that need to be trained. Observing mental content, rather than trying to change it, gives the opportunity to *disidentify* from and begin the process which explores the question of Who am I? and What am I?

The Transpersonal, with its wider spectrum of psychological well-being, affords individuals the opportunity of working at different levels. As Walsh and Vaughan tell us "it is difficult to see beyond our own level, and those individuals and systems that have not recognized the possibility of, or experienced, transpersonal awareness may interpret such experiences from an inappropriate and pathologizing perspective." (Boorstein, 1996, P.21) Interpreting mystical experiences as manifestations of borderline psychotic processes, which is what the Group for the Advancement Psychiatry (GAP, 1977) did, shows a marked lack of understanding of altered states.

OTHER MODELS OF THERAPY

Groft (2000) speaks to the optimal spiritual emergence and the role of the psyche. He reminds us that the experiences which manifest as spiritual awakenings are not artificially produced by aberrant pathopysiological processes in the brain, but actually belong to the psyche. By transcending the narrow understanding we have held of the psyche usually offered by mainstream psychiatry, and using a vastly expanded conceptual framework, such as Ken Wilber's spectrum psychology (Wilber, 1977), Roberto Assagioli's psychosynthesis (Assagioli, 1976), and Jung's concept of *anima mundi*, or world soul (Jung, 1958), we begin to see an emerging pattern of differential diagnosis between spiritual emergence and mental disease. It is important to begin to look at which individual, experiencing an intense spontaneous *Holotropic* state of consciousness, would be more likely a good candidate for a therapeutic strategy that validates and supports the process, and for whom an alternative approach would not be appropriate and current psychopharmacological suppression of symptoms would be more preferable. Groft suggests beginning with an evaluation that eliminates organic and biological conditions from biographical, perinatal, and transpersonal experiences. Groft continues on to say that psychotherapy, as it has been known in the past, does not address the multilevel dynamic structure which may include significant elements from the perinatal and transpersonal domains of the psyche. He suggests that the traditional view of understanding psyche function and why symptoms happen, which leads to a correction of deviant psychodynamic processes, lacks the most fundamental of theoretical issues and appropriate therapeutic measures. With schools disagreeing considerably in regard to the development of the psyche and psychopathology, their strategies and nature of

therapeutic interventions remain limited. Influenced by their formal, basic training and personal philosophy, their activities and interventions become more or less arbitrary.

Groft sees emotional psychosomatic disorders as a representation of the organisms attempt to free itself from old traumatic imprints, to heal itself, and to simplify its functioning. He sees symptoms as a major opportunity, with effective therapy consisting of temporary activation, intensification, and subsequent resolution of the symptoms through facilitator support in which the process spontaneously is set in motion. "This saves the therapists from the impossible task of determining what are the truly relevant aspects of the material the client is presenting." (Groft, 2000, P.180)

In mainstream psychiatry, under the influence of the medical model, psychiatrists see the intensity of symptoms as indicators of a serious emotional and psychosomatic disorder, with amelioration of symptoms seen as improvement. With dynamic psychiatry the intensification of symptoms suggest emergence of important unconscious material and heralds major progress in therapy. "It is also well known that acute and dramatic emotional states rich in symptoms usually have a much better clinical prognosis than slowly and insidiously developing conditions with less conspicuous symptoms." (Groft, 2000, P.180) "…the goal of real therapy of emotional disorder is to attain a situation in which symptoms do not manifest, because there is no reason for them to manifest, not one in which they cannot appear because the signalling system is out of commission." (Groft, 2000, P.181) This Holotropic strategy of therapy encourages, facilitates, supports the full emergence of underlying symptoms and helps to process and liberate traumatic imprints and the emotional and physical energies associated with them.

What mainstream and psychiatrists diagnose as psychotic and serious mental disease can instead be seen as the cartography of the psyche that includes the perinatal and transpersonal domains, which explains the intensity and content of such extreme states. Groft suggests that human beings only function at a fraction of potential, at the level of ego and the physical. "This false identification leads to an inauthentic, unhealthy, and unfulfilling way of life and contributes to the development of emotional and psychosomatic disorders of psychological origin." (Groft, 2000, P.182) A crisis or breakdown of old, useless patterns of functioning makes way for unconscious discharge into the conscious psyche which, if not supported and guided, can lead to life disruption.

By supporting, mobilizing, and bringing to fruition these repressed and forgotten traumas there is the possibility of liberation and discharge of all symptoms and experiences-biographical, perinatal, and/or transpersonal. When the term *therapist* is seen in the Greek context of *therapeutes* (person assisting in the healing process), we can then embrace the experiential unfolding without the need for rationalization. Somatic regressive work, which supports the emotional and physical sensations of the original traumatic situation from the perspective of the child and maintains the adult consciousness, allows for conscious experience, processing, and integration. It is more important to 'hold the space' than to give therapist biased interpretations of material. "When we are patient and resist the temptation to share our own impressions, participants very often find their own explanations that best reflect their experience." (Groft, 2000, P.200)

Schilder (1999) reminds us that many therapeutic approaches value the notion of "psyche" in the root of the word. Other approaches focus on the link between the mind and body and try to access deeper levels of the psyche through manipulation of the physical body (e.g. Rolfing, Pulsing and Postural Integration). He suggests that a distinction should be made between those psychotherapies that employ a medical model and those that employ a humanistic model. In the medical model the client is seen as unwell and the therapist employs their skill to help them back to health. In the humanistic model the therapist facilitates learning in the individual and the clients own natural process draws them to a fuller understanding of themselves.

List of some of the Psychotherapeutic Modalities

- Analytical Psychology
- Autogenic Psychotherapy
- Behaviour Therapy
- Biodynamic Psychotherapy
- Bio-energetic Analysis
- Bio-synthesis
- Jungian Psychotherapy
- Rogerian Psychotherapy
- Cognitive Analytic Psychotherapy
- Cognitive Behavioural Psychotherapy
- Concentrative Movement Therapy
- Core Process Psychotherapy
- Daseins Analytic Psychotherapy
- Encounter Groups
- Existential Analysis
- Family Therapy
- Freudian Psychotherapy
- Gestalt Therapy
- Group Therapy
- Humanistic Psychology
- Logo Therapy
- Neuro-Linguistic Programming
- Person Centred Psychotherapy
- Personal Construct Psychology (PCP)
- Positive Psychotherapy
- Postural Integration
- Primal Integration
- Primal Therapy
- Psychoanalysis
- Psychodrama
- Psychodynamic psychotherapy
- Psycho-Organic analysis
- Psychosynthesis
- Pulsing
- Rational Emotive Behaviour Psychotherapy
- Reichian Psychotherapy
- Rolfing
- Sophia Analysis
- Systemic Therapy
- T Groups
- Transactional Analysis
- Transpersonal Psychotherapy

List of some of the techniques used in Psychotherapy

- Art work
- Body work
- Catharsis
- Coaching
- Dream analysis and interpretation
- Empathy
- Journal work
- Massage
- Minimal Encouragers
- Paradoxical intention
- Reflective Listening
- Regression
- Role play
- Sand play
- Unconditional positive regard
- Validation
- Working through Projections
- Working through Transference

Schilder, Paul **(**1999) *Psychotherapy: International Library of Psychology* Routledge, NY

WHO DOES PSYCHOTHERAPY?

Although there are many similarities, the varied training backgrounds of therapists sometimes lead them to choose different approaches and/or orientations. The table below summarizes some of the characteristics of different licensed practitioners. The special orientations listed are generalizations and individuals differ in their approaches.

Discipline	Training	Special Orientation
Psychologist	Ph.D. (Doctor of Philosophy in psychology) or Psy.D. (Doctor of Psychology) and one year Internship.	Psychotherapy: All modalities and orientations. Psychological Testing.
Masters Level Psychologist	M.A.(Master of Arts) or M.S. (Master of Science) or M.Ed.(Master of Education)	Psychotherapy: Some modalities and orientations. Psychological Testing.
Social Worker	M.S.W.(Master of Social Work)	Psychotherapy: Interpersonal, family, group, milieu orientation.
Psychiatrist	M.D.(Medical Doctor) or D.O.(Doctor of Osteopathy) and Three year Psychiatric Residency	Biological Treatment, Psychopharmacology. Some Psychotherapeutic modalities and orientations.
Counsellor	M.A.(Master of Arts in counselling) or M.Ed.(Master of Education in counselling)	Counselling. Vocational and Educational Testing.

From FreeDefinition.com

THE ROLE OF A THERAPIST

Hawkins (2002) reminds us that in order to understand meaning we have to ask the right questions. "Understanding doesn't proceed simply from examining data; it comes from examining data in a particular context." (Hawkins 2002, P. 26) He reminds us that we need "the appropriate instruments with which to measure the data in a meaningful process of sorting and description." (Hawkins 2002, P. 26)

Some of the faults of our cognitive process include:

- The differentiation between subjective and objective
- Disregarding the limitations of context inherent in basic design and terminology
- Ignorance of the nature of consciousness itself
- Misunderstanding causality

Hawkins reminds us that "Society constantly expends its efforts to correct *effects* instead of *causes"* (Hawkins, 2002, P.26) and suggests that this has caused a delay in human consciousness. We need to remember that information is useless without meaning and that *true* answers always have the hallmark of simplicity. It is not the elaborate schemes of thinking that create a good therapist, but their psychological, physical, and spiritual presence. The law of efficacy requires observation. "No definitive answer to any problem can be found by isolating sequences of events and projecting upon them a mental notion of 'causality'." (Hawkins 2002, P.27) We need to find a way to discriminate the essential from the nonessential, a method to distinguish power from the ineffective. Societal choices have been the result of expediency, statistical fallacy, sentiment, political or media pressure, or personal prejudice and vested interest. *Force* (rules and regulations) and a reliance on reason and feeling, both inherently unreliable, have been the mainstay of therapy, and the life standards of many, for a long time, while

awareness and human consciousness should be at the forefront. “Consciousness automatically chooses what it deems best from moment to moment” (Hawkins 2002, P.29) and if we can learn to patiently observe, we may achieve a new level of understanding. Facts are accumulated by effort and truth reveals itself effortlessly (Kendall, 1971).

“Presence is silent and conveys a state of peace. It’s infinitely gentle and yet like a rock. With it, all fear disappears, and spiritual joy occurs on a quiet level of inexplicable ecstasy. Because the experience of time stops, there’s no apprehension, regret, pain, or anticipation….nothing needs to be done, for everything is already perfect and complete.” (Hawkins 2002, P.20-21)

“The difference between *treating* and *healing* is that in the former, the context remains the same, whereas in the latter, the clinical response is elicited by a change of context so as to bring about an absolute removal of the cause of the conditions rather than mere recovery from its symptoms.” (Hawkins 2002, P.73)

Therapy is meant to resolve issues, such as shame, guilt, apathy, grief, fear, desire, anger, and pride, and bring us to our level of courage, willingness, acceptance, reason, love, joy, peace, and eventual enlightenment. Hawkins (2002) tells us that what is needed to reach awareness is desire to change, discipline and focus to act with constant and universal forgiveness and gentleness, compassion to everything including our own self and thoughts, willingness to hold desires in abeyance, and surrender of the personal will to the Higher Good, or Higher Consciousness.

Gardner (1992) suggests that a therapist should have:

- ?? A genuine desire to help the patient
- ?? A reasonable degree of sympathy and empathy (intellect and emotion), respect and receptivity
- ?? A reasonable capacity to identify with the patient
- ?? Goals of trying to help as opposed to curing the patient
- ?? An understanding of the role family of origin and culture play
- ?? A sense of therapy as an educational experience
- ?? A way of communicating, conceptualizing and providing experience
- ?? The ability to create a genuine therapist-patient relationship
- ?? A sense of pride in what they do
- ?? The experience of having their own therapeutic experience
- ?? A sense of timing and the ability to be 'on the same wavelength
- ?? a strong parental instinct with the ability to support
- ?? a childlike personality characteristic
- ?? a frustration tolerance with flexibility and creativity
- ?? comfort with therapeutic failure
- ?? the ability to terminate therapy while leaving the door open for return (process in motion)

Herman (1992) reminds us that therapists need a support system. "The dialectic of trauma constantly challenges the therapist's emotional balance" (Herman, 1992, P.151) and it is common to have feelings of withdrawal and loss of balance, impulsive, intrusive acts, rescue attempts, boundary violations, attempts to control the patient, doubts or denial of the patient's reality, dissociation or numbing, minimization or avoidance of the traumatic material, professional distancing, and abandonment of the patient. "The guarantee of her integrity is not her omnipotence but her capacity to trust others." (Herman, 1992, P.151)

Therapist's support systems should include peer review and/or supervisory overview. They must have a space to express emotional reactions, technical or intellectual concerns, and a supportive environment where they can be heard and believed , as well as

maintaining a balanced personal and professional life. They need the ability to set realistic limits, to be able to call on their most mature coping abilities and a sense of humour. “By constantly fostering the capacity for integration, in themselves and their patients, engaged therapists deepen their own integrity.” (Herman, 1992, P.153)

Ross (1995) reminds us that as many as 15% of professionals providing treatment to Satanic ritual abuse survivors could either be sexual offenders or have dissociative disorders with probably more than 50% having sexual-abuse histories of some kind. He reminds us that this data serves to highlight the need for attention to boundaries, which he states includes management of countertransference, understanding the meaning of and how to work with polyfragmented systems, and working with the multitude of variances that may present.

Janov (1970) reminds us that when a patient is able to feel, the charting, testing, diagramming, and schematizing done in order to understand human behaviour will be unnecessary. He tells us that therapists need to know something about physiology and neurology so he knows when to treat organic brain impairment and when to work psychologically. He must have an appreciation of scientific methodology and know what evidence consists of. He needs to be open enough to allow patients to tell him what is real and he must be sensitive and perceptive, which comes from living his own pains, and be able to sense the rhythms, the disjointedness, and the neurosis of his patients. He must live in the present and move from labeling to concern about the reality underneath.

WHAT IS DISSOCIATION?

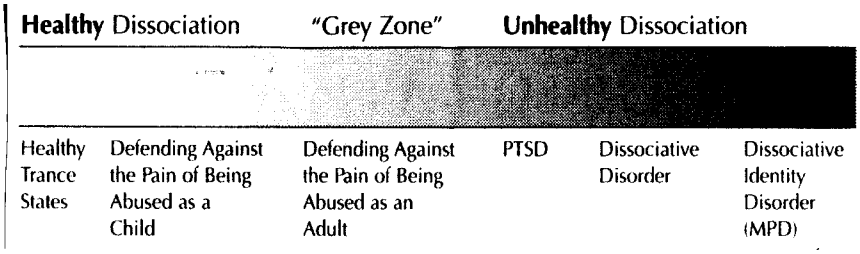
The American Psychiatric Association has taken the time to elucidate and categorize, placing symptoms into recognizable slots. (DSM-IV, 1994) *Dissociative Amnesia* refers to the state of disturbances where there are episodes of inability to recall important personal information, usually of a traumatic or stressful nature. These symptoms must cause significant distress or impairment and not be due to direct physiological or substance effects. *Dissociative Fugue* happens when one travels from home with the inability to recall their past. There is identity confusion, with the possibility of assuming a new identity. *Dissociative Identity* disorder requires the presence of two or more distinct identities or personality states which take control over the person's behaviour. There is an inability to recall personal information that can't be explained by forgetfulness. *Depersonalization* disorder involves a persistent or recurrent experience of detachment from self, as if becoming an observer of one's mental processes or body. There is also a classification called *Dissociative Disorder Not Otherwise Specified* in which there are Dissociative symptoms but the specific criteria aren't met. This may include people who have encountered brainwashing or other forms of coercive persuasion or indoctrination.

Most clinicians today believe that dissociative processes exist on a continuum with mild dissociative experiences (daydreaming, highway hypnosis) on one end of the spectrum and severe, chronic dissociation with serious impairment or inability to function at the other extreme. "When faced with highly anxiety-provoking situations from which there is no physical escape, the child may resort to "going away" in his or her head. This ability is typically used by children as an extremely effective defence against acute physical and emotional pain caused by highly traumatic situations, most commonly severe abuse. Over time, for a child who has been repeatedly abused, dissociation becomes reinforced and conditioned." (Cohen, 1991 P.xx) Even after the danger is long

past these chronic defensive dissociations, which may lead to serious dysfunction in work, social and daily activities, are automatic responses to any anxiety or anticipatory anxiety, even in non-abusive situations.

The common profile factors for a person with severe DID are: endured repetitive, overwhelming, and often life-threatening trauma at a sensitive developmental stage of childhood (usually before the age of nine) and a biological predisposition for auto hypnotic phenomena. Many refer to DID as a highly creative survival technique "because it allows individuals enduring 'hopeless' circumstances to preserve some areas of healthy functioning." (Cohen, 1991 P.xx)

"Theorists have long observed that dissociative experiences appear in minor and major forms (Bernstein & Putnam, 1986) that seem to fall along a continuum (Berstein & Putnam,1986; Ludwig, 1983; Putnam, 1989) ranging from transient everyday events involving absorption (such as daydreaming) to more chronic and relatively rare conditions characterized by dissociative pathology (such as disorders of memory and Identity)". (Butler, 2004)



(Whitfield, 1995)

The Diagnostic and Statistical Manual of Mental Disorders: Third Edition-Revised (DSM-III-R), published by the American Psychiatric Association first included MPD and other Dissociative Disorders in their 1980 edition, legitimizing the diagnosis within the psychiatric community. Many mental health professionals continue to remain skeptical. Some of the symptoms included: depression, mood swings, suicidality, sleep disorders, panic attacks, phobias, alcohol and drug abuse, compulsions and rituals, psychotic like symptoms (including auditory and visual hallucinations), eating disorders, headaches, amnesia, time loss, fugues, trancing, out of body experiences, self persecution, self sabotage, violence (self inflicted and outwardly directed), etc.

Today, DID is seen as a method of coping with and surviving overwhelming traumatic severe, chronic childhood sexual and/or physical abuse, neglect, loss or changes of caretakers. Child autohypnosis creates altered states, or personalities, to contain the pain, anger, and memories. Persons with DID are courageous, intelligent, creative, socially skilled, talented people whose dissociative abilities allowed them to survive traumatic abuse. Some of the symptoms of DID include lack of appropriate emotional response, memory loss, lost time, not knowing what has been said or done, feeling dream-like, a sense of watching oneself speak or act, dizziness, headaches, numbness in body parts, feeling disjointed, spontaneous trance states, not remembering childhood or major life events, hearing voices or thoughts that don't seem to belong to the person, unexplained items in possession, drastic and rapid changes in mood and behaviours, addictions, eating disorders and disruptive sleep patterns, suicide attempts and self destructive behaviours, displays of hypervigilence and denial of behaviour observed by others.

Stout (2001) tells us that dissociation is a normal function of the mind and a universal human reaction to extreme fear or pain. It allows us to disconnect emotional content from conscious awareness and gives us a better chance of surviving the ordeal and getting through a critical moment in which our emotions would only be in the way. The person viewing an ongoing traumatic event becomes the spectator, which prevents the chance of becoming overwhelmed. It is adaptive, and seen as a survival function. The problem begins when this adaptive behaviour becomes a life long disconnection from the self and old terrors reoccur within the present life.

Ross (1994) refers us to core symptoms such as: voices in the head, ongoing blank spells, periods of missing time, depression, anxiety, eating disorders, substance abuse, sleep disorders, sexual dysfunction, psychosomatic disorders, symptoms that mimic schizophrenia, self-abuse and violence, etc.

The current quantitative research on DID comes from using the Dissociative Experience Scale (DES), the Dissociative Disorders Interview Schedule (DDIS), and the Structured Clinical Interview for DSM-III-R Dissociative Disorders (SCID-D).

When we look at the definition of dissociation, we come up with a noun, and the following description:

> **1**. The act of removing from association.
> **2**. A state in which some integrated part of a person's life becomes separated from the rest of the personality and functions independently.
> **3**. (chemistry) the temporary or reversible chemical process in which a molecule or ion is broken down into smaller molecules or ions.
> (WordNet 1.7.1. Copyright Princeton University 2001)
>
> Dissociation comes from the Latin expression ‘dissociatio’.

The word ‘dissociation’ was first used in popular English literature sometime before 1790.

Firman and Gila (2002) refer to Primal Wounding, the results of violation of a person’s sense of self. This may occur from intentional or unintentional neglect by those in the environment and from the inability of significant others to respond empathically. Firman and Gila (2002) believe that no one has escaped from some level of debilitating primal wounding in their lives, which involves a breaking of the empathic relationship by which we know ourselves as intrinsically valuable human beings rather than as nonpersons or objects. “In these moments, we feel ourselves to be ‘it’s’ rather than ‘Thou’s’, to use Martin Buber’s (1958) terms.” (Firman, 2002, P.27) This experience creates feelings of isolation and abandonment, disintegration and loss of identity, humiliation and low self-worth, toxic shame and guilt, feelings of being overwhelmed and trapped, or anxiety and depression/despair.

Using this model, the greater the wounding, the more dissociated and polarized the parts of the self can become as the entire personality system responds to the wound. Firman and Gila refer to this state as a painful, self-destructive synthesis that embodies the higher unconscious qualities with the pain of the lower unconscious.

Spiegel (1994) reminds us that the depiction of self is culture bound. “People in other cultures do not demand the same amount of continuity, consistency, univocality, or rationality in behaviour.” (Spiegel, 1994, P.114) What some call an illness or disorder can be looked at, in other cultures, as socially sanctioned solutions for problems. He states that additional pathology may be missed, such as too much ‘I’ can be as pathological as too little. He reminds us that dissociative phenomena are often subtle, delicate, and involve the interaction of ordinary cognitive and social processes related to imagination and self-characterization through memory and narrative. While DID may exhibit unique features they are certainly not the only phenomena of clinical interest. He suggests that DID is a self coherent story constructed about our actions

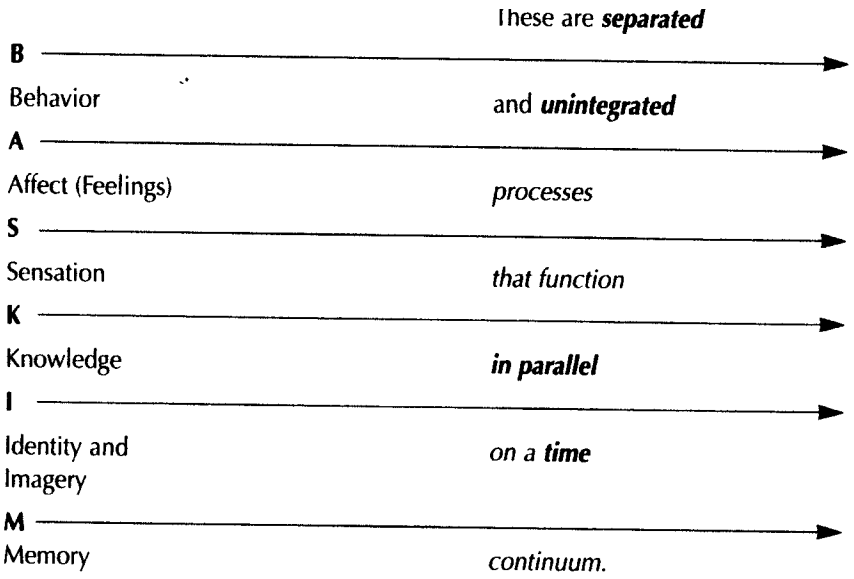
with the 'I', or narrative center creating multiple stories with different narrative centers or multiple selves and that we should not get caught up in the drama and urgency of the distress.

Kirmayer (Spiegel, 1994) refers to states of mind, as opposed to experience, with shifts away from consciousness leaving gaps in experience. He speaks to "Much of conscious awareness is not focused on the self but directed toward objects or events that are the content of experience" (Spiegel, 1994, P.99), which take the person away from the self and place their experience in the external world. He suggests that this external world may actually occur within their body. Kirmayer refers us to a model in which we shift our attention to restore self-consciousness, from which we always drifting, and try to contextualize cues and emotions and re-address them in terms of personal meaning, describing and contrasting the 'I' and the 'not I' with our consciousness of the external world. Kirmayer reminds us that DID, which is directly linked to childhood trauma, must also take into account temperament and family pathology and he refers to religious possession cults which consider a visitation holy and worthy of welcome.

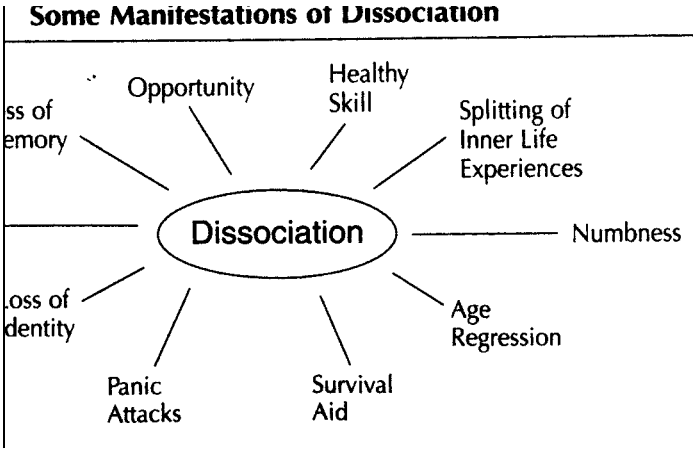
Firman and Gila (1997) remind us that dissociation, a creative mode of mental functioning, can be useful in such things as focusing on an important task and only becomes problematic when it is unconscious and chronic.

In contrast to repression, Whitfield (1995) reminds us that dissociation and denial are a part of healthy psychological functioning. He tells us that what was an adaptive and useful skill in defending against the pain of childhood abuse when continued into adulthood becomes a maladaptive habit requiring healing and recovery and that when we dissociate we alter our state of consciousness which leads to spiritual advantages and an ease with connecting to our Higher Power.

Whitfield refers to the BASKIM model,



shows us some manifestation of Dissociation,



and reminds us that the healing will involve the 'why's, the 'can I find meaning', and the 'letting go'.

People like Spanos (1996) hold true to the belief that DID does not exit. Before his death he wrote and delivered a blistering rebuttal to long-held assumptions about multiple personality disorder. Bolstered by a thorough examination he declared that MPD is not a

legitimate psychiatric disorder but a cultural construct with roots in early beliefs about demonic possession. He held, to his death, the belief that MPD was created by misguided therapists and willing patients.

THE HISTORY OF DISSOCIATION/MULTIPLE PERSONALITY DISORDER

S.L. **Mitchill** and his patient Mary Reynolds was the first publicly recorded case of Multiple Personality Disorder in New York City in 1816 (Crabtree, 1985).

William **James,** in the late 1800's, believed that psychology should study mental life and that dissociation provided this key information. James believed that all people had 'selves' which had different functions, desires, and activities. He often referred to examples such as the social self, the spiritual self, and the family self. What unified all these selves, which he stated were often in conflict and power shifts, was the feeling of ownership in regard to the stream of consciousness. To him, cases of MPD proved this belief, yet were abnormal because the stream of consciousness was affected (Heidbreder, 1993). James explained that normal people have a stream of consciousness that links together the memories and separate parts of the self. In those affected by MPD, the dissociation of ideas creates different streams of consciousness that do not span across these different parts. In *The Principles of Psychology* (originally published 1890) he states that in order for the states of personality to change so thoroughly, so abruptly, and with different memories, that the well-organized association paths in the brain must change and develop along with the altered states. He proposed that this physiologically affected neurological path model explained how different alters could be present at the same events, or be unaware of events that were occurring to other alters.

Sigmund **Freud** and Josef **Breuer** co-authored *Studies on Hysteria* (originally published in 1895), in which they addressed dissociation and MPD as subsets of hysteria. Breuer's infamous patient, Anna O, was diagnosed as having MPD and her case sparked

Freud's interest. Together, Breuer and Freud wrote that trauma which involved extreme emotional content was the cause of MPD and dissociation. Unlike James, they believed that dissociation of ideas that were inadmissible to the consciousness of the primary self created a splitting of the mind. Freud believed this because he thought that splitting of the consciousness was impossible. He pointed to the fact that an altered self could recall the information that was inaccessible to the primary self to prove that the information was still in the consciousness somewhere. Freud went on to say that the alters were defined by what memories they held that were inadmissible to the complete consciousness. He called for abreaction done with the assistance of hypnosis in order to bring those memories back into complete consciousness as the cure for MPD and dissociation. Breuer and Freud also brought forth the idea that alters could affect each other without direct contact, such as through emotional and memory leakage.

Alfred **Binet** wrote *Alterations of a Personality* (originally published in 1896) in which he focused solely on MPD and dissociation. He witnessed and conducted research done on MPD and dissociative patients, including tests of memory, hypnotizability, autonomic writing, and differences between alters' handwriting, speech, and intelligence. He noted, from this research, that there was a stable base of symptoms that linked MPD patients. He felt that each alter had characteristics that differentiated them from another alter, which included: memory recall, state or disposition, and the state of sensibility, movement, mental capacity, and physical differences or problems. Some similarities he found in early cases were: headaches, loss/shift in appetite, body pains from psychological sources, being highly hypnotizable, experience of loss of time and memory, and different pain thresholds for different alters. Binet felt that studying MPD

and dissociative patients provided much information because he felt they magnified the phenomena not shown in cases of hysterical symptoms. Binet agreed with Freud and Breuer that different altered states could affect and interact with each other, either directly or indirectly. He felt that something more profound than associationism must be present. According to Binet, the process of dissociation was creating different consciousnesses, which could be identified by character and memory.

Pierre **Janet** in *The Mental State of Hystericals* (published in 1901) related psychological phenomena that characterized disturbances as retraction of the field of consciousness and dissociation. He stated that hysterics display a retraction of consciousness so that perceptions are not assimilated into normal consciousness and personality and are, therefore, not synthesized into personal perception or memory. This non-assimilated mental phenomena was perceived and stored and began to lead a life of its own. **Moreau de Tours** (1845) introduced the descriptive concept of dissociation but Janet was the author who most profoundly studied its manifestations, observing that dissociative processes find expression in somatoform disturbances of sensation, movement, speech, vision, and hearing, as well as disturbances of consciousness, memory, and identity. (Nijenhuis, 1999) It was Pierre Janet who coined the word disaggregation to identify changes in consciousness which disturbed the normal, well-integrated functions of identity, memory, and thought in several of his patients. This term was later translated from the French as *dissociation*. (Cohen, 1991) Janet studied patients with amnesia, fugue, and 'successive existences', now known as alter personalities. He saw these symptoms as an affect of split-off parts of the personality which were capable of independent thoughts, actions, and identities. These patterns appeared to be coming

from past traumatic experiences with the symptoms being alleviated by splitting off from memories and feelings. While Janet's contemporaries expanded upon his research and produced a model for the diagnosis and treatment of dissociation, the 1930's, and Freud's theories, pulled the professional community away until an increased public and professional awareness of child abuse and Vietnam veterans' post-traumatic stress syndrome occurred in the 1980's. (Putnam, 1989)

Morton **Prince** in *The Dissociation of a Personality* (originally published in 1905) offers information about MPD and dissociation as well as an early cross-cultural study of these phenomena. Prince was much like James in his belief that studying cases of MPD offered knowledge about the normal functioning of the human mind. He noted that the alters had distinct characteristics, including different trains of thought, views, tastes, habits, memories, ideals, and temperaments. He argued that the term double or multiple personality should be changed to disintegrated personalities since this was a process of disintegration and separation, and not degeneration or destruction. For Prince, each of the alters merely made up the whole, normal self, which had undergone a process of the personal ego breaking apart. He felt that MPD patients were not insane, but 'functionally dissociative' with their 'elementary psychical processes' remaining normal. In addition, he said that since nothing was being destroyed in the process of dissociation, that the alters were capable of being re-associated into a normal whole.

Cornelia **Wilbur** is considered to be the originator of the term *Multiple Personality Disorder*, which is now called *Dissociative Identity Disorder*, and was the first to describe the complexity of the alter system in patients. She saw it as a developmental disorder related to childhood abuse and trauma and was the first to formulate the modern view of dissociative defences and multiple transference reactions. In 1980 DID had only about 200 cases reported in the world. Since then publications have accumulated as well as many research groups forming centred around DID studies. Since then it seems like there has been an explosion of cases, when, in fact, the diagnosis

of Dissociative Disorders is really a result of the recognition of patients who have always been with us but simply were not ‘seen’ before.

Ross (1989, 1997) and **Duncan** (1994) , in their trace of the history of MPD for the years of 1910 through 1980 see this as a time in which dissociation and multiple personality disorder fell from interest and research due to several concurrent factors. Duncan refers to this time as when the field reached its full maturity and then experienced an unfortunate decline, so severe that dissociation and MPD were eliminated almost completely. The authors point to the changes within the schools of psychology as a cause of the rapid decline. Pavlov's theory and research on learning and conditioning ushered the behavioural movement to the foreground. This school of psychology repressed the study of dissociation and MPD as being irrelevant, unnecessary concepts. Furthermore, Freud broke away from Breuer and repudiated their earlier theory that childhood sexual trauma was the foundation and cause of hysteria. He insisted that the reports of incest and child abuse were really incestuous dreams and desires that women were having, which fit into his theory of psychosexual development. In addition, Freud also took the stance that hypnosis was not a treatment modality. Another cause of the great decline was the rise in attention given to schizophrenia. As Ross cited Rosenbaum's 1980 research on the issue, from 1914 to 1926 there were more diagnoses of MPD than schizophrenia. In the late 20's and early 30's, Rosenbaum says that the diagnosis of schizophrenia "caught on." He says this is due to the field becoming more physiological and biological in focus.

A sign of this pattern was found by **Hilgard** (1987), as cited by Ross. Hilgard points out that 20 abstracts concerning dissociation and MPD appeared in Psychological Abstracts from 1927 to 1936, eight from 1937 to 1946, two from 1947 to 1956, and only

three abstracts from 1957 to 1966. Duncan states that two MPD patients with the same symptoms would most likely be diagnosed schizophrenic or hysteric during this time frame.

Ross also cites an article published by **Taylor** and **Martin** in 1944, in which the patterns found in 76 patients with MPD from the US, France, Britain, Germany, and Switzerland were analyzed. They found that 49 of the subjects had dual personalities, and that only six subjects had five or more alters. They claimed that the causes of MPD could be head injury, fatigue, intoxication, unbalanced urges, and excessive learning and forgetting. At that time, no mention of trauma surfaced in their study. (http://www.2multiples.com/twcrew/index.html)

In the 1950's a personal account of MPD was published, and turned into a popular movie. *The Three Faces of Eve* appeared to present a rare case to the public eye, and some felt that Eve was the only living case of MPD at that time. Duncan recounts being instructed in graduate school in the late 60's that MPD was extremely rare, usually caused by incompetent therapists and attention seeking patients, and probably something many psychologists would never encounter directly.

As well, an important psychologist hit the scene in the 50's, yet received little acknowledgment at the time for his work. George H. **Estabrooks** began to study the early literature that seemed to have been forgotten. Through his studies of Binet, Janet, Prince, Sidis and Goodhart, Estabrooks began to publish articles concerning hypnosis, trances, and MPD. Unlike the other psychologists who were also beginning to realize the vast amount of information that they had lost over the years, Estabrooks included Studies of

Hysteria by Freud and Breuer. He began to talk about trauma and its role in dissociation. In his 1957 edition of *Hypnotism*, Estabrooks presents case histories in which W.W.II personnel were placed through rigorous techniques in which MPD was artificially created. In order to facilitate infiltration and other top secret, dangerous operations for the government, the subjects were submitted to months of intensive conditioning, training, and hypnosis. One reason Ross feels that Estabrooks is very important to the field is the fact that he shows that iatrogenic MPD can occur. In contrast to the image of an overzealous, inadequate therapist with a suggestible, eager-to-please patient, Estabrooks stresses that the creation of MPD took an extreme amount of control, time, intent and effort.

The next major time period ranges from the 1970's to the 1990's in which dissociation and MPD began to be studied and taken seriously as their own entities once again. This period is marked by the publication of Hilgard's *Divided Consciousness* (1977). This book brought dissociation back to the research forefront. Two social influences that helped the resurgence were the attention to Post Traumatic Stress Disorder (PTSD) after the Vietnam War, and the attention to child abuse brought forth by the Women's Movement. The publication of *Sybil* in 1973 helped the public see not only how the patient, but also the therapist, deal with MPD. It was at this time that there was a revival in Janet's work, thanks to **Ellenberger** (1970), Hilgard (1977), and **Van der Hard** (1991), however this renewal has been restricted to psychological manifestations of dissociation. (Nijenhuis, 1999)

In 1980 the Diagnostic and Statistical Manual of Mental Disorders (DSM) III officially considered Multiple Personality Disorder to be a diagnosis in the field of

Psychiatry and Psychology. During this time the amount of literature on the field greatly increased. Trauma, especially childhood abuse, began to be looked at once again as the cause of the dissociation and MPD. In 1984 the first major conference on MPD was held in Chicago by the International Society for the Study of Multiple Personality and Dissociation (ISSMP&D). This society continued, and in 1994 was renamed the International Society for the Study of Dissociation (ISSD). In 1983 and 1984 major journals published special issues on MPD, which Ross cites: American Journal of Clinical Hypnosis, International Journal of Clinical and Experimental Hypnosis, Psychiatric Annals, and Psychiatric Clinics of North America. Researchers began to notice that Freud and Breuer had been correct in their hypothesis that trauma was the cause of MPD and dissociation. More research began to appear to illustrate that. Hilgard published a second edition of *Divided Consciousness* in 1986 and in it says that MPD is an effective method of coping with a very difficult childhood, which includes: violent and excessive punishment, overt sexual assaults, and unbalanced parental roles.

In 1988, the leaders in the field of MPD were Bennett **Braun** and Richard **Kluft**. In addition to the large amounts of literature they produced, they established the first dissociative disorders psychiatric unit and the first journal devoted exclusively to dissociative disorders, entitled *Dissociation*. In 1989 two books for clinicians were published concerning the diagnosis and treatment of MPD, which marked the field coming back full circle.

Today the field of Somatoform Dissociation is being brought forward from the works of Janet and Charcot by theorists like **Kihlstrom** (1992), **Nemiah** (1990), **Nijenhuis** (1990), and **Van der hart** & **Op den Velde** (1991) and in the International Classification

of Diseases, tenth edition (ICD and10, WHO, 1992) it now states that dissociation may apply to a partial or complete loss of the normal integration of immediate sensations and the control of bodily movement, which brings in an acceptance of dissociative disorders of movement and sensation. To date there are studies being done to validate somatoform dissociation and the early vies of Briquet and Janet.

I would be remiss if I didn't include Ralph B. **Allison** here, mainly for his unorthodox way of working with MPD (he refuses to acknowledge the term DID). Allison was the editor of the newsletter Memos on Multiplicity (1977-78) and was a colleague of Dr. Cornelia Wilbur's. His paper *A New Treatment Approach for Multiple Personalities*, published in the American Journal of Clinical Hypnosis spoke to symptomatology, characteristics of alter-personality states and etiology of MPD. He formulated the concept of the "Inner Self Helper" and described the first male multiple. He wrote the first paper on the forensic aspects of MPD and was the professional that examined Kenneth Bianchi (Hillside Strangler murders) which led to the recognition that MPD could be malingered in order to avoid criminal responsibility. His findings that 50% of his patients had integrated their personality system after an average of 14.7 months was the first attempt at follow up of a series of MPD patients. He was the first to attempt psychological testing on a group of MPD patients and he set the template for the American Psychiatric Association's Diagnostic and Statistical Manual of Mental disorders (3rd edition, 1980). It is to his credit that, even while being criticized, he listened to his patients' beliefs that they were spirit possessed and he used unconventional therapy techniques to achieve true healing.

HOW THERAPISTS HAVE DEALT WITH DISSOCIATION

DID is a treatable, albeit difficult, disorder with tools that are eclectic, psychodynamically oriented, as well as containing some cognitive principles. Since the patient presents with a conflicted internal family of selves, it is easy to think in systemic terms. With a cognitive focus we would look towards rules, boundaries, power, and roles. It is not uncommon for patients to get caught in childhood double binds such as: I am responsible for the abuse and not responsible for my own behaviour, I deserve punishment, and why is this happening to me. Many patients are guilt-ridden, blame themselves for the abuse and punish themselves. The core beliefs can take the form of erroneous syllogisms or logical propositions with the quality of automatic thoughts. There are usually moral injunctions, all-or-nothing thinking, personalization and overgeneralizations. Psychodynamic analysis would speak in terms of regression, projection, and psychotic transference. There are infinite permutations in their assumptions and cognitions.

Believing that the different parts of the self have different bodies allows for self abuse, denial, and inability to take responsibility. The primary personality usually can't handle the memories so there is amnesia of the abuse and idealization of the abusers. Cognitions must be dismantled gradually through a negotiated process of memory recovery. Acting out and dangerous behaviour requires definement/refinement. Many times the cognitions occur in overlapping sets. Non-cognitive techniques would include abreactions, adjunctive hypnosis, negotiation and internal dialogues between alters.

The International Society for the Study of Dissociation has suggested guidelines for treatment for adults with DID, keeping in mind the fact that most patients, given the

complexity of the disorder, have been frequently misdiagnosed. With an accurate diagnostic procedure, early screening, and appropriate treatment there is more hope for a positive outcome. It is suggested that primary treatment be outpatient psychotherapy with sessions reflecting the patient's functional status and stability. While a once or twice a week meeting may be sufficient, marathon sessions (longer than 90 minutes) should be scheduled, structured, and have a specific focus. Cognitive therapy protocols can be used for depression and anxiety with psychodynamically aware psychotherapy often eclectically incorporated with other techniques. In patient treatment should be used for specific therapeutic goals and objectives. It should occur in the context of a goal-oriented strategy, designed to restore stable levels of functioning. Emphasis should be on building strengths and skills to cope with the destabilizing factors. Group therapy is not considered to be a viable primary treatment and electroconvulsive therapy has been shown to be ineffective and inappropriate. There is no evidence to support psychosurgery and pharmacotherapy may or may not be effective for anxiety and stress symptoms but is still experimental. Physical contact is not recommended. Restraint, while indicated for violent acting out, needs to be used cautiously. Hypnotherapy can be used as crisis management for flashbacks as well as ego strength and stability during painful somatic and traumatic material retrieval. Abreactions, while not a therapy in itself, may be useful for retrieving information, for planning, exploration, and titration strategies and to help develop a sense of control over the emerging material. Art therapy, occupational therapy, sand tray therapy, movement therapy, play and recreational therapy can be helpful toward achieving treatment goals. The timing and integration into the overall treatment plan is important. Boundary management must be monitored with treatment taking place at

predictable times with a predetermined session length. Relevant legal and ethical codes with respect to gift exchanges, dual relationships, and informed consent for treatment must be taken into consideration and abided by. Couples, family, or sibling sessions may be indicated for DID patients that are parents.

Chu (1998) reminds us that we need to be cognizant of the fact that while dissociation is a normal pattern along a continuum, DID is the end of the spectrum and only occurs in 20% of dissociative cases. He suggests the word pseudodissociation which can occur due to poor therapeutic practices and sites cases where patients appear to have some level of dissociative experiences and some level of trauma in their backgrounds, or an intense identity diffusion and internal emptiness, and use the DID diagnosis to disavow responsibility for their impulses and out of control behaviours. While he acknowledges that patients with DID need to be diagnosed and follow appropriate treatment, those that are, as he calls, masquerading, must be held accountable and confronted and Malingerers, who are unable to manifest consistent alternate personalities over time, or those with Munchausen's Disease, when given little attention tend to later recant the DID and associated history of abuse and go on to other forms of gaining attention. Chu reminds us that there is no one way of understanding the nature of DID and dissociative symptoms. "We must…acknowledge that apparent DID and dissociative symptoms may sometimes emerge from different circumstances. Those of us who treat and study trauma related disorders must now integrate multiple views of dissociation." (Chu, 1998, P.204)

Crabtree (1985) mentions six main points or principles of treatment:

?? the personalities must be identified

?? the therapist must discover the reason for their existence

?? therapy must be done with all of the personalities in order to bring about change

?? the therapist must concentrate on positive qualities, trying to effect compromise among the personalities

?? the patient must be made fully aware of the situation and actively contribute to its positive resolution

?? antipsychotic medication should be avoided

He refers to basic elements of therapy that include exploration of conventional therapeutic possibilities, the alteration of the therapeutic expectation framework, the amplification of weak signals and the discovery of the elusive element. He suggests that therapists accept the experience as valid and worthy of serious attention and refers to therapy involving human possession. He suggests that the possessing entity be allowed to make contact with the relationship being explored and end result being a resolution and moving on into the next phase of existence.

Crabtree combines the occult with the psychological and, while acknowledging that the traditional views of either are not accepted by the other, suggests that Multiple Man or Multiple Mind gives a broader view of available techniques.

Sliker (1992) brings us back to the idea of sub-personalities expressed two thousand years ago by Paul of Tarsus and well laid out by John Rowan (1990, Routledge) in his book *Subpersonalities.* Freud, Jung, and Assagioli represent three generations of thought on subpersonalities, with Jung focusing on the inner experience and Assagioli concerned with the conscious management and development of inner potential. Assagioli (1965) reminds us that everyone has different selves, and that this is normal.

HOW DO INDIVIDUAL THERAPIES VIEW DISSOCIATIVE STATES

Classical Psychoanalysis presumes that human beings are locked in mental conflict which can be reduced but never fully resolved (Brenner, 1974). A strong ego, the mediating factor between an irrational id and a controlling super ego, is considered the hallmark of health. Health is defined as the absence of pathology.

"Psychoanalysis … was not originally, and is not now, designed to deal with impulses toward ultimate states" (Boorstein, 1996, P.11).

Psychoanalytic models encourage therapists to minimize their affective involvement and offer themselves as blank projection screens, putting aside their own feelings, reactions, and personal growth (Bugental, 1965, 1976).

Behaviourism insists on measurability and verification of behaviour and change. It is highly effective in delimiting behavioural problems, which tends to remove subjective experience from consideration. Consciousness, thoughts, and feelings have been ignored so classical behaviourists cannot encompass central aspects of the human condition, such as positive health and well-being. It is limited to the treatment of pathologies which are clearly defined, overt, and relatively simple.

Analytical Psychology includes the in-depth exploration of the psyche beyond both the ego and existential levels where it deals with archetypes and the collective unconscious. It recognizes that the psyche has a capacity for self-healing and self-realization, however it remains predominantly concerned with the contents of consciousness rather than with consciousness itself as the context of all experience. It stops short of valuing direct, imageless awareness and prefers to refer back to the mythological dimensions of experience and images of dreams and active imagination.

Humanistic Psychology is a holistic, growth-oriented model concerned with health and pathology. While the healthy individual is seen as self-actualizing and aiming for a balanced integration of the physical, emotional, and mental dimensions, the spiritual dimension is usually ignored or invalidated. Humanistic psychology addresses predominantly the ego and existential levels, with the development of the personality and achievement of ego goals being central.

The humanistic/existential model encourages the therapist to open themselves fully to the client's and their own reactions (Bugental, 1965, 1976).

The human capacity for self-transcendence, as well as transpersonal experiences beyond the self are neither recognized nor explored.

Existentialism comes close to the transpersonal concern with the search for meaning and purpose, the confrontation of death and aloneness, the necessity for choice and responsibility, and the demands of authenticity (Bugental, 1965, 1976). There is a belief that we can shape our own reality, that freedom can be real if we believe in it and that we can choose to cultivate many other values, brining the client closer to transpersonal work. The mask of our separate and alienated individuality can be revealed with its underlying interconnectedness with all life. With a centring in dualistic knowledge of ego-defined identity, the transpersonal experience may be overlooked; suffering has been discovered but not the way out of it.

Transpersonal Psychotherapy includes goals that include both traditional (symptom relief, behaviour change) as well as those aimed at the transpersonal level (conceptual framework, psychological potential, assumption of responsibility, life experience as

learning, altered states, dangers of attachment, identification/disidentification, heightened mindful awareness, modeling and service).

The Transpersonal model is seen as one in which the therapist and client work together in the ways most appropriate to their particular roles, with the therapist modeling a process of learning and service. The therapist is no longer the expert who provides information and competency, but rather provides a learning-to-cope model with transparency, acknowledging and sharing their own efforts. The transpersonal perspective states that conflicts of the ego can be transcended.

"Psychosynthesis therapists work with both interpersonal and transpersonal problems. Because the full range of pathologies and positive human possibilities is the appropriate concern of the transpersonal therapist, he/she is interested in and supportive of psychological work being done across the entire spectrum." (Boorstein, 1996, P.12)

Over the years the research on MPD and dissociation has remained fairly constant in a number of ways. Throughout the entire history of MPD and dissociation psychologists have questioned the validity of the two phenomena. Prince claimed that somnambulism was the underlying disorder for MPD and dissociation. Freud believed that MPD was a rare subset of the disorder hysteria. In the contemporary period, many believed that the diagnosis of schizophrenia was the problem, with MPD being a false entity. Currently, much research has been done comparing MPD subjects with other subjects with disorders including schizophrenia, borderline personality disorder, DDNOS, and histrionic personality disorder. The results of the current research show striking differences between the groups, indicating that MPD is a separate diagnosis and not merely a part of another disorder. Early psychologists lacked standardized tools to help them diagnosis,

and consequently work with MPD and dissociation. Today, the DES appears to be one of the most useful diagnostic tools available for practitioners. Other tests and measurements, such as the MMPI, the SCIDD, and the DDIS have all been found to be highly accurate and useful in the field. Further trends that have stayed throughout the years have been the set of clinical characteristics of MPD patients and the treatment modality preferred by mental health professionals. Binet noted that cases of MPD shared symptoms such as headaches and somatic symptoms. Freud and Breuer noted that cases of MPD appeared to be caused by childhood trauma. Current research by Putnam, Ross, Loewenstein, and Coons has supported these patterns. Freud and Breuer called for abreaction done with the assistance of hypnosis, while Prince spoke of re-association of the ideas and memories that had been dissociated. Current research shows that integration of alters provides significant improvements for the patient (Ross, & Ellason, 1996). A survey of mental health professionals also shows that most believe that hypnosis combined with psychotherapy to be the treatment method of choice for MPD and dissociation (Putnam, & Loewenstein, 1993)

There appear to be two trends that do seem to have faded over time. The first trend is trying to justify studying dissociation and MPD. James, Binet and Prince all suggested that the processes involved in MPD and dissociation needed to be studied in order to shed light on the normal human mind functioning. Freud and Breuer felt that the processes were pathological and occurred due to trauma. Current researchers seem to believe both with an accommodation for the normal and pathological levels of dissociation (the Dissociation Continuum). The other trend that has faded is the argument of whether MPD and dissociation are psychological, physiological, or a combination of the two. The

problem of lacking the appropriate technological equipment to study the question is still a problem today. Although tests have been done to look at EEG's and PET Scans in the late 1980's, technology is still not able to answer that debate. For now, researchers seem content to focus on other factors. Another possibility for this trend fading may be the incredible amounts of research which point to the extremely high percentage of MPD cases involving severe early childhood abuse. This could be answer enough for many in the field.

THE TRANSPERSONAL/ REACHING BEYOND THE SELF

The personal and the transpersonal dimensions are distinct but not separate. Both are natural to human enfoldment. Andra Angyal (1965) refers to the individual's need to achieve autonomy as well as 'homonomy', or, union with a greater whole.

Roberto Assagioli refers to personal psychosynthesis (development of a well-integrated, effective personality) and spiritual psychosynthesis (leading to the realization of one's higher nature). Abraham Maslow introduced the term *transpersonal* and recognized three groups of people: self-actualizers (well-integrated, strong, effective, minimal experience of transcendence), transcenders (strong spiritual contact, frequent transcendent experiences, underdeveloped personalities), and transcending self-actualizers (strong and effective personalities, capable of transcending limitations of personal identity, deep sense of eternity and the sacred (1971). "Self-realization, the realization of our Transpersonal Self (Assagioli, 1965, 1973; Carter-Haar, 1978; Miller, 1978), involves the progressive unification, at higher and higher levels, of the two dimensions of growth. It is important to remember that Self-realization is not something we should *do* or *make happen*. Self-realization is a natural process, and it occurs spontaneously." (Firman and Vargiu in Boorstein, 1996, P.121)

When we are functioning normally, in a stable environment, we begin to experience, from the moment of birth, urges and needs that motivate us into activity. We develop a sense of motivation and achievement, something that has value and meaning. Physical survival is our first, basic, primary need. When this need is satisfied we move into new goals with different and/or greater meaning. We learn to master physical competence and

meaningful relationships with the sensitive, deep emotions that this encompasses. We desire to understand ourselves and learn more about the world, with the mind taking a central place in our lives. We learn to coordinate and integrate our inner resources in a unified way, in line with our aims. (Vargiu, 1977) Our feelings develop and harmonize so we can relate to others in a satisfying way. We learn to think creatively, flexibly, and with specific details and we move towards the full, harmonious integration of the personality: body, mind and feelings.

When personality development has been stifled, or arrested, and latency, or total disruption has occurred, as in severe abuse, the self needs to find different ways to express itself, to deal with the deficiencies in specific personality functions or conflicts between the functions, which is what most forms of psychotherapy propose to do.

Psychosynthesis suggests an approach to self-actualization, aiming at the positive development of particular aspects of the personality, contributing to the gradual integration into a unified, dynamic whole. Because there is not only a harmonization of the personality needed, but also a gradual emergence and empowering of the 'I', or center of personal identity, Psychosynthesis, with it's resources such as the integration of subpersonalities and identification with the 'I', is the ideal form for working with this dual process. As people move through the existential crisis, which changes and creates the seeking of new goals and brings in the consciousness of the Transpersonal Self, life reorients itself and the search for the truth begins. The move towards the disidentification from the known self of personality moves into identification with a higher form and meaning.

But, what of those that have been so abused that they feel that they have no right to existence? Arieti (1955) refers to the child's experience of parent hostility and the utter hopelessness of obtaining parental love and approval. Believing themselves to be the 'bad one' the unloved child begins to see himself as unlovable and his self-esteem undergoes injurious attacks as he begins to hate himself more than anyone else possibly could. The defence mechanisms become incapable of coping and the anxiety is experienced with the same violence as experienced in childhood. The behaviour becomes more and more symbolic, continues to be distorted by the power of the repressed experiences, and, over time, may be experienced as panic or psychosis. Arieti suggests that the treatment of these individuals becomes very difficult because of their lack of contact and fear of their feelings. "He fears lest they be used against him to demonstrate how bad he is, just as he originally feared his parents would do. He is still afraid that feelings will bring about rebuff, anxiety, and attacks on his self-esteem." (Arieti, 1955, P. 65)

"Psychotherapy has branded…certain altered states as intrapsychic aberrations, and has been quite oblivious to the energetic basis of the symptomatology." (Don, in Boorstein, 1996, P.353) while we know through scholarly studies of yogic texts (Eliade, 1969) of the dualism of body and mind and of the 'bodies' and states of consciousness experienced through their particular 'organs' of perceptions (Meher Baba, 1967; Isherwood, 1969) which speak of levels of bodies, with the physical body as the bottom and higher levels of energy above. Although Freud had originally formulated his theories in terms of an energy variable, it was the work of Wilhelm Reich (1972, 1974) who formed the basis of the energy-oriented body therapies in the Western world with Lowen (1971, 1976), Pierrakos (1975), Brown (1971) ,Kelly (1971) ,Keleman (1975), and Baker

(1974) continuing on and developing systems for therapy based upon the release of energy and muscular stasis in the body, coupled with psychological interpretations.

Norman Don reminds us that "working with people … the therapists' state of consciousness, intentionality, and energy level are being perceived by some level of the client's consciousness." (Boorstein, 1969, P.373) Assagioli (1965) refers us to fact that in practical psychosynthesis, or the actual construction of the new personality, we need to use the available energies (forces released by the analysis and disintegration of the unconscious complexes and latent tendencies which exist on the psychological levels), develop aspects of the personality which are deficient or inadequate (evocation, autosuggestion, creative affirmation, methodical training, i.e. memory, imagination and/or will) and coordinate/subordinate psychological energies and functions and create a firm organization of the personality. He also reminds us of the inherent polarities: polarities of the manifest and unmanifest, of spirit and matter, of the sympathetic and the parasympathetic nervous system, emotional attraction and repulsion, ambivalence and the *compensatory* function, the masculine and feminine elements, the emotional polarities: pleasure-pain, excitement-depression; confidence-fear; attraction-repulsion; love-hate, the mental polarities: analytical activity (concrete mind) and abstract intelligence, inductive process (from particular to general) and deductive process (from general to particular), lower Unconscious and Superconscious; Pathos (Receptivity, Sensitivity, Reactivity) and Ethos (Activity, Dynamism, Will), Eros (Feeling) and Logos (Reason), and the spiritual polarities: personality and the Transpersonal Self (which is the cause of many inner conflicts until harmonious relationships and an increasing blending or unification is achieved).

Assagioli also talks about interindividual polarities, such as: Man and Woman, adults and young people, parents and their children, and the various relationships between individuals and the different groups to which they belong. There is also a psychic entity polarity in families: members who are alive and ancestral influences and family traditions which can be both an influence as well as oppression. There are also social groups of different kinds (social and professional classes, cultural and religious groups, nations) with which the individual may find himself associated, in a condition of passive subordination or of cooperation, as leader and directing agent or in conflict. In groups one may find polarities between families and families, classes and classes, nations and nations, etc. and the hierarchical ones, between the family and the state, classes and nations and between a state and a federation of states. As the last step in looking at polarities, Assagioli even looks at that between the northern and southern individuals and groups in each nation and continent and that between Western and Eastern peoples. Assagioli refers to the method of synthesis which is analogous in a certain sense to a chemical combination which includes and absorbs the two elements into a higher unity endowed with qualities differing from those of either of them. It is to this purpose that the understanding of Transpersonal Psychology can be most attributed.

A BRIEF HISTORY AND INTRODUCTION TO PSYCHOSYNTHEIS

Roberto Assagioli formulated the idea of Psychosynthesis in 1910.For most of his life he was unrecognized except for a small group of people in Europe. He was an Italian psychiatrist who was a student of Freud, a member of the Zurich Freud society, and Italy's first psychoanalyst. Along with those who are considered humanistic psychologists such as Fromm, Rogers, Jung, Maslow, Bugental and Frankl, Assagioli believed that there are facets of the human being that are just as powerful as instinctual drives, and that a standard of emotional health must include the aspects of altruism, creativity, love, and a sense of purpose in life. Assagioli believed that, in order to fully express such qualities, the individual must integrate his personality to the degree that he is free to fully express his potential, similar to what Maslow refers to as self-actualization.

Assagioli states that the individual should be freed to explore more fully his spiritual nature and that the spiritual is a vital aspect of the human being. His attention to and writings in this area have had some bearing on the emergence of the field currently called transpersonal psychology.

Specific Psychosynthesis Techniques

Assagioli suggested specific techniques for personality integration which were later further developed and refined. Such techniques are intended to help the patient make sense of inner chaos and to strengthen the ego/self and cognitive awareness so that the patient has more charge over and more choice about his inner nature.

Subpersonality work involves exploring the nature of inner conflict through clarifying the conflictual patterns in the person's current life, defining the personality aspects involved and gradually resolving the conflicts through helping the patient assume an objective 'observer' stance that enables more insight, responsibility and choice. Subpersonalities are similar to Jung's persona and Roger's false self, and to the concepts developed later, in the sixties, by Perls (Gestalt), Berne (Transactional Analysis) and, more recently, Stone and Winkelman (Voice Dialogue) and Watkins (Ego State Therapy). Getting a sense of the patient's subpersonalities can

aid the therapist in assessing ego strength and in hypothesis factors such as patient safety issues, boundaries, and speed and pacing of the work.

Disidentification is a core tool and process used in sessions, along with journaling and reflective work. This involves taking an objective stance in relation to, for example, subpersonalities as well as to other personality contents and material that may be emerging from the unconscious. This objective observer is similar to James's "I". In essence, it strengthens and enlarges the ego/self, empowering the patient with more options and the ability to make choices more clearly. This disidentification technique is so key that Assagioli recommended formal practices to support disidentifying from personality contents and identifying with the central self.

Imagery work is a third major area considered at length by Assagioli. He states that the imagination is a key function of the self (the others being thought, intuition, emotion-feeling, impulse-desire, sensation, and, the function most intimate with the central self, the will).The imagination itself, he observed, is of a somewhat integrative nature, combining as it does thinking, feeling, and sensation. He stressed the power of the image, for good or for ill; the effect of images on the will; and the importance of training patients in the right use of the imagination. To aid the patient in strengthening higher qualities of his nature, Assagioli recommended the use of positive images as a focus for meditation. Imagery work is often also used to help explore subpersonalities, or material emerging from the lower or from the higher unconscious.

Psychosynthesis posits the existence of three levels of consciousness: the lower so –called Freudian unconscious containing instinctual drives, conflicts arising from childhood themes, and anything from the personal past that lies outside the patient's awareness, including emotional, cognitive, or meaning aspects of partially remembered material. The middle unconscious containing material that is easily accessible to us, such as remembering a name or phone number. At the center is the point of awareness, that which one is conscious of at any given moment. The third level of consciousness is the superconscious or higher unconscious. It is in this domain that the qualities which are the most evolved, such as love, will, joy, compassion, exist. The higher

unconscious is also the source of intuitive insights, creative ideas, illumination, and the drive toward meaning and purpose. By providing access to this domain experientially, we have found that a patient can be helped to see themselves in a less critical and self-demeaning light and that the healing process is expedited.

Assagioli distinguishes two levels of self, the personal self or "I" and the transpersonal or Higher Self. In a Subpersonality map the ego is played out through major identification. The "I" or self is the first transcendence of the ego/personality level of being or development, where we experience ourselves more centred in the core of our being in contrast to being caught up in our personality. The central, or functional "I" is the most centred place a person can 'get to' at a given point in time before reaching the stage of pure self-awareness. The discovery of the "I" can be a profoundly healing experience and is invariably accompanied by an increased freedom and clarity of will. Every disidentification from a limited identification and recognition of what one was identified with brings more freedom and choice.

Assagioli's view is that selfhood, once attained on a personal level, has the capacity to open to the spiritual or transpersonal Self. These 'peek' experiences are considered to be normal and he suggest that people from all walks of life have moments where they move beyond their personal ego concerns. The psychosynthesis worldview is that each person is unique, evolving, capable of reaching towards a personal self or "I", and is a spiritual being. Psychosynthesis refers to the "ongoing synthesis of the psyche, a process which transcend specific models and methods" (Brown, 1983, P.ix), and it was Assagioli's observation that this process goes on naturally in life. The beginning is where the person is in his/her current life and works to help the patient disidentify enough to see patterns and resolve intrapsychic conflicts that may be impacting interpersonal and work relations. Patients leave with a stronger ego, an experience of the personal self or "I" and may connect deeply to their spiritual nature.

A comparative study with other therapies

Psychosynthesis utilizes interpretation, the evoking of insights from the client, which are common psychodynamic and ego-building techniques, and is open to exploring any emerging theories of psychology and integrating them into its practice. Developmental and ego psychology, cognitive psychology and behavioural psychology are all being used by practitioners of psychosynthesis, as well as using the transference and counter-transference tools of psychodynamics.

"Erikson defines the ego as a central principle of organization in…experience and action" (Erikson, 1963, P.415). Rogers description of 'person' (Rogers, 1961, P.124) also resonates with the psychosynthesis conception of the personal self or "I".

Chart 1-Psychotherapeutic Comparisons/ The Five Forces of Psychology gives a comparative description of the various levels of therapy, the theorists, and the methods used. (Next Page)

Using Psychosynthesis with Dissociative clients

Psychosynthesis believes that we are wholeness bringing together our parts, much like the actual therapeutic techniques used for Dissociative clients. It is a transpersonal psychotherapy that calls itself a *psychology with a soul* and it holds, as its primary belief, the fact that humans have an innate instinct to wholeness and health. Psychosynthesis draws from many former, active psychotherapeutic techniques while it solely maintains the multi-polar model of the human psyche, the central position of the self, the importance of the will, the existence of the transpersonal realm, the pathology of the sublime, the use of imagery for the exploration of the unconscious, the transformation of neurotic patterns, and the expansion of awareness, the concept of a natural tendency towards synthesis and syntropy, and the move towards the spontaneous organization of meaningful and coherent fields within the psyche.
Psychosynthesis is known as a therapy in growth.

THE FIVE FORCES

Chart 1-Psychotherapeutic Comparisons/ The Five Forces of Psychology

Behavioural	**Psychodynamic**	**Existential/Humanistic**	Transpersonal
John Watson B.F. Skinner ***Albert Bandura***	***Freud*** ***Erikson-Ego psychology*** ***Berne-Transactional Analysis*** ***Lacan-Psychodynamic Psychoanalysis*** ***Lowen-Bio energetics*** ***Perls-Gestalt Therapy*** ***Klein, Guntrip, Kernbert-Object relations***	***Carl Rogers-Person centred*** ***Fritz Perls-Gestalt*** ***Victor Frankl-logotherapy/I centred*** ***Buber-I/Thou relationships*** ***Gendlin-focusing*** ***Kierkegaard, Sartre, Camus, Heldeggar, Laing, Husserl, Tillich, May, Boss, Brnswanger***	*Roberto Assagioli* *Piero Ferrucci* *Carl Jung* *Herman Keyserling* *A.H. Maslow* *Robert Desoile*
Emphasizes the impact of science **Rooted in the ideal of progress** **Devaluation of the past** **Behaviour=Behaviour** **Impact of the Environment** **Reinforcer/Punisher** **Counselling-Applied behavioural analysis**	The past shapes the future Developmental stages Organized Human functioning Central Importance of the superconscious Id, Ego, Super Ego	People are empowered to act on the world and determine their own destiny Concerned with human existence and the infinite life possibilities Individuality Reality constructed through transactions	Organisms striving for wholeness Potential for growth, Expansion of consciousness, health, love and joy
Assertiveness Training **Relaxation Training** **Systematic desensitization** **Modeling** **Positive Reinforcement** **Charting changes** **Relapse prevention**	**Free Association** **Symbols** **Dream based on sexuality** **Analysis of resistance** **Transference/counter-transference** **Interpretation** **Self destiny** **Insight**	**Analysis (eigenwelt, mitwelt, umwelt)** **Intentionality** **Rapport-structuring, data gathering, determining outcomes** **Generating alternative solutions** **Generalization**	Systematic use of all available active psychological techniques Starting/ending points dependant on individual Can be done by the individual or with a guide practitioner

Tri-Therapy: Body, Mind, Soul 1990 (Shamai Currim)

THE FIVE FORCES

The Five Forces in Psychology is a model for viewing the history of Western Psychology. Abraham Maslow suggested this model when he designated the humanistic approach as "the third force". He was indicating that humanistic psychology was a major development distinct from psychoanalysis and behaviourism. He also anticipated fourth and fifth forces, which he labelled "transpersonal" and "transhuman". Assagioli also recognized five forces, labelling the fifth "psycho-energetics". (Assagioli, 1980)

Psychoanalysis, the **First Force**, and still in current fashion, is based on a medical model: diagnosing people and providing treatment so they can become well-adjusted to their social environment. Psychoanalysis looks to a personal unconscious based on past history for the source of psychological problems. Sigmund Freud (1856-1939) advanced history with a comprehensive and influential theory of human behaviour while trying to solve the problems of the mentally ill. He saw man as an animal and living matter as a result of the evolution of action of cosmic forces on inorganic matter. Freud hoped to reduce human behaviour to chemical and physical dimensions by speaking to the animal origin of basic, innate, instinctual, genetic drives and the conflict between the life instinct for survival and propagation and the impulse to obtain satisfaction through the pleasure principle.

The **Second Force**, Behaviourism, is the study of observable behaviour. The general theory, formulated by John B. Watson (1878-1958) reduces man's behaviour to chemical and physical terms. Today this term is used to describe the work of a number of related theories of psychology, sociology, and behavioural sciences covering the work of Edward Thorndike, Clark Hull, John Dollard, Neal Miller, B.F. Skinner, as well as his predecessors Isaac Newton and Charles Darwin. Influenced by Ivan Pavlov, behaviourists place stress on the associative or stimulus-response learning as a major explanation for human behaviour. While still holding the belief that man is an

animal, like Freud and Darwin before him, Watson built on the theory by including the types of behaviour man displays.

The Humanistic movement is seen as the **Third Force** and deals with the central concern with human identity, acknowledging each person as unique, valuing growth, recognizing the capacity of individuals to discover meaning in life, acknowledging that we can take responsibility and be aware of motivations, recognizing the role of anxiety and suffering in life, and seeing the future as playing a dynamic role in the present. Abraham Maslow (1908-1970) wanted to prove that human beings were capable of something better than war and prejudice and hatred. His experience with the Northern Blackfoot Indian tribe in Alberta, Canada and their non aggressive lifestyle brought forward a humanistic approach which was seen an as alternative to objectivistic psychology and orthodox Freudianism. His work was an attempt to assess what was useful, meaningful, and applicable to mankind in both psychologies (first and second forces) and to go on from there. He saw his job as an integration of various truths into a whole .His study of the best of human beings caused him to conclude that there was a change in human nature and the image of man and that the world can, and will change, along with everything in it.

James F. T. Bugental wrote extensively on the humanistic movement and he identified the following characteristics of the Humanistic Movement:

1. Man must be the central subject matter of psychology, not data from rat, monkey, or pigeon studies
2. Man, being more than the total of his parts, must be studied as a unified organism
3. a high value must be placed on individual freedom, with the individual predicting and controlling his own life
4. emphasis must be placed on human rather than non-human objectives which contain intrinsic meaningfulness, coherence with other conceptions, validation through observation and effectiveness in changing human experience

As defined by Bugental, the Humanistic point of view includes such terms as: man is aware, man has choice, man is responsible and man has potential greater than he has yet actualized.

Psychosynthesis, a form of Transpersonal Psychology, and a part of the **Forth Force**, began with the work of Roberto Assagioli, an Italian psychiatrist. In a doctoral thesis in 1910 Dr. Assagioli presented a vision of a holistic approach in psychology emphasizing growth and including the spiritual dimension of human experience. His studies focused on the higher aspects of human nature, and represented a psychology of the whole person. Psychosynthesis is often described as a process or a way of life rather than a theory or a specific point of view. It is dynamic and changing and known for its openness and continuous growth. For this reason there has been a reluctance to define it or formulate a precise theory, since definitions can be limiting. When compared to psychoanalysis, psychosynthesis is seen as a method that is based on a growth model: assessing people's strengths and weaknesses and assisting them in self-improvement, self-fulfillment, and transformation. What Freud referred to as neurotic patterns of childhood, are acknowledged and worked with actively in psychosynthesis. Where psychoanalysis looks to a personal unconscious based on past history, psychosynthesis includes a "higher unconscious," a realm of the future, of hidden potentials, and it confronts blocks to discover and actualize latent talents and abilities. When compared to Behaviourists, psychosynthesis goes beyond the observable behaviours and does a deep exploration within the realm of feelings and images, beliefs and attitudes, right into the deeper levels of the inner core of being. The behaviourist method of "systematic desensitization," a technique for dealing with phobias, is combined effectively with guided imagery by psychosynthesis therapists. While there are many similarities between Humanistic Psychology and Psychosynthesis, the main differences to be noted are : the emphasis on the Will as an essential function of the self, the idea of a self which experiences awareness beyond content, the recognition and active fostering of positive, creative, joyous experiences, the idea that loneliness is not ultimate or essential, the use of active techniques for

transforming, sublimating, or redirecting psychological energies, for strengthening undeveloped function, and for activation of superconscious energies or latent potentials, and the conscious and planned reconstruction of the personality.

Rational emotive therapy works with the mind, developing new ways of reasoning to change emotional reaction patterns. Psychosynthesis encourages new ways of using the thinking mind and specific exercises are provided for training the mind so that one can take a centred stance, focus, and direct energies, and become more intuitive. Gestalt therapy emphasizes working with the emotions, while Psychosynthesis also emphasizes work with the mind, moving toward the future. Gestalt philosophy and techniques are often used in psychosynthesis to promote awareness and a sense of responsibility for oneself and one's actions. The notion of responsibility and view of individual growth holds that each person is an integral member of various groups and the larger family of humanity, with the responsibility to support others' growth along with one's own.

WHERE DO WE GO FROM HERE?

Siegel (1999) tells us that our mind emerges at the interface of our interpersonal experience and the structure and function of the brain. He reminds us that "emotion and interpersonal relationships are fundamental motivational aspects of learning and memory" and that "forms of communication directly shape a child's developing brain", and that "Interactions with the environment, especially relationships with other people directly shape the development of the brain's structure and function" (P.xx), and that "experience shapes development" (P.xi). Farther on he tell us that "the mind may be capable of dis-associating component modules by impairing the integrative function of essential associative neural pathways" which "can lead to a child's inability to mentalize" with a "blockage of the corpus callosal fibres interconnecting the two hemispheres, and of interconnections within the right hemisphere itself, may be a mechanism that allows mindsight to be impaired as an adaptation to certain overwhelming situations" and that "the child adapts to particular relationship context with the inhibition of reflective function and avoidant or disorganized attachment." He further states that this can "allow for the dis-occiation of normally associated modes of processing information."(P.202)

Where does that leave us? I believe we need to begin to focus on the child, and the development of all children. We need to become responsible adults and create centres of training for all those who have had insufficient mirroring in childhood and who now require support and guidance on their journey.

Alice Miller says it so succinctly in the appendix - The newly Recognized, Shattering Effects of Child Abuse, an amended version of the Afterword to the second edition (1984) of her book *For Your Own Good*. I quote, in her words:

> "People whose integrity has not been damaged in childhood, who were protected, respected, and treated with honesty by their parents, will be–both in their youth and in adulthood-intelligent, responsive, empathic, and sensitive. They will take pleasure in life and will not feel any need to kill or even hurt others or themselves. They will use their power to defend themselves, not to attack others. They will not be able to do otherwise than respect and protect those weaker than themselves, including their children, because this is what they have learned from their own experience and because it is this knowledge (and not the experience of cruelty) that has been stored up inside them from the beginning. It will be inconceivable to such people that earlier generations had to build up a gigantic war industry in order to feel comfortable and safe in this world. Since it will not be their unconscious task in life to ward off intimidation experienced at a very early age, they will be able to deal with attempts at intimidation in their adult life more rationally and more creatively".
>
> (Miller, 1984, P.161)

THE FUTURE OF TRANSPERSONAL PSYCHOTHERAPY

One of the limitations of the transpersonal is felt to be its lack of adequate experimental foundation. Many of the concerns of the transpersonal therapist lie outside the range of interest, competence, and investigative arenas of most researchers. Assumptions remain experimentally untested and many feel that, if the transpersonal is truly to become what it claims to strive for, namely, an effective synthesis of Eastern wisdom and Western science, then practitioners need to do all they can to ensure that their work is subjected to careful scientific scrutiny. While there is a growing body of research on meditation, few other transpersonal areas have been examined. One wonders if the investigation of transpersonal phenomena is applicable to traditional scientific paradigms. Novel approaches which are less interfering, more sensitive to subjective states, and involving trained participant observer investigators need to be found. Intellectual comprehension demands an experiential foundation (Deikman, 1977; Walsh, 1977, 1978). It is important to recognize that it is through the experience that one can appreciate the power and implications of the changes. Even the most intellectually, sophisticated mental health practitioners, if they are experientially naïve, may have no reference point from which to draw an understanding. Transpersonal Psychotherapy places stringent demands on its practitioners, representing subtler, deeper demands because the phenomena with which they are working are themselves subtler and deeper. Ferrucci (Weiser, 1984) reminds us of the dangers of the transpersonal. After the original enthusiasm generated by spiritual awakening, people have discovered that the transpersonal dimension can oppress, torture, confuse, and even annihilate if it is approached with

inadequate psychological equipment. If the attitude of the Higher Self is immature there can be a violation in the name of the spirit. “The numinous is not protected as it was in the past, and we are on our own, entering free, naked, and vulnerable into a world of energies unknown.” (Weiser, 1984, P.23, 24) Some believe that schizophrenia is the result of stepping into the spiritual while still identified with some unresolved subpersonality. Ferrucci refers to Alberto Alberti who states that the remedy is humility and not moralistic imposition from the therapist. It is a natural force which is spontaneously grown and needs to be skilfully evoked. As we move toward greater health these psychological phenomena will become increasingly subtler, and the tools most suitable for dealing with them will become correspondingly less active and interfering, and more simply observing, accepting, and allowing (Walsh, 1976, 1977).

The perspective, attitude and orientation of a transpersonal therapist or counsellor must include the following:

- ?? Be on their own spiritual/transpersonal path
- ?? Acknowledge that any person be accepted and allowed to pursue their own path and to change to another if that seems desirable
- ?? Commitment to the principle that all human beings have continuous impulses toward emotional growth and ultimate states and that it is the responsibility of the transpersonal therapist to help in the realization of emotional growth as well as ultimate states
- ?? Know, including their function, the knowledge of the role of mechanisms throughout the life cycle that can be self-deceptive

?? All individuals have impulses toward ultimate states whether or not they are on a personal path, i.e., work with techniques and forms of relating that are directly relevant to the current state

RESEARCH

WESTBROOK UNIVERSITY

Ph.D. RESEARCH PROJECT

Student's Name: Shamai Currim ID# 040-04-3357

Degree Program: Ph.D.-Transpersonal Psychology

College: Westbrook University Course: RP 605

First presented on: September 29, 2003
Research presentation on July 23, 2004

Research Topic: ***The Five Forces: Working with Dissociative States***

_x_ **Précis & Outline** Approved: Date: 11/06/03 By: Dr.Maurice Kouguell

_x _ **Rough Draft** Approved: Date: 8/15/04 By: Dr. Gibson –Paul
8/19/04 Dr. David A. Frederick

_x_ Please **Revise** per comments: Date: 8/02/04 By: Dr. John Lewis Laughlin

Final Grading: A

Comments:

Precis & Outline: You have an impressive study. You will find as you go along that you may have to focus on a more limited aspect. Focus on the quality and not quantity. Good luck. Dr. Kouguell.

Rough Draft: Excellent work, well presented and thought out. Minor editorial errors.

Your questionnaire was comprehensive and the results were very interesting. Keep holding on to your dream of helping patients.

Excellent job! Your research has shown you have covered all the bases with the most effective therapeutic interventions and remember no two people are alike so think out of the box! You're doing great. One thing is add NLP to your methods as it is an effective tool.

Professors' Signatures on file

THE FIVE FORCES: WORKING WITH DISSOCIATIVE STATES

Preamble

This study comes from the experiences of therapists who already have a good understanding of Dissociation and the Dissociative States, and have experience working in the field. It is a compilation of therapeutic interventions, broken down into the forces of psychology, so that the actual techniques being used can be traced back to their historical roots.

The International Society for the Study of Dissociation (ISSD) formed a committee which looked at the necessities of creating an outline for therapists to use when dealing with dissociative clients. Because their members came from many different backgrounds, their eclecticism created a difficulty of delving deeper into the authentic, effective tools necessary to work with. The ISSD came up with a list of general guidelines, and ended with the wish that eventually they would be able to create a study that deals with the many, varied tools and their effectiveness. It is to this state that this research study is addressing.

This study originally hoped to show that there are some therapeutic techniques that are more effective than others, and more commonly used by therapists and hoped to become a guide for therapists in their further study of effective management of their patients.

INTRODUCTION

Statement of the problem

The International Society for the Study of Dissociation (ISSD) at its meeting in Vancouver, BC, Canada, in May 1994 adopted "Guidelines for Treating Dissociative Identity Disorder (Multiple Personality Disorder) in Adults (1994)." The guidelines present a broad outline of what has thus far seemed to be effective treatment for Dissociative Identity Disorder (DID). They are not intended to replace the therapist's clinical judgment, but they do aim to summarize what most commonly has been found to benefit DID patients. Where a clear divergence of opinion exists in the field, the guidelines attempt to present both sides of the issue. Written by the members of the ISSD Standards of Practice Committee, a diverse and opinionated group, they nevertheless found much common ground. The committee invited input from ISSD members and they received about 100 letters. These guidelines, updated in 1996 to include the requested feedback, attempt to summarize the numerous publications on the dissociative disorders, including case reports, open clinical trials, and investigations utilizing standardized tools. The guidelines reflect current scientific knowledge and clinical experience specific to diagnosing and treating DID, supplementing generally accepted principles of psychotherapy and psychopharmacology.

Given the complexity of dissociative disorders, patients have been frequently misdiagnosed for a period up to 20 or more years. Considerable progress has been made in the diagnosis, assessment, and treatment of dissociative disorders during the past decade, as reflected by increased clinical recognition of dissociative disorders, the publication of numerous scholarly works focusing on the subject, and the development of specialized diagnostic instruments. As there are, at present, no controlled outcome studies of different treatment regimens, future research, depending upon the use of new specialized clinical and research tools, will further add to our present understanding of the efficacy of the various therapies for the dissociative disorders.

The Five Forces in Psychology is a model for viewing the history of Western Psychology. Abraham Maslow suggested this model when he designated the humanistic approach as "the third force." He was indicating that humanistic psychology was a major development distinct from psychoanalysis and behaviourism. He also anticipated fourth and fifth forces, which he labelled "transpersonal" and "transhuman." Psychoanalysis, the First Force, and still in current fashion, is based on a medical model: diagnosing people and providing treatment so they can become well-adjusted to their social environment. Psychoanalysis looks to a personal unconscious based on past history for the source of psychological problems. The Second Force, Behaviourism, is the study of observable behaviour. The Humanistic movement is seen as the Third Force and deals with the central concern with human identity, acknowledging each person as unique, valuing growth, recognizing the capacity of individuals to discover meaning in life, acknowledging that we can take responsibility and be aware of motivations, recognizing the role of anxiety and suffering in life, and seeing the future as playing a dynamic role in the present. Gestalt therapy, another humanistic modality, emphasizes work with the emotions. Psychosynthesis, a form of Transpersonal Psychology, and a part of the Forth Force, began with the work of Roberto Assagioli, an Italian psychiatrist. In a doctoral thesis in 1910 Dr. Assagioli presented a vision of a holistic approach in psychology emphasizing growth and including the spiritual dimension of human experience. His studies focused on the higher aspects of human nature, and represented a psychology of the whole person. Psychosynthesis is often described as a process or a way of life rather than a theory or a specific point of view. It is dynamic and changing and known for its openness and continuous growth. For this reason there has been a reluctance to define it or formulate a precise theory, since definitions can be limiting. When compared to psychoanalysis, psychosynthesis is seen as a method that is based on a growth model: assessing people's strengths and weaknesses and assisting them in self-improvement, self-fulfillment, and transformation. What Freud referred to as neurotic patterns of childhood, are acknowledged and worked with actively in psychosynthesis.

Where psychoanalysis looks to a personal unconscious based on past history, psychosynthesis includes a "higher unconscious," a realm of the future, of hidden potentials, and it confronts blocks to discover and actualize latent talents and abilities. When compared to Behaviourists, psychosynthesis goes beyond the observable behaviours and does a deep exploration within the realm of feelings and images, beliefs and attitudes, right into the deeper levels of the inner core of being. The behaviourist method of "systematic desensitization," a technique for dealing with phobias, is combined effectively with guided imagery by psychosynthesis therapists. While there are many similarities between Humanistic Psychology and Psychosynthesis, the main differences to be noted are : the emphasis on the Will as an essential function of the self, the idea of a self which experiences awareness beyond content, the recognition and active fostering of positive, creative, joyous experiences, the idea that loneliness is not ultimate or essential, the use of active techniques for transforming, sublimating, or redirecting psychological energies, for strengthening undeveloped function, and for activation of superconscious energies or latent potentials, and the conscious and planned reconstruction of the personality. Rational emotive therapy works with the mind, developing new ways of reasoning to change emotional reaction patterns. Psychosynthesis encourages new ways of using the thinking mind and specific exercises are provided for training the mind so that one can take a centred stance, focus, and direct energies, and become more intuitive. Gestalt therapy emphasizes working with the emotions, while Psychosynthesis also emphasizes work with the mind, moving toward the future. Gestalt philosophy and techniques are often used in psychosynthesis to promote awareness and a sense of responsibility for oneself and one's actions. The notion of responsibility and view of individual growth holds that each person is an integral member of various groups and the larger family of humanity, with the responsibility to support others' growth along with one's own.

Psychosynthesis, a transpersonal psychotherapy, was not included in the original research and collaboration of the ISSD committee that set up guidelines.

This research project hoped to address the needs of the ISSD and its members, and the greater therapeutic community at large, as well as the many patients who find themselves in the dissociative state with a need for therapeutic intervention. Through a questionnaire (appendage) which includes the expansive list of therapeutic tools used by the multi-disciplinary team of therapists, and space to record their own thoughts and experiences, this study should provide some direction for the work of tomorrow.

Therapeutic techniques used by Transpersonal Psychologists, such as Psychosynthesis, have been included in the hope of finding that, indeed, therapists are using this methodology perhaps without giving it a formal name. Through this research project it was hoped that, in the compilation of information, that therapists, the clinicians who have the most experience in this field, will express that their experiences support the use of an eclectic list of therapeutic interventions, which includes the use of transpersonal expression.

CURRENT RESEARCH

In a search of the Psychological Abstracts from 1991 to 1997, there are over 400 abstracts listed under MPD/DID , 56 of which deal with more than 5 subjects. These can be arranged into the following categories of research articles that focus on:

-The Continuum of Dissociation (3)

-General Information and Treatment of MPD (9)

-Beliefs of Mental Health Care Professionals on MPD (3)

-Cross-Cultural Studies (7)

-Tests and Measurements for MPD (11)

-Comparative Studies (9)

-Secondary Aspects of MPD (7)

-Rarities in MPD (7)

These articles deal with the dissociative continuum, defensive altered states, dimensional and typological models, types of dissociative experiences which can be empirically justified, general traits of MPD, the clinical history, phenomenology, symptom profile, history of violence and the involvement with the criminal justice system and the relative commonality in inpatients, the prevalence of abusive childhood histories and cross-cultural studies that deal with comparisons in terms of prevalence and symptomotology.

In terms of diagnostic and therapeutic progress, the studies showed that individual psychotherapy facilitated by hypnosis was uniformly endorsed as the primary treatment modality for MPD clients. Adjunct drug therapies with antidepressants and anti-anxiety medications were also highly supported (Putnam & Loewenstein, 1993). Anne Mills, who offered art therapy on an outpatient basis for MPD patients, found that most of the subjects felt that treating MPD was a clinical specialty. The practitioners were both primary and adjunct therapists, and often met with the client once a week. They used art to help with pacing, containment, managing chronic suicidal tendencies of the clients, and enhancing self-efficacy of the client (1995). Richard Kluft found

that MPD patients are far from uniform in their response to treatment, even in cases where the nature, orientation, and experience of the therapist are constant (1994). Latz, Kramer, and Hughes found that those who met the DES and DDIS criteria for MPD scored significantly higher on the DES, and were younger than the non-MPD group. They also found that there was no difference in the length of hospital stay or admission status in the two groups (1995). Ellason and Ross studied the effects of integration after a two year period and found that integration provided the patient with significant improvements of scores on the self-defeating, borderline, anxiety, dysthymia, avoidant, passive-aggressive, and major depression scales of the Milton Clinical Multiaxial Inventory-II. They concluded that MPD presents with polysymptomatology yet much treatment progress can be achieved through the process of integration (1996).

A few studies have been conducted to see how mental health care professionals view MPD as a diagnosis. Dunn and his associates surveyed found that 97.5% of psychologists and psychiatrists believed in dissociative disorders, while 80% reported a belief in MPD, 12.3% did not believe in MPD, and 7.7% were undecided. Younger professionals with less experience in the field, as a whole, believed in MPD more than older, more clinically experienced professionals. Furthermore, those who had previous experience with MPD clients tended to be more accepting of MPD (1994). Hayes and Mitchell found that scepticism and knowledge about MPD are inversely related, with moderate to extreme scepticism expressed by 24% of the sample. They also found that MPD is diagnosed with less accuracy than schizophrenia and that the misdiagnosis can be predicted by the scepticism of the professional (1994). Francois Mai found that 27.8% of psychiatrists doubted the existence of MPD and blamed the media and inept psychiatrists for the diagnosis of MPD. Again, younger psychiatrists were more likely to diagnose and believe in MPD, which the researcher says may be due to the introduction of MPD in the DSM-III (1995).

Research has also been done covering aspects which do not occur frequently in MPD cases. Torem speaks of research done on eating disorders which found that five of the women who met the DSM-III-R criteria for anorexia nervosa or bulimia really had MPD, and that the eating disorder could not be alleviated until the MPD was dealt with (1990). Bergu et al. discovered that nine inpatients for eating disorders in Japan met the criteria for MPD and six more were either MPD or PTSD (1994). Research has also been done with over 500 mental health professionals on the prevalence of diagnosing MPD and/or ritual abuse. No differences were found between ritual abuse or MPD diagnosis rates of Christian and non-Christian therapists (McMinn & Wade, 1995), or across disciplines or licenses (Bucky & Dalenberg, 1992). The effects of religious exorcisms have also been researched in recent years. Almost all of the subjects who had been exorcised reacted negatively, created new alters to deal with the exorcism, experienced PTSD and depressive symptoms following the exorcism, and felt their spirituality/religious fervor numb or cease (Fraser, 1993; Bowman, 1993). Hendrickson, McCarty, and Goodwin studied five women who had one of more alters that were animals. They traced the creation of these animal alters to childhood trauma involving the death, killing, or mutilation of animals, exposure to acts of bestiality, and being forced to live or act as if an animal. They suggest that therapeutic work with animal alters may be helpful and necessary in order to retrieve the underlying memories that lead to the creation of the animal alters (1990).

Other studies, collected from (c) 1997 APA/PsycINFO, that look at psychotherapeutic techniques for working with dissociative states include:

Adams, M.E. (1990). Some observations on the nature and treatment of multiple personality disorder. Psychoanalysis & Psychotherapy, 8, 161-168.
difficulties with diagnosis are discussed as well as aspects of the psychosocial histories, and behaviors. Various treatments are suggested that emphasize the need for the therapist to be imaginative and non-dogmatic.

Allen, J.G., & Smith, W.H. (1993). Diagnosing dissociative disorders. Bulletin of the Menninger Clinic, 57, 328-343.
reviews dissociative disorders and describes the range of methods developed to assess them (screening instruments, structured interviews, psychological testing, hypnosis). Ways to enlist patients' collaboration in the diagnostic process and space for them articulate their experience helps the clinician begin to educate clients to the universality of their experience The model proposed by J. G. Allen (see PA, Vol 81:1710) can be used to help patients describe the nature of their unfolding dissociative experience.

Allers, C.T., & Golson, J. (1994). Multiple personality disorder: Treatment from an Adlerian perspective. Individual Psychology: Journal of Adlerian Theory, Research & Practice, 50, 262-270.
examines the application of Adlerian techniques in the treatment of clients: building trust, understanding the client's lifestyle, and facilitating co-existence. Future areas of research are also recommended, including examining the issue of integration of fusion as the primary goal.

Altman, K.P. (1992). Psychodramatic treatment of multiple personality disorder and dissociative disorders. Dissociation: Progress in the Dissociative Disorders, 5, 104-108.
describes how psychodramatic group psychotherapy has been effectively used in an inpatient intensive treatment program for adult survivors of childhood abuse.

Anderson, G., & Ross, C.A. (1988). Strategies for working with a patient who has multiple personality disorder. Archives of Psychiatric Nursing, 2, 236-243.
discusses treatment strategies in a hospital setting based on a multidisciplinary approach. The authors discuss the importance of gaining the trust and ensuring the safety of patients, emphasizing the need for ongoing assessment throughout hospitalization.

Andreason, P.J., & Seidel, J.A. (1992). Behavioral techniques in the treatment of patients with multiple personality disorder. Annals of Clinical Psychiatry, 4, 29-32.
illustrates the effectiveness of behavioral techniques in helping to decrease and extinguish self-destructive behaviors. Reality-oriented limits that were placed on Ss' behavior were respected across alter personalities and continued to be effective at follow-up.

Araoz, D.L. (1983). Transformation techniques of the New Hypnosis. Medical Hypnoanalysis, 4, 114-124.
Twelve techniques used by the "New Hypnosis": relaxation, somatic bridge, subjective biofeedback, dissociation, personality activation, materialization, transfer, reliving, rehearsal, emotional bridge, paradox, and parable. Sees the therapist as a teacher or facilitator and the focus of control lies on the client, not the therapist.

Ash, S.M. (1985). Cult-induced psychopathology: I. Clinical picture. Cultic Studies Journal, 2, 31-90.
includes 3 stages of cult departure (reevaluation, readjustment, reacceptance) with psychopathology of dissociation and dedifferentiation of ego boundaries (or mind extension or expansion) while separating the mystical experience from other psychiatric disorders.(105 ref)((c)

Atanasov, A. (1986). The problem of catharsis in the scientific legacy of N. Krestnikov. [Russian]. Zhurnal Nevropatologii i Psikhiatrii Imeni S - S - Korsakova, 86, 758-760.
discusses the treatment of catharsis with emphasis on the technique of reproducing psychologically traumatic experiences.

Axelsen, E., & Sveaass, N. (1994). Psychotherapeutic understanding of women exposed to sexual violence in political detention. Nordisk Sexologi, 12, 1-12.
discusses theoretical perspectives on the psychological reactions to sexual trauma. The psychological reactions to sexual torture, including participation, powerlessness, guilt, meaninglessness, dissociation, negative self-image, and psychological symptoms as coping mechanisms, are identified. The goals and principles of therapy are described: (1) work with self-esteem, (2) finish unfinished experiences and give new meaning to the trauma, (3) see the trauma in a life span perspective, (4) work with body perception, (5) work with guilt, (6) clarify the meaning in the reactions, (7) strengthen self-control, and (8) work with motivation through the therapeutic relation.

Barach, P.M. (1991). Multiple personality disorder as an attachment disorder. Dissociation: Progress in the Dissociative Disorders, 4, 117-123.
sees attachment issues (J. Bowlby, 1988) as the central part of the disorder.

Barker, P., & Herlache, M. (1997). Expanding the view of treatment with an MPD client and her family. Journal of Systemic Therapies, 16, 47-58.
implements a multisystemic treatment approach.

Barrett, D. (1994). Dreams in dissociative disorders. Dreaming: Journal of the Association for the Study of Dreams, 4, 165-175.
looks at the dream characteristics of 48 patients with dissociative disorders.

Baum, E.Z. (1991). Movement therapy with multiple personality disorder patients. Dissociation: Progress in the Dissociative Disorders, 4, 99-104.
endorses group movement therapy: establishing trust through kinesthetic empathy, negotiating social interaction, eliciting expressive movement and traumatic material, and integrating a more coherent sense of self.

Benjamin, L.R., & Benjamin, R. (1992). An overview of family treatment in dissociative disorders. Dissociation: Progress in the Dissociative Disorders, 5, 236-241.
looks at family treatment interventions. Includes parallel therapy with a partner, marriage therapy, child therapy, parenting counseling, group therapy with MPD mothers, and group therapy with partners or parents of individuals with MPD

Benningfield, M.F. (1992). The use of hypnosis in the treatment of dissociative patients. Journal of Child Sexual Abuse, 1, 17-31.
Three related components of the hypnotic state that make it particularly suitable for work with trauma patients (selective attention, dissociation, and suggestibility).

Blizard, R.A., & Bluhm, A.M. (1994). Attachment to the abuser: Integrating object-relations and trauma theories in treatment of abuse survivors. Psychotherapy, 31, 383-390.
object-relations and attachment theories: the need to work in therapy with internalized object relations and with the trauma, and how patterns of attachment to the abuser are manifested in transference and countertransference.

Boon, S. (1997). The treatment of traumatic memories in DID: Indications and contra-indications. Dissociation: Progress in the Dissociative Disorders, 10, 65-79.
indications and contra-indications for entering into the second phase in the treatment of DID patients: the treatment of traumatic memories. Includes a checklist.

Bowman, E.S., Coons, P.M., Jones, R.S., & Oldstrom, M. (1987). Religious psychodynamics in multiple personalities: Suggestions for treatment. American Journal of Psychotherapy, 41, 542-554. different God images in primary and secondary personalities are examined.

Braun, B.G. (1989). Psychotherapy of the survivor of incest with a dissociative disorder. Psychiatric Clinics of North America, 12, 307-324.
behaviour, affect, sensation, and knowledge; the continuum of awareness and dissociation; and the 3-P (predisposition, precipitation, perpetuation) model.

Bromberg, P.M. (1991). On knowing one's patient inside out: The aesthetics of unconscious communication. Psychoanalytic Dialogues, 1, 399-422.
trauma, dissociation, and regression in the context of unconscious communication as a transferential enactment of unsymbolized experience; a key element of the psychoanalytic relationship is bridging dissociated aspects of self through the creation of a dyadic experiential field that is both "inside" and "outside." The writings of M. Balint (1935-1968), D. W. Winnicott (1951-1974), and several other British object relational theorists are explored.

Bromberg, P.M. (1996). Standing in the spaces: The multiplicity of self and the psychoanalytic relationship. Contemporary Psychoanalysis, 32, 509-535.
psychoanalysis as a specialized communicative field. The shifting quality of time and meaning reflects the enactment of self-states in both patient and analyst that define the multiplicity of relationships that go on between the patient's selves and the analyst's selves, only some of which are being focused on at any given moment.

Buchele, B.J. (1993). Group psychotherapy for persons with multiple personality and dissociative disorders. Bulletin of the Menninger Clinic, 57, 362-370.
Group psychotherapy: helping to begin breaking the secrecy, mastering the trauma, learning that talking helps, and accepting the diagnosis in brief group work solely with other MPD/DD patients. Requires a therapist well trained both in GP and in the diagnosis and treatment of DDs and MPDs.

Caddy, G.R. (1985). Cognitive behavior therapy in the treatment of multiple personality. Behavior Modification, 9, 267-292.
cognitive-behavioral approach : analysis of the emotions and behaviors of each subpersonality and then the process of integrating each alternate by cognitively developing in the S the realization that her various alternates were facets of the same individual.

Caul, D. (1988). Prognosis in the treatment of multiple personality disorder. Dissociation: Progress in the Dissociative Disorders, 1, 24-26.
16 questions useful in gauging whether or not a multiple personality disorder patient is likely to have a good or poor prognosis for a relatively straightforward psychotherapy and constructive outcome. Knowledge in advance of the problems likely to be encountered during therapy may reduce countertransference pressures on the therapist.

Chefetz, R.A. (1997). Abreaction: Baby or bathwater? Dissociation: Progress in the Dissociative Disorders, 10, 203-213.
the primary task of treatment is stabilization of the patient prior to "working through" the sequelae of trauma. The mid-phase of treatment may involve continued psycho-educational efforts to identify and name affects, the use of "dream-rules" in the interpretation of abreactive narrative, and a utilization approach which welcomes affect into the treatment setting in a safe, skilled environment. Management of countertransference responses to avoid enactment which could lead to boundary violations is essential.

Chu, J.A. (1988). Some aspects of resistance in the treatment of multiple personality disorder. Dissociation: Progress in the Dissociative Disorders, 1, 34-38.
therapist discomfort with resistance. Psychotherapy that requires the retrieval of past traumas in the context of an interpersonal therapeutic relationship is tremendously threatening to the patient with MPD and the importance of understanding and working with resistance as an intrinsic part of the treatment.

Chu, J.A., Matthews, J.A., Frey, L.M., & Ganzel, B. (1996). The nature of traumatic memories of childhood abuse. Dissociation: Progress in the Dissociative Disorders, 9, 2-17.
psychobiology, cognitive research, clinical research, and clinical practice concerning traumatic memory, focusing on implications for recovered memories of child abuse.

Comstock, C.M. (1991). The inner self helper and concepts of inner guidance: Historical antecedents, its role within dissociation, and clinical utilization. Dissociation: Progress in the Dissociative Disorders, 4, 165-177.
the inner self helper, a specialized psychic structure said to be unique to multiple personality disorder (MPD) patients

Comstock, C.M. (1991). Counter-transference and the suicidal MPD patient. Dissociation: Progress in the Dissociative Disorders, 4, 25-35.
countertransference, pathological relational patterns as they become replicated within the therapeutic matrix, and the potential communicative value of suicide threats by clients with multiple personality disorder (MPD) and their translation into useful dynamic material. The therapist's response is used as a clue to the meaning the patient is attempting to convey

Confer, W.N. (1984). Hypnotic treatment of multiple personality: A case study. Psychotherapy, 21, 408-413.
hypnosis for understanding personality dynamics maintaining dissociation, in recovering dissociated experience, and in merging personality fragments.

Coons, P.M. (1986). Treatment progress in 20 patients with multiple personality disorder. Journal of Nervous & Mental Disease, 174, 715-721.
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Coons, P.M. (1991). Invited discussion of "Bandaging a 'broken heart': Hypnoplay therapy in the treatment of multiple personality disorder.". American Journal of Clinical Hypnosis, 34, 11-12.
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Cornell, W.F., & Olio, K.A. (1991). Integrating affect in treatment with adult survivors of physical and sexual abuse. American Journal of Orthopsychiatry, 61, 59-69.
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Courtois, C.A. (1997). Healing the incest wound: A treatment update with attention to recovered-memory issues. American Journal of Psychotherapy, 51, 464-496.
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Crawford, C.L. (1990). Using images, metaphor, and hypnosis in integrating multiple personality and dissociative states: A review of the literature. Journal of Mental Health Counseling, 12, 416-433.
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Ehlers, A., & Steil, R. (1995). Maintenance of intrusive memories in posttraumatic stress disorder: A cognitive approach. Behavioural & Cognitive Psychotherapy, 23, 217-249.
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numbing, suppression of memories and thoughts about trauma, rumination, activation of other emotions such as anger and guilt and corresponding cognitions, and selective information processing (attentional and memory biases) may be involved in the maintenance of intrusive recollections.

Ellerman, C.P. (1998). The phenomenological treatment of dissociative identity disorder. Journal of Contemporary Psychotherapy, 28, 69-79.
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Elmone, P., Lingg, M., & Schwartz, M.F. (1996). Adult survivors of sexual trauma: A conceptualization for treatment. Journal of Mental Health Counseling, 18, 108-122.
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Engle, P. (1997). Art therapy and dissociative disorders. Art Therapy, 14, 246-254.
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Erskine, R.G. (1993). Inquiry, attunement, and involvement in the psychotherapy of dissociation. Transactional Analysis Journal, 23, 184-190.
the use of inquiry, attunement, and involvement in contact-oriented relationship therapy for dissociated patients. The aim of the therapy is the integration of affect-ladened experiences and the intrapsychic reorganization of the client's beliefs about self, others, and the quality of life. Therapy that acknowledges, validates, and normalizes a patient's phenomenological experience and provides an empathetic presence that allows the patient to safely depend on the therapeutic relationship and assess intrapsychic punishment is discussed. Contact facilitates the dissolution of defenses and the integration of dissociated parts of the personality.

Eyre, D.P. (1991). Therapy with a sexually abused woman. International Journal of Psycho-Analysis, 72, 403-415.
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Fagan, J., & McMahon, P.P. (1984). Incipient multiple personality in children: Four cases. Journal of Nervous & Mental Disease, 172, 26-36.
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Finch, J.E. (1990). Trust issues with multiple personality clients. Journal of Mental Health Counseling, 12, 99-101.
clients must learn to trust the mental health counselor and the therapy process. The trusting relationship will begin to develop with the personality that 1st comes for therapy, and trust must be established with each emerging personality. Effective statements to be made to MPD clients that address major fears about the therapy process are suggested.

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Fine, C.G. (1994). Cognitive hypnotherapeutic interventions in the treatment of multiple personality disorder. Journal of Cognitive Psychotherapy, 8, 289-298.
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Fink, D. (1992). The psychotherapy of multiple personality disorder: A case study. Psychoanalytic Inquiry, 12, 49-70.
psychotherapy sequence of confrontation, clarification, interpretation, and working through.

Fink, D.L. (1988). The core self: A developmental perspective on the dissociative disorders. Dissociation: Progress in the Dissociative Disorders, 1, 43-47.
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Florit, R., & Linos, R. (1998). Training in social skills in a group of chronic mental patients. [Spanish]. Anales de Psiquiatria, 14, 339-346.
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Fraser, G.A. (1991). The Dissociative Table Technique: A strategy for working with ego states in dissociative disorders and ego-state therapy. Dissociation: Progress in the Dissociative Disorders, 4, 205-213.
series of techniques to access the inner ego system: relaxation imagery; dissociative table imagery; and spotlight, screen, memory protection, and fusion/intergration techniques.

Fraser, G.A. (1993). Special treatment techniques to access the inner personality system of multiple personality disorder patients. Dissociation: Progress in the Dissociative Disorders, 6, 193-198. techniques used to access the inner personality system including formal hypnosis, self-hypnosis, guided imagery, meditation techniques, fear and pain, and chemical inductions of trance states such as those induced by sodium amytal.

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Gainer, M.J., & Torem, M.S. (1993). Ego-state therapy for self-injurious behavior. American Journal of Clinical Hypnosis, 35, 257-266.
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treatment of the neuroses: phobic disorders (agoraphobia, social phobia, and nosophobia), anxiety disorders (panic disorders and generalized anxiety disorder), obsessive-compulsive disorder, dissociative disorder, and depersonalization-derealization syndrome. Three treatment categories are covered: (1) drug treatment, (2) non-pharmacological physical treatment (e.g., psychosurgery, ECT), and (3) psychological treatment (e.g., combined cognitive-behavioral treatment, exposure therapy with response prevention, relaxation training, dynamic psychotherapy, counseling, or psychoanalysis).

Some of the tests that have been used to study and diagnose and compare MPD and other dissociative disorders to other disorders have included:

- ?? The Questionnaire of Experiences of Dissociation (QED)
- ?? The Minnesota Multiphasic Personality Inventory (MMPI)
- ?? The Rorschach test
- ?? The DES and DES-II

?? The Child Dissociative Checklist (CDC).

?? The Positive and Negative Syndrome Scale (PANSS)

?? The SCID-D

?? The Beck Depression Inventory

?? The MCMI

?? Somatic symptom reports

?? The DDIS

?? The Glover Vulnerability Scale

?? The Wechsler Adult Intelligence Scale Revised (WAIS-R

?? Visual tests

?? Evaluation of dreams with school performance (1994).

?? The Millon Clinical Multiaxial Inventory-II

LITERATURE: which supports the belief that there is a need to include the transpersonal when fulfilling the mandates for a complete list of therapeutic techniques:

Psychosynthesis is a viable and extremely useful tool when dealing with Dissociative States:

Assagioli, Roberto (1991) *Transpersonal Development: The Dimensions Beyond Psychosynthesis*, San Francisco, The Aquarian Press (P.43)

Assagioli, Roberto (1976) *Psychosynthesis: A Collection of Basic Writings*, NY, Penguin Books (P.98)

Assagioli, Roberto (1974) *The Act of Will*, NY, Penguin Books (P.160)

Brown, Molly Young (1993) *Growing Whole*, Minnesota, Hazelden Educational Materials (P.78-79)

Brown, Molly Young (1983) *The Unfolding Self: Psychosynthesis and Counselling*. LA, Press (P.18)

Caveney, Therese A (1992) *Healing the Wounds of Adults Abused as Children: A Transpersonal Approach*, California, Sara Graphics

Ferucci, Pierro (1982) *What We May Be*, Los Angeles, Tarcher (P.85)

Firman, John, Gila, Ann (2002) *Psychosynthesis: A Psychology of the Spirit*, Albany, State University of New York Press (P.68, 162-163)

Kramer, Sheldon Z.PhD (1995) *Transforming the Inner and Outer Family: Humanisitic and spiritual Approaches to Mind-Body systems Therapy*,NY, The Haworth Press.(P120-121)

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Whitmore, D (1991) *Psychosynthesis Counselling in Action*, London, Sage

Psychosynthesis is a tool that gathers other therapies and expands on them:

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Hardy, Jean (1987) *A Psychology with a Soul: Psychosynthesis in Evolutionary Context*, NY, Viking Penguin Books (P.55)

Sullivan, Rosemary (1980) *Psychosynthesis: A bridge Between Psychological and Theological Conceptions of Human Nature*, Montreal, McGill University

Weiser, John, Yeomans, Thomas (1984) *Psychosynthesis: In the Helping Professions: Now and for the Future* , Toronto, The Department of Applied Psychology/The Ontario Institute for Studies in Education (Yeomans, Psychosynthesis in the Helping Professions P.5-15; Friedman, Will-Psychosynthesis, Psychoanalysis, and the Emerging Developmental Perspective in Psychotherapy P.31-45)

There are a variety of techniques that can be used to work with patients diagnosed with Dissociative Identity Disorder

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Masterson, James F (1983) *Countertransference and Psychotherapeutic Techniques*, NY, Bruner/Mazel

Miller, Alice (1983) *For Your own Good: the roots of violence in child-rearing*, NY, Farrar, Straus and Giroux

Bugental, James F.T (1987) *The Art of the Psychotherapist*, NY, Norton and Co.

Erikson, E.H. (1968) *Identity and the Life Cycle*: selected papers, NY, International Universities Press Inc.

Jones, Franklin Ross, Garrison, Karl C, Morgan, Raymond F (1985) *The Psychology of Human Development*, NY, Harper and Row

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Rogers, C.R. (1961) *On Becoming a Person*, Boston, Houghton Mifflin

Marmer, Stephen S (1980) *Psychoanalysis of Multiple Personality*, Int. J. Psycho-Anal, 61, 439

Kluft, Richard P.M.D. (1985) *Childhood multiple personality disorders: predictors, clinical findings, and treatment results, in Childhood Antecedents of Multiple personality*, Washington, American psychiatric press, pp 167-196

Weiser, John, Yeomans, Thomas (1988) *Readings in Psychosynthesis: Theory, Process, & Practice* , Toronto, The Department of Applied Psychology/The Ontario Institute for Studies in Education (Tackett, Victoria Treating mental and Emotional Abuse, P.15-29; Young, Penelope Family of Origin: Land of Opportunity for Transpersonal Therapists, P.6-13; Dummer, Vincent, Greene, Mary The Core Personality: Treatment Strategies for Multiple Personality Disorder, P.75-81)

Russell, Douglas (1981) *Psychosynthesis in Western Psychology***,** Psychosynthesis Digest Vol.1**,** No.1. Fall/Winter 1981

Goble, Frank (1970) *The Third Force* , NY, Grossman Publishers

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PURPOSE OF THIS STUDY

This study is meant to provide a list of viable, effective psychotherapeutic techniques which aid the clinician in their work with dissociative clients. There is a hope by the author that, in the compilation of information, the transpersonal therapy called Psychosynthesis will be proven to be a viable, and perhaps ideal tool when dealing with people who are living at the extremes of the dissociative continuum as well as within the normal dissociative patterns of every day living.

Advocacy/participatory issue

This research gave birth to a questionnaire (see appendices) which was given to therapists already recognized as working in the field of dissociation.

Research Questions

Some of the questions which were included in the questionnaire came from these original questions:

?? How does dissociation express itself in every day life?

(to get a sense of what the therapists consider to be dissociative behaviour. This would be taken from the DSM IV outline on DID as well as from their own experience)

?? What are the means by which you deal with dissociative as well as 'other' clients?

(this would be in the form of a checklist divided by, but not labelled, by the different disciplines and would also include space where therapists could add in their own viewpoint/experience)

?? In what field of discipline did you receive your original therapeutic training? And what additional training do you have?

Delimitations/limitations

Initially, this study was to be confined to therapists working in the field, preferable current members of The International Society for the Study of Dissociation (ISSD). Other disciplinary schools were meant to be contacted if there was an insufficient gathering of information.

In reality, ISSD did not give permission for this questionnaire to be sent out to its members so other professional organizations were contacted, as well as people in private practice, social workers and psychiatric hospitals.

Procedures

This research study attempted to provide, from the knowledge base and experience of professionals, a list of appropriate therapeutic techniques and interventions which are viable when working with a population of clients that are dissociative.

Qualitative research strategy

This research used a questionnaire that draws from professionals and their ability to explore and expound on the techniques that they use on a daily basis in their practices. While data collection tools which explore the continuum of dissociation (SCID-D [Structured Clinical Interview for DSM-IV Dissociative disorders], DES [Dissociative Experience Scale], DQ [Dissociation Questionnaire], QED [Questionnaire of Experiences of Dissociation]) are available to find out if clients show an preponderance to dissociation, the move from this diagnostic procedure to the actual healing takes a great deal of thought, training and experience. It was the hopes of this writer that the research would give the therapeutic community the chance to view what they and their colleagues have been experimenting with, in the hopes that more efficient doorways to knowledge may be opened and other techniques be researched and experienced.

Role of the researcher

The researcher had, in keeping in mind the stated problem, compiled research questions from the multitude of material of different therapeutic techniques. The researcher placed these questions in order of disciplines, while keeping in mind that the reader should not be influenced, but should be allowed room to express. The researcher contacted ISSD, in particular the committee that compiled the 'Guidelines,' in an attempt to gain some prior knowledge regarding past assemblage and present and future research already completed or in process. The researcher did not gain

permission from the ISSD, or their support and guidance. The researcher found a way to present this questionnaire in a format that was computer adaptable. The researcher created and presented a précis, outlining the topic and specific problem to be solved, to the Westbrook University's committee for approval, which was received on November 6, 2003. The researcher set a deadline for collection, compilation, evaluation and comparison, and preparation of final material and a method by which to receive the incoming material which focused on those needs. A summation of the findings was prepared and submitted in written form to the University committee, and is included in this completed work.

Data collection procedures (**including the collaborative approaches used with participants)**

To find comparative literature the researcher:

- identified the key words (dissociation, Dissociative episodes, Dissociative scale, Dissociative continuum, psychosynthesis, the history of psychotherapy, psychotherapeutic descriptions/comparisons, tools for working with dissociation, methods for working with dissociative client, the five forces of psychology, Psychoanalysis, Behaviourism, Humanistic Psychology, Transpersonal Psychology, etc.)
- searched through journals, books, databases, available literature, thesis, dissertations, studies, abstracts
- overviewed, designed, drafted and organized summaries, concepts, themes, and a final proposal
- got in touch with as much material on dissociation, or dissociative disorders as possible
- got in touch with professional organizations that may have had journals, or research material in the field
- searched the World Wide Web Virtual Library for pertinent information
- searched the American Psychoanalytic Association Jourlit Bookrev Search for relevant information
- searched the American Psychological Association 'resources for students'
- searched for University Dissertations on the subject
- did a web search on all the web search engines to find out any other material that was available
- spoke to other professionals in the field to get their feedback and experience
- got in touch with a reputable computer company that helped to present this questionnaire on a professional website

For participants the researcher:

- explained the reason for the research and how it would benefit them
- helped them to see how this research would benefit their clients ,their practice, and their role as a therapist
- included a misnomer and guarantee of anonymity

Data recording procedures

The actual material for this research was collected:

- ?? as a self-administered questionnaire (hard copy and internet accessible). Two hundred hard copies and five hundred emails were sent out to therapists, social workers and psychiatric hospitals and hospices.

Data analysis procedures

The material was organized and prepared for analysis. The answers were screened and collaborated. The material was observed for repetitive patterns with a view on gaining a general sense of the information and a reflection on its overall meaning. The tone, the general impression of the depth, the credibility and the usefulness of the information was overviewed. The detailed analysis was then coded, addressing topics that were expected, not expected, and issues that reflect a larger perspective. The themes were then represented in a qualitative narrative with a detailed discussion of themes, perspectives from individuals and what that meant in relation to the whole. The final step of interpretation included a personal interpretation, understanding, or meaning derived from the comparison and correlated information, included in the narrative.

Strategies for validating findings

While also occurring throughout the process of research, it was important that all findings be seen as accurate (trustworthiness, authenticity, credibility). There was a checking of the validity of the understanding of the information, a clear description along each step of the journey and counter material, which may have been negative or discrepant, was viewed. Time was taken for the process to complete itself, both in the intake and in the understanding.

Questionnaire

Since this researcher didn't have enough clinical experience, and because it was important to get as broad a view as possible, this questionnaire was intended to reach out to active therapists currently working with and classified as therapists with experience working in the field of dissociation.

The questionnaire (included) was to have been sent out in both hard copy as well as emailed copy to professional organizations, such as the International Society for the Study of Dissociation (ISSD) and the Association for the Advancement of Psychosynthesis (AAP), with a request to receive permission to send this out to their membership. ISSD did not give their permission because of the lack of an Internal Revue Board (IRB). AAP approached their Steering Committee who formulating a plan of action for future requests and allowed an email to be sent out to their members, informing them of the questionnaire which could be answered on line or in hard copy at their annual conference. The format was made easy enough to answer in a short amount of time and self addressed stamped envelopes were included with hard copies.

Working from the ISSD Basic Guidelines on working with Dissociation, and following **Chart 1-Psychotherapeutic Comparisons/ The Five Forces of Psychology** , the researcher asked therapists what their experiences had been, in which therapeutic techniques they had received their training, and which they currently use to best advantage with dissociative clients. The questionnaire was broken up and presented in the format of the five forces of psychology, unknown to the recipients, and easier to decipher when the results were tabulated and deciphered.

The questionnaire has been constructed using:

Chart 1-Psychotherapeutic Comparisons/ The Five Forces of Psychology.

Applying the five forces in Psychology to the work of dissociation:

First Force-Behavioural

Assertiveness Training

Relaxation Training

Systematic desensitization

Modeling

Positive Reinforcement

Charting changes

Relapse prevention

Second Force-Psychodynamic

Free Association

Symbols

Dream based on sexuality

Analysis of resistance

Transference/counter-transference

Interpretation

Self destiny

Insight

Third Force-Existential/Humanistic

Analysis (eigenwelt, mitwelt, umwelt)

Intentionality

Rapport-structuring, data gathering, determining outcomes

Generating alternative solutions

Generalization

Forth Force-Transpersonal

Systematic use of all available active psychological techniques

Starting/ending points dependant on individual

Can be done by the individual or with a guide practitioner

Fifth Force-Transhuman

Some believe that this will come forward in a body based, kinesthetic form of therapy.

To be seen…….

Working with Dissociative States Questionnaire

As a therapist working in the field of Dissociation, you are being asked to take a moment to answer these questions around therapeutic techniques. Your answers could help to further the field and aid those who most need our services.

This Questionnaire fulfills the requirements for a PhD Dissertation with Westbrook University. The study looks at the techniques currently in practice, and is meant to provide a list of viable, effective psychotherapeutic techniques which aid clinicians in their work with dissociative clients. Since the material collected through this questionnaire is non traceable and no personal information, such as name, address, or telephone number is requested, the information will remain anonymous and you, as a participant will not be contacted for further follow up unless you specifically request it.

1. Male__ or female ____ 2. Date: _____

3. Years of working as a therapist _____ 4. working with dissociative clients_____

5. Primary/Formal training _____6. which would include which

methodology/ies

_____

7. Purist__ 8. or additional training _____9. which would add in what additional

methodology/ies _____

10.When you first meet or interview a client, what is your primary goal _____

_____

11.Number of clients you see in a month_____

12.Number that are male _____female_____

13.Percentage of those clients that are Dissociative_____

14.Percentage of those that are Male _____female_____

15.Looking at the DSM1V description of Dissociative disorders, which ones hold meaning for you?

_____

_____

_____

16.What dissociation means to me:

_____

_____

_____

17.When working with Dissociative clients I find that I tend to use the following techniques the most

_____

_____

18.What is the shortest and longest therapeutic relationship you have had with a Dissociative client? _____

19.How long do you think it would take to heal someone who is Dissociative?

_____

20.What does healing mean to you?

_____

21.When dealing with clients with dissociation, which of the following therapeutic interventions do you use? Please check the ones that apply.

a.__ I give my clients active exercises in the hope of redirecting their experiences

b.__ I offer advice on how they can change their behaviour

c.__ I suggest that they write down their experiences and I offer alternative solutions

d.__ I listen carefully and offer positively reinforcing words and actions

e.__ I encourage them to speak out for themselves

f.__ I aid them in changing their patterns of behaviour

g.__ I offer relaxation techniques to aid them in their growth

h.__ I invite them to look at their fears and walk through different patterns leading to change

i.__ I reinforce their learning through role modeling

j.__ I ask them to keep a journal and then we chart the noticed changes

k.__ I invite them to look at their patterns of behaviour, noting when changes occur

l.__ I invite them to become aware of their actions and reactions

m.__ I encourage them to seek out help when they are having difficulty

n.__ I sit back and listen carefully to my clients, noting patterns on paper

o.__ I allow my clients to speak. I never speak, or try to interrupt their flow

p.__ I offer words and allow them to follow an associative pattern

q.__ I encourage dream interpretation

r.__ I look for areas of resistance and note them

s.__ I keep aware of my feelings and the reactions of my clients

t.__ Patterns of transference and countertransference are important areas to look at

u.__ I help my clients with interpretation of their experiences

v.__ I try to keep aware of insightful ideas and I share them with my clients

w.__ I listen carefully for patterns and symbolic interpretations

21.When dealing with clients with dissociation, which of the following therapeutic interventions do you use? Please check the ones that apply

x.__ I encourage my clients through active listening skills

y.__ I respond by mirroring their words and actions

z.__ I engage in dialogue, following their cues

aa.__ I look for patterns of behaviour, with my client, and we share experiences

bb.__We look at the effect of certain behaviours on their life

cc.__ I allow space for re-enactment of memories

dd.__ I encourage the client to identify with their experiences

ee.__ I encourage the client to visualize a positive outcome to their fears/memories

ff.__ I invite the client to change the outcome of their memory/fear

gg.__ I invite alters, or parts of the personality to speak and become known

hh.__ I help the client identify with their fears and memories

ii.__ I encourage abreaction and allow lots of space for this to occur

jj.__ I use hypnosis to encourage memory retrieval

kk.__ I allow abreaction and then encourage action/reaction

ll.__ I encourage my clients to map their progress

mm.__ I suggest that clients keep journals to help them understand their process and progress

nn.__ Helping the clients to contain and understand their experiences, through writing, drawing, movement and/or sound is encouraged

oo.__ I have space in my office where clients can identify with any part of themselves that they need

pp.__ I create a safe space where clients can do anything they feel they need to

21.When dealing with clients with dissociation, which of the following therapeutic interventions do you use? Please check the ones that apply

qq.__ I make contracts with my clients, and parts of my clients, to ensure safety

rr.__ I make sure my client is grounded enough to leave my office before allowing them to leave

ss.__ I have space in my office for clients who need some 'alone time' before leaving

tt.__ My clients can call for an appointment any time then want/need to

uu.__ My clients have a regularly kept schedule of appointments to ensure continuity

vv.__ I provide alternative methods of reaching me when I am unavailable

22.Are there others that are not listed here?

_____

_____

23.When dealing with clients that are dissociative, are there rules that you follow, like a 'do and don't' list that is specifically for these clients?

_____

24.Please mark which statements are True in regard to your patients that are displaying symptoms of dissociation or are coming with other complaints:

	Dissociative	Other
A. Patients need to go through stages of growth in order to develop	___	___
B. Personality integration is an important step	___	___
C. There is a potential for personality transcendence	___	___
D. Mastering the physical body is important	___	___
E. Learning to regulate and direct emotional energies must be considered	___	___
F. There is a sense of centred self that needs to be fostered	___	___
G. Relationships with others is very important	___	___
H. Denial and dismissal of self and potential are defences used	___	___
I. Projection or the admiration of others to the detriment of the self is a defence used	___	___

24.Please mark which statements are True in regard to your patients that are displaying symptoms of dissociation or are coming with other complaints:

	Dissociative	Other
J. There is always a sense of self, or "I" that will eventually manifest	___	___
K. There is a sense of a higher consciousness, or a higher knowing that can be called in to help give direction	___	___
L. By embracing healthy realistic beliefs and attitudes one is able to resolve inner conflicts	___	___
M. Development comes with a mastery and expanded awareness of self and others	___	___
N. Patients show a great deal of guilt and pain coming from their inability to actualize their potential	___	___
O. Actions, images, emotions and thoughts are all varied forms of energy	___	___
P. Intuition can be trusted to guide and reveal new inner qualities and the next step ahead	___	___
Q. When the point of energy can be recognized then the cues or way towards solving a problem can be identified	___	___

24.Please mark which statements are True in regard to your patients that are displaying symptoms of dissociation or are coming with other complaints:

	Dissociative	Other
R.I am aware of the energy around my client and am able to guide them to the next step by being aware of this energy	___	___
S. Tough mindedness, bold assertiveness and a strong will are all aspects of human nature	___	___
T. Peace, love and joy are all aspects of human nature	___	___
U. Integration, dis-integration and re-integration is to be encouraged, understood and appreciated	___	___
V. Our current experience or sense of identity is only a moment in time-a step in a larger process of development	___	___
W. Physical mastery to emotional and mental mastery to higher consciousness is some of the work that I do	___	___
X. There is an inner blueprint which guides our growth and comes from the Higher Unconscious	___	___

24.Please mark which statements are True in regard to your patients that are displaying symptoms of dissociation or are coming with other complaints:

	Dissociative	Other
Y. Stress, pain, or frustration can come from a loss of self or a connection to our Higher Knowing	___	___
Z. Harmonious personality is the goal to reach for	___	___
AA. Self autonomy must be considered for health to occur	___	___
BB. Learning appropriate expression and sublimation of emotions and desires is important in order to adapt to the social environment	___	___
CC. As one grows to a deeper identity there is the possibility to reach the soul, or Higher Self	___	___

Many thanks for taking the time to complete this questionnaire.

Budget

I incurred the following costs:

Printing of 200 copies of the questionnaire	$ 80.00
Computer: programming cost	$ 200.00
Mailing: stamps/envelopes	$ 174.00
Total actual output	$454.00

Time Line

Once approved by the committee of Westbrook University, I had anticipated a one month leeway to get the questionnaire up and running on my professional website (with links to professional organizations). I had thought it would probably take at least one month, if not two, to get permission from the various professional organizations to create a link and at least another two to three months to collect the data. I anticipated two months to decipher and graph the information and prepare the report to give back to the University committee. In total, this part of the research was expected to be completed by the spring of 2004. In actuality, the questionnaire was up on the website within a month. It took more than five months to get the final rejection of approval from ISSD and a total of six months to complete the intake and seven months to present the first rough draft to the University Committee.

THE RESULTS

This questionnaire was answered by 10 men and 15 women who have worked from 5 to 53 years in the field, with a mean of 21 years as a therapist and a mean of 14 years working with dissociative clients. Their stated training went from none at all to Masters and Doctorates in Art, Divinity, Education, Medicine, Nursing, Social Work and many different forms of Psychology (cognitive-behavioural, group, Freudian, Humanistic , Transpersonal, Psychoanalytic, Psychosynthesis).

They are licensed in and certified as Alcohol & Drug Counsellors, clinical Hypnotists, Imago and Adventure Based Therapists, Gestalt therapists, Psycho Pharmecologists, Psychodrama and Reiki therapists and Traumatologists, and have hours of training in Domestic Violence, Sexual Trauma Training and Child Abuse, Mental Health Clinics as well as assessment, diagnosis and treatment of all major disorders (esp. mood disorders, trauma, human sexuality and personality disorders), and 79% say they are not purist in their methodology.

They work with: abreaction techniques, Adlerian therapy, art and expressive therapies, Attachment Theory , Brain Cognition, bringing memories to consciousness, Cognitive Behavioural , CBT, CDG , Child Development, Colin Ross training, Counselling Psychology ,couples work , DBT, defence and transference issues ,dream analysis and interpretation , ecopsychology, EFT,EMDR, energy based interventions, expressive therapies, feminist orientation , focusing, free association , Friesen, Gestalt, Grounding, group therapy, Healing Touch ,Hope Alive ,hypnosis, imagery, indigenous healing, individual counselling, intersubjectivity, insight oriented, Kluft , Mapping, Massage, Masters and Johnson-Sexual Trauma Training, Parenting, meditation, Personality Theory, post-abortion recovery, prayer, Psychoanalysis, Psychodrama, Psychodynamic Experiential Object Relations, Psychoeducational training, psychological testing, Psychosynthesis, Putnam, regression, Reiki ,reintegration,

relational , Rogerian , Ross, self training tapes, shame and anger redirection, somatics, subpersonalities, synthesis, systems thinking, transference/countertransference, TAT, TFT, TIR, theosophical prayer, 'I' , legal issues, Trauma resolution/theory, TIR, using drugs appropriately and women's issues, as well as a wide variety of trainings from generic trauma thru traumatic grief.

38% of respondents said that their primary goal in working with clients is assessment and evaluation of purpose, goals and levels of functioning. Another 34% emphasized the importance of creating a safe space where the client can feel comfortable. 41 % mentioned establishing a rapport within the therapeutic relationship. 16% specifically mentioned finding out why the client has come forward 4% mentioned seeking God's lead and 21% mentioned determining the fit between the therapist and the client.
The words that came forward were: alliance, assessment, contact, determine goals, establish connection, evaluate, explore, God's lead, process, identify, rapport, resonance, safety, listen, serve, understand and work.

On the average, these clinicians see from 1 to 150 clients per week with from 1-25% being male and from 10-100% being female. The number of these that are dissociative ranged from 1-66% with 1-100% being male and from 1-100% being female.

They see these clients anywhere from 1 session to 30 years with the longest client/therapist relationship coming in at an average of 11 years.

Although the questionnaire did not list the DSM IV descriptors for DID, the participants cited DID, DDNOS, Fugue, Psychogenic Amnesia ,Depersonalization , PTSD and Bi- Polar as those they most believed in. 8% said they didn't believe in any of them.

When asked what Dissociation meant to them, the respondents became more expressive. They mentioned: patterned energy, not consciously aware, capacity that we all have to drift away/remove ourselves from situations, create an alternative mental/emotional space, use of alters to function, division of the personality, some degree of loss of voluntary control/awareness over mental/physical actions, phobic avoidance, involves neurobiological processes, rigid/ involuntary retraction of the field of consciousness, lowering of the level of consciousness, involves the encoding and storage of information in different parts of the personality, necessary, often life saving defence in childhood, old patterns get in the way of living a full life in the present., a response to trauma that protects, ego splits off the intolerable experience, personality split :one part is unaware of another part, period of time where a person is out of contact with mind/body, split in consciousness/will, extreme case of sub-personality identification, process of organizing and processing psychological (thinking, feeling, perceiving, sensation, etc) content., alteration in normal mental and emotional functioning, loss of consciousness for the present moment, loss of focus/structure, escape-shut off neurological emotional experiential connections to trauma/triggers, pathological (originally defensive) disintegration and compartmentalization of otherwise normal psychological processes, periods of time missing, personality disorder, individual blocks out chaos, invalidating environment or lack of control of a situation, people do things they don't know they've done, loss of time that cannot be accounted for and cannot be attributed to an alcoholic blackout or something similar, major portions of the personality function (body, feeling, mind) outside normal waking consciousness and A little girl day dreaming about a little girl who is daydreaming about a little girl who is being sexually/physically/ emotionally abused.

When asked what 'healing' meant to them many referred to balance, integration and function. These respondents cited: conscious awareness and balance and integration of different aspects of the unconscious/having body mind and spirit in balance, person is able to effectively manage their system-able to consistently do the maintenance to keep that in place, continuum of increased functioning, reduced symptoms, boundary building, restoration/establishment of satisfactory relationship with God, integration of all parts of the personality into an adaptive whole, ability to be self aware, focused, to act reflectively rather than reactively, have flexible and intimate relationships, more and more comfortable in life, able to manifest best qualities and abilities in the world, living a congruent life that is stable, functional, able to deal with stressors without switching, to be whole and to know it, more communal and interpersonal interaction, client knows alters and works with them, emotional well-being, high interpersonal, social and occupational functioning, internal awareness, easy access to personal history, reduced dissociative episodes and be with him/her self in satisfactory manner.

In terms of how long it takes to reach a state of healing, the answers ranged from "We are already whole (healed) and how long it takes to know it varies with the individual" to "forever." Most responded that it is dependant on the individual and the degree of investment and pathology. Of those that responded with a time frame, 8 years came in as the average.

These therapists then went on to describe their actual working techniques as: planning and implementation, grounding, resource building, EFT, TIR, reintegration strategies, EMDR, prayer, TIR, cognitive restructuring, journaling, relational work (skills and transference/countertransference working with inner conflicts, physiological and psychological regulation techniques Keeping therapy focused on process rather than content), client centred approach , talk, art, holding a Psychosynthetic understanding of wholeness, acceptance of clients' subjective experience, positive regard, hypnosis, trans/countertransference analysis, dream interpretation, Psychosynthesis, Psychoanalytic techniques, exploration of function of identity/state, Gestalt techniques., DBT therapy and skills, supportive, deductive, empower, mingle, imagery, sub-personality maps and Centring (strengthening "I" consciousness), personality dialogue, mindfulness, development of Will and goals, Psychodynamic, inter-subjective, self psychology, CBT, facilitating internal communication, allow them to do what they need to do, insight oriented, self care, catharsis, encourage personalities to communicate with other personalities, establishing and maintaining safety, affirmation of the presence of alters, evidencing, mapping and audio taping for PT playback.

When looking at actual therapeutic techniques that therapists use, these were the 10 most chosen from a list of 48:

96% stated that "I keep aware of my feelings and the reactions of my clients

91% stated that "I make sure my client is grounded enough to leave my office before allowing them to leave"

87% stated that "I make contracts with my clients, and parts of my clients, to ensure safety" and "I encourage my clients through active listening skills" and " I invite them to become aware of their actions and reactions" and "We look at the effect of certain behaviours on their life"

83% stated that "I offer relaxation techniques to aid them in their growth" and "My clients have a regularly kept schedule of appointments to ensure continuity"

79% state that “I encourage them to speak out for themselves” and I invite them to look at their patterns of behaviour, noting when changes occur” and I engage in dialogue, following their cues” and “I invite alters, or parts of the personality to speak and become known”.

Of the therapeutic techniques least chosen:

4% stated that “I allow my clients to speak. I never speak, or try to interrupt their flow”

16% stated that “I encourage abreaction and allow lots of space for this to occur”

23% stated that “I use hypnosis to encourage memory retrieval”.

Some of the other techniques that respondents felt had not been included in the original list included:

encourage all parts to participate in each session, support and direct an experience of remembering in the safe present while oriented to the present and to the therapeutic relationship, encourage collaborative processing of the therapeutic relationship, consistency, reach another therapist in my absence, set flexible but firm and very consistent therapeutic boundaries, encourage them to attend community support groups and workshops, identify polarities and devise experiments to help client come in contact with polarity, mirror awareness of limitations/boundaries, calling upon Wise Being and other spiritual sources through imagery, they can phone, email, write snail mail, readings, journaling, encourage to stay in here and now, may reference past but do not desire to retraumatize, internal shame and anger reduction.

When asked what they “do” and “don’t do” with dissociative clients, these were the responses:

DO:

encourage phone messages as check-ins between sessions, encourage outside support besides the individual sessions, encourage medication evaluation by psychiatrist, encourage a collaborative process, encourage the therapeutic relationship, support adaptive dependency and adaptive autonomy, encourage all parts to relate to each other more than they relate to the therapist, be aware of and treat comorbidity--it is almost always present, have adequate backup in the therapist's absence, support secure attachment, stay flexible, warm, clear, and grounded, treat the patient respectfully and as an adult at all times, view the patient as one person, be aware of sexual, cultural, religious, and social issues in the therapy, make crisis calls short with the goal of grounding, not conducting therapy, engage in regular self-care of the therapist, treat each part with equanimity and respect, regression in service of the ego, be consistent... be ready and able to deal with whatever comes up, respect their subject experience, follow the wisdom of their psyche, contact ALL professionals working with this person so that splitting does not occur, rules as limit setting/special allowance for needs, smaller steps, avoidance i.e. of retraumatization, treat dissociative clients in the same way that I treat other clients and try to ensure that I do not do things for them that I would not do for other clients, work on grounding/stabilization before anything else, work on staying in the present., validate the patient's perceptions, not everything the patient does is "transference" to be fed back to him or her, be consistent and transparent in your rules of conduct, set good boundaries and be clear on what is expected as well as their safety, tell them their diagnosis, but time intervention carefully.

DON’T:

make any physical contact without asking, get too many on a caseload at any one time, work harder than the survivor, react without thinking to client's requests or demands, encourage abreaction, encourage maladaptive dependency: don't need to be needed, treat without

supervision or consultation, cross a boundary without reflection, awareness of the consequences, and checking with several trusted and knowledgeable colleagues, suppress parts, or otherwise try to make them go away, treat clients in private setting that are unable to control behaviour that is dangerous to themselves or others, lead them, impose own reality, allow them to 'trash' the office or come into the office building to 'hang out', use hypnosis to retrieve memories, assume that we know what happened to them in childhood, say that a particular memory did or did not occur, allow yourself to be/feel abused by the patient, allow physical violence acted out toward others, prescribe drugs without careful discernment –hospitalize, use EMDR, contact for 24 hours if hospitalized.

In the question area that queries the practice techniques used for clients that are dissociative, as opposed to what is referred to as 'other' clients, there are certain features that stand out. Fostering a sense of centred self seems to be very important for clients that are dissociative, as is taking a step towards personality integration. Defences of denial and self-dismissal are more often used by clients with dissociation and there tends to be a sense of a higher consciousness, or higher knowing that can be called on to give direction. There tends to be more of a sense of stress, pain, or frustration coming from the loss of self and the learning of appropriate expression and sublimation of emotions and desires is important for adaptation and eventual integration. The idea of a sense of self, or "I" eventually manifesting was seen more for 'other' than for the dissociative as is the embracing of a healthy, realistic belief and attitude which leads to resolution of inner conflicts. Tough mindedness, bold assertiveness and a strong will, as well as the reaching for a harmonious personality, were all thought of as techniques for 'other' more than for the dissociative. Mastery, expansion, growth, relationships and the potential for personality transcendence were all seen as balanced for all.

When we begin to look at all this information in light of the background of the participating therapists in relation to their original training and background experience, one can see that many have not allowed their original training to be their main mode of working. It is obvious that this group of therapists have spent many long hours in gaining more and more diverse technical tools in order to do their work. Two participants, who claimed they didn't have the educational background, cited many different ways of acclaiming the necessary skills. Many hold multiple degrees and certifications. In looking over the pattern of their answers, one can see the eclecticism of their responses.

While the questionnaire was originally set up in a breakdown fashion of therapies that build on each other (see Chart 1), it was obvious that, other than one or two respondents, there was no set pattern that was emerging. Therapists with a great deal of different training were more apt to use more and varied techniques and appeared to be more mindful and expressive of their motives. Therapists with minimal orientation used simple, modest, effective techniques. Transpersonal therapists were giving cognitive answers, and behavioural therapists were cluing into more energy based approaches. Therapists with the same training background were not showing any influential patterns. It appears that their belief and voicing of the fact that each individual client needs to be assessed and followed in their own unique fashion certainly rings true here at some level. Many times the pattern of thinking and responding did not match the original orientation. While the response sometimes appeared to come from a basic training pattern, the actual deference to a certain agenda was not in evidence. My original thinking that therapists are oriented according to their own inner consciousness was being shattered and replaced with the understanding that we all have individual processes, understanding from experiences, and need allowance for individual internalization of ideas. While therapies can be labelled and boxed into parameters, therapists can not. Each individual reacts, knows, understands, and acts from self based knowledge and experience.

This researcher hopes that all who have taken the time to complete this questionnaire will come out enriched in some way. Perhaps, having read the many different modes of working therapeutically, and being allowed the opportunity to give some thought to their own actions, they will come away with a new found sense of discovery and continue to honour their eclecticism and allow it to carry them forward in their work.

Some of their closing comments included:

"I see dissociation on a continuum as both a way of organizing information and as a process that is employed by most human beings (if not all)."

"risky to use hypnosis to encourage memory retrieval and to allow abreaction and encourage action/reaction. Don't allow patients with DID to re-enact memories or identify with their experiences. Clients need safe boundaries."

"While personality integration may be an important step, some clients want only symptom relief. By embracing healthy realistic beliefs and attitudes one is able to resolve inner conflicts neglects unconscious conflict. Harmonious personality is not always the goal to reach for-it could be an over ambitious goal."

CONCLUSION

While the original vision for this study was to show that psychosynthesis, a Transpersonal Psychology, was a viable alternative and perhaps one of the best options, for working with clients that are dissociative and, while the questionnaire was set up in such a way as to differentiate the different modes of therapy, the final results were difficult to fit into this mold. It was found, by this researcher, that the respondents in this study had very diversified backgrounds and, while continuing to include many more therapeutic techniques into their repertory than their original training, showed how eclectic a therapist working with clients who are dissociative can, and perhaps should, be. Dissociation can be very difficult to diagnose, and even more difficult to work with without the proper training. Psychosynthesis therapists relate back to their belief that we are all in a state of perfection and just finding our way back to that perfect state and do not refer to dissociation as a pathological state. The respondents that showed a background of Psychosynthesis did not use the DSM IV diagnosis to fit their patients into. They showed more awareness of the idea of the transpersonal, or beyond the sense realm, and used the term 'super conscious' to refer to the state of being that is perfection, and which guides us to that state.

When looking at actual therapeutic techniques that therapists use, the 10 most chosen from a list of 48 were:

"I keep aware of my feelings and the reactions of my clients" (96%)
and
"I make sure my client is grounded enough to leave my office before allowing them to leave" (91%)

which amplifies and affirms the two most important attributes of a good therapist: that of being present, conscious and alert and that of making sure that the client is safe. It was obvious that none of the therapist respondents felt the need to use hypnosis, even though many of them had this initial training, and some even discouraged its use for memory retrieval. They also did not

encourage abreaction, for fear of retraumatization, and preferred to be present to whatever presented and to set firm boundaries which lead to self realization, acceptance and actualization into whoever they are meant to be. Creating a safe container, for the client, in which to do their work came forward many times, as well as supporting adaptive dependency and adaptive autonomy. Fostering a sense of centred self seemed to be very important to keep in mind, as well as helping client to take a step towards personality integration, although the majority of therapists made a point to say that integration is not the main focus of therapy. While some of the therapists showed that they had some training in the Energy Psychologies, very few were actually aware, at the level of intuition, of the energy fields around them at the time of the therapeutic relationship. While a wide margin of the respondents had some form of transpersonal training, many were not aware of, or did not respond to the questions on the Higher Self or Higher Conscious or Soul Realization. The main thrust of focus seemed to be on the concrete, on the actual 'can do' forms of therapy, rather than on the abstract. The adage "process over product" certainly rings true in this situation and these therapists have certainly reached a level of proficiency in using many, varied therapeutic techniques.

Personal Reflection

I found that the most difficult part of this research was in reaching those therapists working in the field, and helping them to feel safe enough to answer the questionnaire. We are currently in a societal time where people in the healing professions are being held accountable for their actions to a degree that stifles creativity and openness. The fear of being sued by clients has multiplied and Insurance companies have taken advantage of this. Universities have set up Internal Review Boards to make sure that all research material is not hazardous to the health and well being of its participants. What I interpret as 'over precaution' has prevented this study from reaching out to more, and very experienced therapists in this field. While I tried to manoeuvre, and over extend, and even tried to fit into the mold, I found this very difficult and, eventually, was unable to meet

their requirements and had to let go of my initial wish. While I feel that I have gleaned much information, and look forward to my work as a therapist working with dissociative, as well as many other forms of clientele, I hope that I can continue to hold my 'dream of helping others' out in front of me and do not eventually succumb to the fears of society. As a therapist I hope I always remember the lessons of this study and continue to more forward with curiosity and the eagerness and creativity needed to make this work a craft of art.

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