FOR REFERENCE
Do Not Take From This Room
PRE-VERBAL TRAUMA, DISSOCIATION AND THE HEALING PROCESS

A DISSERTATION

submitted by

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In loving memory of
Sant Ajaib Singh, I dedicate this
journey of discovery
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PRE-VERBAL TRAUMA, DISSOCIATION AND THE HEALING PROCESS

Dorothy Dreier Scotten

ABSTRACT

This qualitative research study examines some of the ways in which the healing process takes place in adults who have experienced dissociation, and who have most likely been psychologically traumatized before full language development. The impact of early trauma on human cognitive, socio-emotional, and spiritual development are explored within the context of participant narratives in order to develop an understanding of what may be helpful in developing effective teaching strategies for clinical and teacher education.

In-depth interviews were conducted with four adult persons who had been diagnosed with Dissociative Identity Disorder. All had histories of infant psychological trauma and all had undergone their own recovery process. Qualitative methodology used included autoethnography, heuristic inquiry, phenomenology and grounded theory.

A cross-case analysis of the four study participants yielded themes of recursivity, social change, metaphor and cognitive restructuring. The undergirding of participant healing process was the expression that their healing was a soul-centered activity and was also a cognitive act that helped to break the cycle of their dissociative thinking processes. Participants said that they needed to engage in both activities to become integrated persons.

Implications for clinical and teacher training bore witness to these underlying dissociative processes by yielding a teaching technique that would help dissociative
persons learn in a more integrated associative way. This method, called Sensate teaching, is based on the application of metaphor wherein both subjective and objective experience are used as an aid to concretize and internalize learning.

Issues for further inquiry and exploratory research included considering: 1) the concept of dissociation and its cross-disciplinary and cross-cultural implications; 2) pre-verbal issues, dissociation and the attenuation of a culture of violence in schools and society; 3) the need for an integrated curriculum that brings together the ‘heart and head’; and 4), the question of identity and transference for the teacher-trainee —its importance in educational settings.
# TABLE OF CONTENTS

## PART ONE: INTRODUCTION

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Outline of Dissertation</td>
<td>8</td>
</tr>
<tr>
<td>II. Personal Statement</td>
<td>11</td>
</tr>
<tr>
<td>III. Statement of the Problem and the Research Question</td>
<td>12</td>
</tr>
<tr>
<td>1. Statement of the Question</td>
<td>12</td>
</tr>
<tr>
<td>2. Placing the Question in Context</td>
<td>12</td>
</tr>
<tr>
<td>3. Methodology Introduced</td>
<td>12</td>
</tr>
<tr>
<td>4. Purpose of this Study</td>
<td>15</td>
</tr>
<tr>
<td>IV. Presuppositions</td>
<td>16</td>
</tr>
</tbody>
</table>

## PART TWO: A REVIEW OF THE LITERATURE

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Underlying Theories and Assumptions</td>
<td>19</td>
</tr>
<tr>
<td>II. Developmental and Trauma Literature</td>
<td>19</td>
</tr>
<tr>
<td>1. Normal Language Development</td>
<td>19</td>
</tr>
<tr>
<td>2. Theories of Language Development</td>
<td>21</td>
</tr>
<tr>
<td>3. Conclusions: Language Development</td>
<td>25</td>
</tr>
<tr>
<td>4. Normal Cognitive and Socio-emotional Development</td>
<td>26</td>
</tr>
<tr>
<td>5. Psychological Trauma</td>
<td>34</td>
</tr>
<tr>
<td>a. Trauma Theories</td>
<td>35</td>
</tr>
<tr>
<td>b. The Effect of Infant Trauma on Early Language Development</td>
<td>37</td>
</tr>
<tr>
<td>6. Conclusions/Questions for Discussion</td>
<td>42</td>
</tr>
<tr>
<td>7. Indications for Further Study</td>
<td>44</td>
</tr>
<tr>
<td>III. Dissociation: An Overview</td>
<td>45</td>
</tr>
<tr>
<td>1. Introduction</td>
<td>45</td>
</tr>
<tr>
<td>2. Definition of Dissociation and Dissociative Disorders</td>
<td>45</td>
</tr>
<tr>
<td>3. History of Dissociation</td>
<td>50</td>
</tr>
<tr>
<td>4. Current Research</td>
<td>61</td>
</tr>
<tr>
<td>a. Advancement in the Field of Dissociation</td>
<td>61</td>
</tr>
<tr>
<td>b. The Evolution of Treatment</td>
<td>62</td>
</tr>
<tr>
<td>(1) The First Generation</td>
<td>62</td>
</tr>
<tr>
<td>(2) The Second Generation</td>
<td>63</td>
</tr>
<tr>
<td>(3) The Third Generation</td>
<td>64</td>
</tr>
<tr>
<td>5. Current Treatment Models</td>
<td>65</td>
</tr>
<tr>
<td>a. Hypnotherapy</td>
<td>66</td>
</tr>
<tr>
<td>b. Psychodynamic Therapy</td>
<td>68</td>
</tr>
<tr>
<td>c. Ego-State Therapy</td>
<td>69</td>
</tr>
<tr>
<td>d. Family Systems Therapy</td>
<td>70</td>
</tr>
<tr>
<td>e. Cognitive Restructuring</td>
<td>73</td>
</tr>
<tr>
<td>f. EMDR</td>
<td>73</td>
</tr>
</tbody>
</table>
PART THREE: METHOD AND FINDINGS

I. Introduction 117
II. Research Design and Methods 117
III. Precedents for Methodology and Research Design 130
IV. Pilot Autoethnographic Study
   Researcher’s Process: Healing Through the Arts 131
      1. Introductory Remarks 131
      2. Treatment 137
      3. Concluding Remarks 155
V. Participant Choice 157
   1. Criteria 157
   2. The Interview Guide as Basis For Thematic Exploration 157
   3. Procedure 159
   4. Participants 160
VI. Identification of Emergent Themes 163
VII. Findings 164
   1. Categories and Participant Expressions and Emergent Themes 164
      a. Pre-Verbal Experience 164
      b. Experience of Dissociation 169
      c. Experience Before Recovery 173
      d. Participants’ Definition of Healing/Integration/Recovery 178
      e. Breakthroughs/Landmarks in Recovery 180
      f. Experience After Recovery 184
      g. Experience of What Was Helpful in the Healing Process 190
      h. Future Projections 223
   2. Synthesis 226

PART FOUR: CONCLUSIONS

I. Introduction 229
II. Dialogue With Presuppositions and Pilot Study 229
III. Dialogue With The Literature Review 237
IV. Dialogue With The Methodology 248
V. Theory Gathered From The Data 251
   1. Sensate Teaching 256
VI. Issues For Further Study 260
VII. Reflection 262

APPENDIX 265

A. Preliminary Query Letter 265
B. Consent Form 267
C. Interview Guide 269

BIBLIOGRAPHY 271
PART ONE: INTRODUCTION

Outline of Dissertation

In my effort to structure this dissertation within the parameters of an experiential methodology, I partially adapted an outline of another dissertation (Thayer, 1995) to support a more phenomenological mode of inquiry. To this end, I have divided the paper into four parts:

Part One, or the Introduction, focuses on introducing the study. This includes a definition of terms, a brief personal statement describing the origins of my interest, the statement of the problem and the research question. I then place the question in context and introduce the methodology and purpose of this study and my own presuppositions or assumptions.

Part Two, A Review of the Literature, surveys some of the prominent underlying assumptions and theories that exist in the professional literature. The review explores developmental language theory and trauma theory and continues with a summary discussion of dissociation, its origins and current clinical treatments available to persons diagnosed with a dissociative disorder (either DID or DDNOS). A review of some major Eastern and Western theorists and practitioners who view healing as a spiritual process follows, for one of my presuppositions considers that personal spiritual development is a natural consequence of healing as persons work through their own resultant traumatic psychological issues.

Part Three, Method and Findings, proffers a general history of autoethnography, phenomenology and heuristic methodology and grounded theory. This will outline the
particulars of the research methodology and the research findings. Included in this part is a description of my personal experiential narrative account of the healing process involved in dissociation that became the basis for choosing study participants. Following this, my choice of participants is explained in more detail. Experiential expressions and emergent themes elicited from the in-depth interviews are discussed. Part One will conclude with a reflective synthesis of these themes.

In Part Four, Conclusions, I revisit my own underlying assumptions or presuppositions and the central thoughts and themes from the literature review as well as from the practice of the research methodology. I then dialogue with the research findings, and discuss the implications and limitations for future research.

The Appendices include copies of the Query Letter, the Informed Consent form and the Interview Guide which were sent to each participant.

**Definition of Terms**

*Pre-verbal Trauma:* As used in this dissertation, the term, pre-verbal trauma refers to psychological trauma experienced in infancy prior to full language production.

*Dissociation and Dissociative Disorders:* A more detailed definition of dissociation will be found in Part Two within the review of the literature. Briefly, though, dissociation can be formally defined, according to the Chambers Dictionary (1993), in psychological terms as “the splitting off from consciousness of certain ideas and their accompanying emotions leading to fragmentation of the personality into independent identities” (p.488). This dissertation study focuses on dissociation as experienced through the nomenclature of a group of psychological disorders known as the Dissociative Disorders in the official American Psychiatric Association’s diagnostic
manual, *Diagnostic Criteria from DSM-I V* (1994). I specifically focus on two of these disorders: Dissociative Identity Disorder (DID) formerly known as Multiple Personality Disorder and Dissociative Disorder Not Otherwise Specified (DDNOS).

*Spirituality:* There have been numerous definitions for spirituality, both in Western and Eastern religious traditions. The conventional dictionary definitions of the term spiritual is as follows: The *Chambers Dictionary* (1993) defines spiritual as relating to spirit, to the higher faculties, or to the soul (p. 1664). The soul therein is defined as the “innermost being or nature”; the essential part of human nature, our essence or the “moving spirit” (p. 1468). I use the word spirituality in the context of this study to mean in a broader sense, the process of inner unfoldment or self-analysis which can lead to what Kirpal Singh (1990) and others have called self-knowledge and inner unity or transcendent unity (Adler, 1992; Jung, 1957, 1933; Becvar, 1997; Boadella, 1997; Borysenko, 1993; Khan, 1982; Lueger & Sheikh, 1989; Moore, 1992; Ramaswami & Sheikh, 1989a, 1989b; Scotten, 1981; Singh, K., 1990, 1980; Washburn, 1994; Vaughan, 1986).

*Healing:* The word healing in its generic sense means "getting better" or recovering from some malaise in either body or psyche. This study considers psychological healing as a soul-centered or spiritual activity as central to the process of recovery for those persons whose dissociative disturbances were the result of early trauma.
Personal Statement

My interest in this topic arose out of a series of personal and professional crises that prompted me to explore my own early psychological history to determine if that had any effect on some of my maladaptive adult behaviors. I had known that I as a child exhibited behaviors that bordered on autism—language difficulties, physical rocking back and forth, failures to make social contacts, etc. I thought that through my personal therapy and through my professional work as a clinical social worker that I had come to a certain resolution about my early life. I was wrong. At the suggestion of a colleague, I began to paint, draw, and sculpt my way into my unconscious in an attempt to bear witness to the angst of separation within myself. I discovered that throughout my life I had lived many segmented lives. I had devised a way of keeping an early trauma unconscious, so that as a young child I could survive.

This exploration has led to the examination of current theories of trauma, developmental psychology, the creative arts, adult learning, and Eastern and Western spirituality as applied to the process of dissociation. The rationale for such an examination is rooted in my professional observations of the dearth of information and understanding of the impact of early trauma on human cognitive, socio-emotional, and spiritual development. Without this basic understanding, it would seem highly improbable that care-givers and teachers could offer survivors of pre-verbal trauma effective modes of treatment and communication skills.

My own understanding has evolved through personal healing experiences of an eight-year duration which has been documented through diary notes and art-work of
various kinds. A chapter is devoted to this as an example of infant trauma resulting in dissociation. This presenting process will be analyzed through the contextual cues from the experience itself and by examining the existing literature on human development, psychological trauma, spirituality, and dissociation.

**Statement of the Problem and the Research Question**

**Statement of the Question**

A question has arisen as a result of my personal experiences: Was my experience of pre-verbal trauma and its subsequent healing a subjective interpretation or have other persons who have been traumatized early on gone through a similar healing process?

**Placing the Question in Context**

In order to discover the similarities or dissimilarities, I have interviewed four adult persons who have been diagnosed with either DID or DDNOS and who stated that they were traumatized in infancy and have undergone their own recovery process. By uncovering certain thematic components in the healing process, it was my intention to arrive at a hypothesis about the scope and dimensions of the healing process for those persons who have experienced dissociative disturbances. This was to be tested by further study in order to develop a curriculum for training social work clinicians and educators in the field of infant trauma.

**Methodology Introduced**

As I began to reflect on the research question, I knew that I needed to limit my focus on the participants' history or narratives that they chose to present. These narratives pertained to their experience of dissociation, the trauma that led to dissociation and to the material involved in their recovery or healing process. I wanted to not only
look at the data in an objective way, but I also wanted to be able to immerse myself in the participants’ experience — to understand their sense of lived experience. Consequently, there had to be some synthesis in my arrangement of the data that was both objective and subjective. I needed to know what I was feeling and thinking, to be clear about my own transference and also to be able to hear and understand their experience within the context of their own cognitive and socio-emotional awareness.

This is why it was necessary for me to use the autoethnographic method as part of my methodology as a basis for not only choosing the participants in my study but also to understand their lived experience apart from my own. This method involves studying one’s culture and oneself as part of a similar culture (Patton, 2002, p. 85). Dissociation was an inherent part of my particular “culture”, as defined by my subjective experience. Consequently, I felt that my own experience of dissociation and/or dissociative behavior certainly lends itself in a positive way towards establishing researcher parameters that support objective study of the phenomena associated with dissociation and the recovery process (research question).

The autoethnographic method was the starting point in ascertaining how I would continue with this study. This study, by its very nature is highly subjective, relying on the personal narratives of the participants. In order to understand their lived experience, I needed to broaden my research design to include methodology that supported experiential inquiry. I, therefore, chose to use phenomenological and heuristic research methods (Moustakas, 1990, 1994; Patton, 2002; Willig, 2001) to support the experiential component of the study and a design utilizing grounded theory (Moustakas, 1994; Strauss & Corbin, 1998; Seidman, 1993; Patton, 2002; Willig, 2001). As Part Three will offer a
more detailed discussion of these methods and research design, I will only briefly define these three methods here:

1. **Phenomenology** focuses on the content of consciousness and the individual’s experience of the world; the interpretative phenomenological analysis maintains a certain objectivity in its attempt to describe and document the lived experience and does not attempt to explain it (Willig, 2001, pp. 52, 64). According to Patton (2002), phenomenological methodology concerns itself with discovering the meaning, structure, and essence of an individual’s or a group’s lived experience (p. 104). What differentiates this approach from others is the notion that there is an essence or essences to shared experience. Those essences are the core meanings that are mutually understood through a phenomenon that is commonly experienced (p. 106).

2. **Heuristic inquiry**, according to Patton (2002) and Moustakas (1990, 1994), focuses on the essence of the lived experience as shared by both participant and researcher. Patton, explains that there are two distinguishing characteristics of this method: one in which the researcher must have personal experience of the phenomena under investigation which is a contextual reference point; and, two, the participants, otherwise known as co-researchers, must share the intensity of experiences with this phenomenon (p. 107).

3. **Grounded theory** examines data in an objective way; it is a concrete process versus the intuitive processing of heuristic methodology. It begins with basic description, moves to conceptual ordering and ends with theorizing or generating a theoretical construct—inuiting ideas or concepts (Willig, 2001; Patton, 2002). In this dissertation I incorporate the grounded theory methods of data analysis as explicated by
Strauss and Corbin (1998) who explain that it is a theory derived through this systematic gathering of data and analyzed through the research process (p. 12). The theory will emerge by itself from the data presented through thematic analysis of it content.

I have, therefore, chosen to work with four methodologies that I think are thoughtfully related in an interdisciplinary way, starting with personal researcher-narrative (autoethnography) and then moving to more phenomenological/heuristic methods that examine the lived subjective experience of the researcher and participants in two ways: descriptive analysis of core, essential experience that focuses on content and substantive and integrative analysis that involves a creative synthesis of the experiential essence. Thus, I shift from the personal to shared experience, and finally, after examining thematic apperceptions, ascertain if there are any linkages to my original questions by the emergence of a new theoretical construct.

**Purpose of This Study**

Although dissociation is not a new concept in the field of mental health, a review of the literature of both trauma and dissociation speaks little of the healing process as it evolves for adult persons who have been traumatized before full language production. My study examines some of the ways in which the healing process takes place in adults who have experienced dissociation, and who have most likely been psychologically traumatized before full language development.

In the broader spectrum of the behavioral sciences, many practitioners and thinkers of the Eastern and Western traditions have had questions as to what kind of process leads to deep psychological healing. In the West, for example, there have been four major models of psychotherapeutic intervention during this century according to

In the East, generally speaking, there are few therapeutic models; the models are based mostly on some ancient spiritual traditions such as described in the literature of the Hindu and Buddhist traditions.

In addition, it has been suggested by theorists in the expressive therapies field (Lorenzetti, 1994; Adler, 1992; Lewis, 1993; Arnheim, 1986; Politsky, 1995; Moreno, 1988, 1995)) that the creative arts are influential in the healing process. In terms of psychotherapeutic intervention, these researchers state that the arts can help people discover their own metaphors, or stories and access those feelings that have been locked within the psyche. The arts therapies can and should be used as a primary treatment mode just as any other type of therapeutic intervention. These practitioners also advocate that the arts should become an integral part of the training of mental health clinicians who need to be sensitive to their healing influence and to bring inner direction and focus to clients who may have a history of traumatic incidents in their lives.

It is my purpose within the scope of this dissertation, then, to draw from the personal and shared experience of dissociation and from the interdisciplinary professional literature in order to find a common ground to present an educational teaching method that will speak to the needs of those persons who have been traumatized before full language production.

**Presuppositions**

I approached this study with certain underlying presuppositions as a result of my own experience of dissociation and how I negotiated the healing process. I have tested these with the data derived from the research. They are as follows:
1. Psychological and spiritual development are a synonymous process. I did not separate psychological and spiritual experience in my own recovery; I found I could not experience one without the other.

2. Healing involves environmental connection, social connection, and interior connection to the Self. My healing was predicated on an understanding of my physical and biological environment, personal and shared experiences, and making a connection to my own inner world, or spiritual self. All of these ways of being-in-the-world overlapped and were intimately connected (as noted in previous research on an existentially based practice theory (Scotten, 1981).

3. Recovery from dissociative identity disturbances also involves:
   a. the use of metaphor as a way of opening up access to the imagination or imaginal realm; Because my trauma was pre-verbal, and I had poor language skills, I had an undeveloped imagination. I needed to learn how to access that.
   b. some kind of dynamic expression of the metaphor before a witness whether it be verbal or non-verbal; I used visual images to express what I could not verbalize. Words came later.
   c. establishing a corrective trusting relationship as the witness accepts unconditionally the metaphor in the context of the lived experience; I learned to trust another human being within the therapeutic relationship who was without judgment of the material that I brought to her.
   d. a movement towards a heightened awareness of the transcendental nature of this metaphor and how it relates to self-knowledge and how this self-knowledge becomes the real Self, as the lover and the loved; As I worked through the images, I was
able to learn how to distinguish between fact and fantasy, to discover a deeper meaning, and purpose to my life; the memories did not matter, but my internal separation and existential angst did.

e. surrender to what some would call God or the divine as the source of one’s being, one’s real identity or whole self, i.e. integration of all the dissociated aspects of the personality. For me, this concept of total surrender to the divine was the final integration of my person.

These suppositions, as stated, are the products of my own narrative concerning dissociation. To test these, in my study, I read the participants’ transcripts for common thematic content in an attempt to understand their lived experience of dissociation. I identify major experiential expressions and emergent experiential themes across the interviews and make a grouping of similar themes and expressions, and offer a synthesis of the findings. This is discussed in detail in Part Three, Methods and Findings. Finally, in Part Four, Conclusions, I bring this data all together and enter into a dialogue with my original Presuppositions which includes a reflection on their relationship to my own process, the Review of the Literature, and with my chosen methodology. I conclude with a discussion of the results and their implications for further research and training.
PART TWO: A REVIEW OF THE LITERATURE

Underlying Theories and Assumptions

The initial steps taken in a study of this kind involve a survey of some of the prominent underlying assumptions and theories which exist in the professional literature. This study will begin with an explanation of developmental language theory and trauma theory and continue with a summary discussion of dissociation, its origins and current clinical treatments available to persons diagnosed with a dissociative disorder (either DID or DDNOS). A review of some major Eastern and Western theorists and practitioners who view healing as a spiritual process will follow, for it is my assumption that a renewed interest in one’s personal spiritual development may be a natural consequence of healing as persons work through their own inner issues/traumata specific to dissociative disorders.

Developmental and Trauma Literature

The contiguous developmental and trauma literature which explores the etiology of psychological trauma in infancy from birth to age three and may predispose adults to arrested development will be discussed. Pre-verbal psychological trauma in the context used here may be defined as trauma incurred prior to full language acquisition. In order to understand more clearly the role of trauma within this developmental period, normal language, cognitive and socio-emotional development in infancy will be reviewed as well as contemporary trauma theories. In conclusion, this writer will examine some ponderable questions that remain after a review of this literature.

Normal Language Development

What is language? According to Santrock (1997) every human culture has a language. There are thousands of human languages throughout the world, and, we may
not understand all of them, yet there are certain characteristics which are common to all human language. Santrock defines language as "a system of symbols used to communicate with others" (p. 169), and he states that human language is characterized by the concept of infinite generativity and rule systems. Infinite generativity implies that language generates and regenerates itself ad-infinitum by its ability to make many different kinds of sentences using a finite set of words and rules. This, he asserts, makes language a highly creative enterprise (p. 169).

All human language is made up of a rule system which includes:

1. **phonology**, a study of a language's sound system;
2. **morphology**, a study of the rules for combining morphemes which are the smallest meaningful units in language;
3. **syntax**, a study of the ways in which words are combined to form sentences or complete phrases;
4. **semantics**, a study of the meanings of words and sentences;
5. **pragmatics**, which involves using appropriate conversation based on an underlying knowledge of the language in context. (Santrock, 169-172).

The question(s) that have been asked by linguists over the years regarding this rule system can be roughly broken down into two: Is this ability to generate a rule system of language a learned experience or are the rules a product of human biology and evolution?

There have been many researchers who have held divergent views on this matter of language development, but all would certainly agree that the seeds of language are sown in infancy. Observing language development on a world-wide scale, most researchers also agree that there are certain biological milestones in the infant's cognitive development that are true for everyone. According to Lenneberg (in Clark et al., 1985, pp. 74-77), the following milestones are typical in normal infant language development:
a. 12 weeks—less crying than at 8 weeks; cooing, squealing, gurgly sounds; sustained cooing, 15-20 seconds.
b. 16 weeks—responds to human sounds, turns head and eyes seem to search for speaker; occasionally some chuckling sounds.
c. 20 weeks—vowel-like cooing, interspersed with some consonant sounds; acoustically different vocalizations from mature language of environment.
d. 6 months—cooing changes to babbling, resembling one-syllable words; neither vowels nor consonants are very fixed; most common utterances sound like ma, mu, da, di.
e. 8 months—reduplication more frequent; intonation patterns become distinct; utterances can signal emphasis and emotions.
f. 10 months—vocalizations mixed—sound play—gurgling, bubble-blowing; imitates sounds, though never quite successful; beginning to differentiate between words heard, makes some adjustments.
g. 12 months—identifies sound sequences; words emerging—mama, dada; signs of understanding some words, simple commands.
h. 18 months—repertoire of words—more than 3, less than 50; babbling but now in several syllables, with a more intricate intonation pattern; words 'thank you', 'come here'; understanding increasing.
i. 24 months—vocabulary of more than 50 words; some two-word phrases and phrases of own creation; increase in communication and interest in language; not frustrated.
j. 30 months—fastest increase in vocabulary—new additions, and no babbling; frustrated if not understood; at least 2 or as many as 3-5 child-like sentences.
k. 3 years—1000 word vocabulary; grammatical complexity roughly that of colloquial adult language.
l. 4 years—language well-established; deviations from adult norms tend to be more in style than grammar.

Theories of Language Development

Lenneberg proposed a biological theory of language acquisition (in Santrock, 1997; and Dacey, 1996) in which he asserted that anatomical and physiological agents (internal factors) play a major part in language development. Language acquisition is a maturational process and there is a critical period at about 18 months and at puberty when a first language can be acquired. Lenneberg felt that language is learned rapidly in the
pre-school years as a result of maturation, and once one is past that period, it is difficult to regain language acuity and fluidity. He based his theory on studies of children who were raised without language (i.e. case of Genie, the "wild-child", who was found in California severely abused and deprived of environmental stimulation and language, at age 13. She learned simple commands and never learned how to ask questions, or to understand grammar).

Noam Chomsky (Santrock, 1997; Dacey, 1996; Bradley, 1989) held that babies are born with a Language Acquisition Device (LAD) in the brain. The brain is 'prewired' with the innate ability that enables the child to detect simple language rules such as syntax, phonology and semantics (Santrock, p.172).

Behaviorists, like Skinner (in Bradley, 1989) felt that language is a learned skill, reinforced and shaped by the environment: 'Verbal behavior is behavior that has been changed through the mediation of other persons' needs.' Verbal behavior in a newborn is equal to an unconditioned response. For some it is a function of varying amounts of deprivation and aversive stimulation: when crying is followed by parental attention, which is reinforcing, it becomes verbal (Bradley, p. 69).

Piaget (1954), a cognitive theorist, said that there are two major speech categories in the pre-operational child, ego-centric speech—the child doesn't care to whom he/she speaks (private speech), and socialized speech. Vygotsky(1962), felt that the true direction of thought and language is from social to individual, and Jerome Bruner (in Santrock, 1997) added the social interaction viewpoint, and offered his own theory, called the Language Acquisition Support System, which supported the notion of language being a growth of communication between adult and child—it is a joint achievement.
Bloom (1960, in Bradley, 1989) in a criticism of Chomsky, felt that one has to consider language in context, the context of children's utterances. The brain is not a computer. Chomsky's approach leans toward engineering and physiology more than it does towards interpretation of experience.

John Locke (1993) asserts that social interactionist aspects of language have been underplayed in explaining language development. Linguists, he said have concentrated on the structural aspects of language and not given adequate attention to it as a communicative device. In his book, *The Child's Path to Spoken Language*, Locke speaks about prenatal experience as an important pre-cursor of verbal language development. If the fetus is exposed to sound, there are neuro-developmental effects—there is selective development of the auditory cortex. The sound of the mother's voice as it carries in utero stimulates the cortex. He speaks about prosody and affect being the cortex's primary venue (that is, poetry and emotions). One might assume from Locke's statements that poetry could be the primary language. He exhorts researchers to approach the world in child's terms—how does the infant's learning mechanism develop? He feels that human beings have a strong neural specialization for spoken language. It is therefore necessary to study language from a baby's point of view—what is it like to be a baby? Babies usually pay attention to things people do while speaking. In a perceptual approach, there is a tendency to concentrate on sounds of speech, but speech sounds are related to visual cues. He cited the work of Gottlieb and Gilbert who suggested that hearing, auditory and vocal learning, motor activity, and their adaptation are equal learnings.

Steven Pinker (1994), in his book, *The Language Instinct*, might add to or complement Locke's theory. He said that infants come equipped with language skills.
They do not learn them by listening to parents' speech. He cites evidence of this in the sucking reflex, and he also speaks about the melodies of mother's speech that are carried through the body and are audible in the womb. He also asserts that brain circuitry is more plastic in childhood, and that language could be maturational, like teeth—the basic organization of grammar is wired into the brain, and the child's experience must include speech of other human beings, and cites the use of motherese as an important part of language development. The short babbling-like sentences that mothers speak to their infants often reassures them and have a certain melody about them that enables the child to feel more secure and to be able to recognize certain sounds.

Selma Fraiberg (1959) seemed to have added a dimension that does not appear in the literature on language development. She says: "Language originates in magic" (p. 112). She suggested that infants' first words were not words but "magical incantations". Language makes it possible for a child to incorporate parents' verbal prohibitions. By acquiring a verbal form of prohibition, the child can incorporate it and use it for self-control. She also felt that language plays an important role in the formation of conscience.

Roger Brown (1973, in Santrock, 1997) classifies children's language development in terms of the number of utterances and Friedlander (1970) speaks of language as a whole process of learning to listen. It is a dynamic process, he says, one that calls upon the highest capabilities a child can mobilize in adapting to challenges of external and internal environment. Receptive language functioning appears to involve processes and variables that lie at the very heart of the child's mental development—his/her successful adaptation to the world of things. He speaks about
auditory sensitivity in neonates, audio reinforcement, and the sucking reflex, and music and the discrimination of phonetic cues. He concludes by saying that speech is generative—open-ended, and that listening is reconstructive—processing the speech of others.

**Conclusions: Language Development**

As a result of reviewing the literature on normal language development in infancy, I did not find references to psychosocial/emotional factors that might impact on language development. Except for Selma Fraiberg, there was no mention of the uniqueness of expression that is inherent in each individual child as s/he enters the world of communicable dialogue. There are commonalities, milestones of language development that seem to surface cross-culturally, but when Fraiberg is referring to "magic", just what does she mean? Could it be that children have their own way of perceiving the world, and find their own language based on an inner experience that is uniquely theirs? One might proffer that if language theorists could perhaps develop more empirical data based on modern constructivist theory, one might begin to understand the importance of the inner life of the child and how this impacts on language development. The "constructivist perspective", according to Mahoney and Lyddon (1988, in McCann & Pearlman, 1990):

...is founded on the idea that humans actively created and construe their personal realities. The basic assertion of constructivism is that each individual creates his or her own representational model of the world. This experiential scaffolding of structural relations in turn becomes a framework from which the individual orders and assigns meaning to new experience. Central to the constructivist formulations is the idea that, rather than being a sort of template through which ongoing experience is filtered, the representational model actively creates and constrains new new experience and thus determines what the individual will perceive as "reality" (p. 14).
It would appear that Locke and Pinker might be embracing more of a constructivist approach as they examine language from the child’s point of view. They both seem to be looking at pre-natal development as well as early infancy in a more holistic way that incorporates the child’s biologic, social, and intra-psychic environment. It occurs to this writer that the inner world of the Self may need to be addressed in developmental terms. In terms of a research study of pre-verbal trauma, it would be interesting to explore environmental antecedents prior to birth, and, indeed the birthing process itself. If the fetus is that sensitive to sounds, there must be a linkage perhaps to other environmental nuances that may affect language development such as psycho-social/ emotional influences. In order to better understand the interaction between a child’s inner experience and the development of language, normal cognitive and socio-emotional development in infancy will be reviewed.

**Normal Cognitive and Socio-Emotional Development**

According to Crain (1992,2000), the two most influential stage theorists in the developmental literature are Jean Piaget and Erik Erickson. Piaget’s focus is on intellectual development, while Erikson speaks of maturation in terms of certain psycho-social tasks that need to be resolved in each stage of one’s life, beginning with birth. According to Erikson, each individual must go through all the life stages; the reason for this has to do with the forces that move the person from stage to stage: biological maturation and social expectations. Each stage has a certain timetable whether or not one has been successful in the earlier stages (p. 264).

Crain compares these two theorists in a general way by stating that Erikson is concerned with feelings and social forces that shape children and prepare them for
making life transitions. Piaget, on the other hand, says that children are motivated to grow by solving their problems cognitively; that is, if they have a problem that they cannot handle within their existing cognitive structures, they become challenged, curious and are then motivated to create new structures within themselves. The driving force here is curiosity, and if s/he is not concerned about another area or subject matter, the child may never reach the highest stage. So, in Piaget’s schema a child only goes through the stages to the extent that s/he is motivated to build new structures. Maturation and social pressures drive the child through Erikson’s stages whether they are ready or not (p. 265).

Erikson broadened Freud’s earlier psycho-sexual stages of development by departing from what he felt was too specific: i.e., Freud’s focus on body zones (Crain, 1992). He, instead replaced Freud’s specific stages, (i.e., Oral, Anal, Phallic [Oedipal], Latency, Genital) with his own general stages:

<table>
<thead>
<tr>
<th>AGE</th>
<th>FREUD’S STAGE</th>
<th>ERIKSON’S GENERAL STAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to one</td>
<td>Oral</td>
<td>Trust vs. Mistrust: Hope</td>
</tr>
<tr>
<td>One to three</td>
<td>Anal</td>
<td>Autonomy vs. Shame, Doubt: Will</td>
</tr>
<tr>
<td>Three to six</td>
<td>Phallic (Oedipal)</td>
<td>Initiative vs. Guilt:Purpose</td>
</tr>
<tr>
<td>Six to 11</td>
<td>Latency</td>
<td>Industry vs. Inferiority: Competence</td>
</tr>
<tr>
<td>Adolescence</td>
<td>Genital</td>
<td>Identity vs. Role Confusion: Fidelity</td>
</tr>
<tr>
<td>Young Adulthood</td>
<td></td>
<td>Intimacy vs. Isolation: Love</td>
</tr>
<tr>
<td>Middle Adulthood</td>
<td></td>
<td>Generativity vs. Self-Absorption,</td>
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<tr>
<td></td>
<td></td>
<td>Stagnation: Care</td>
</tr>
<tr>
<td>Old Age</td>
<td></td>
<td>Ego-Integrity vs. Despair: Wisdom</td>
</tr>
</tbody>
</table>

Crain (1992), p. 252

Consequently, Erikson expanded into his own theory which as stated above emphasized biological and social maturation. In the first stage, Trust (0-1), he and Piaget are both concerned with the infant’s secure object development. Erikson, however, speaks of the reliance on and dependability of people in the environment whereas Piaget focuses on the infant’s sense of permanent objects. But, in a sense, they are both
concerned with the child’s experience of stability (Crain, p. 265). For Erikson, if basic trust is not developed in the first year of life, the infant loses the sense of safety and begins her/his life in a state of psychological mistrust and instability, and s/he will be unable to make the successful maturational transitions that will permit social interactions.

It would seem to me that for Piaget, this represents a severe cognitive delay in the establishment of intellectual motivation, because, for the infant there is no sense of “permanent” things, an objective environment, that would challenge h/his curiosity.

In Erikson’s second stage, Autonomy (1-3), Erikson speaks of children developing more independence based on their knowledge that their caregivers will be there if needed. Piaget’s process is similar, though he deals with the permanency of objects: children begin to see that objects are permanent, so they can act independently of them. Crain cites the example of Piaget’s observation of his daughter at that age: when a ball rolled under the sofa, she knew that it was not in the spot where she last saw it. She knew that the ball was permanent though hidden and could now find alternative ways to find it again (p. 266).

L.S. Vygotsky, a Russian cognitive theorist (1896-1934), read Piaget and appreciated the importance of Piaget’s concepts, but felt that human beings could only be understood in the context of their social-historical environment. There is a “natural line”, he said, that emerges from within and the “social-historical line” that influences the child from without (Crain, p. 194). According to Crain, Vygotsky felt that children learn from inner maturational promptings, but these do not take them very far. In order to fully develop their minds, they need intellectual tools provided by their cultures. These tools may be in the form of language, memory aids, numerical systems, writing or scientific
concepts. The task is to understand how these tools are acquired. Vygotsky said that these are learned in social interactions with others: children speak in order to communicate; then they internalize their speech as they talk to themselves in order to plan and direct their behavior (Crain, p. 217).

In addition, Vygotsky said that children learn conceptual tools in social interactions in schools before they can use them on their own—He calls this phenomenon, *internalization of cultural tools*. According to Crain, he also suggested that we should study how intrinsic developmental and cultural forces interact and produce new transformations. There should be an understanding or study of what happens when opposing forces meet, because life is full of contradictions. For example, Piaget believes a child learns on his own whereas the environmentalists believe that s/he learns from others. Different theorists have different theories. Vygotsky emphasized the need for a growing child to figure out what to do when s/he has to interact, for example, with an adult who is trying to teach her/him something. These interactions are very complex and need to be viewed with scrutiny. Vygotsky, according to Crain, was not able to develop his theory further as his life was cut short; he gave us an idea of how children internalize their culture, but was unable to offer a solution as to how a child might challenge or criticize the culture (Crain, pp. 217-218).

Another developmental theorist offered an additional viewpoint of infant intra-psychic development. Margaret Mahler, a psychoanalyst in the mid-twentieth century, has linked her observation of young children with psychoanalytic theory, in order to create a more innovative elaboration of earlier Freudian developmental theory. She used as her laboratory a nursery school and made detailed observations of young children from
birth to age four. From these observations, she proposed that there are three phases of early development, leading the child at about age four to establish a sense of identity, or object constancy. These stages are: [1] autistic; [2] symbiotic; [3] separation-individuation (Blanck & Blanck, 1974, p. 53).

Blanck and Blanck said that Mahler concluded from her observations that from birth on there begins a complex and multi-faceted circular developmental process (p. 54). The first weeks of life are spent in “a state of primitive hallucinatory disorientation, in which need satisfaction belongs to his (the neonate’s) own omnipotent, autistic orbit” (Mahler, 1968, p. 7-8). The goal here is homeostasis, and the infant has no sense of relationship to objects. Shortly after this the infant is unable to distinguish her/his own tensions/stress from mother and then starts to separate pleasure and painful experience. Some time during the second month, the child moves from autism to symbiosis which begins when the infant becomes aware of a “need-satisfying” object, i.e. mother (Blanck & Blanck, p. 54). Mahler (1968) says that “the essential feature of symbiosis is hallucinatory or delusional, somatopsychic omnipotent fusion with the representation of the mother, and, in particular, the delusion of a common boundary of the two actually and physically separate individuals” (p. 9).

According to Mahler, in the third month of life, infants go through two parts of a phase which Freud calls primary narcissism, but which she refers to as autism and symbiosis. Central to Mahler’s theory is that optimal symbiotic gratification is essential to healthy development. Some infants and some mothers are unable to attend to this union; if the symbiotic deprivation is profound, there may be regression to autism or a symbiotic psychosis may occur. With adequate symbiotic experience, she says, ego
maturation advances and the foundation for the building of a body-image is laid. The infant is now able to establish a fundamental capacity to negotiate between the inner and outer reality as perception becomes active: “The ego is molded under the impact of reality, on the one hand, and of the instinctual drives, on the other.” (Blanck & Blanck, p. 55; Mahler, pp. 10-11)

The symbiotic experience sets the stage for the next phase of development which is separation-individuation. For Mahler, failure to achieve object constancy in the process of separation-individuation is the core problem in borderline pathology in adults. With optimal symbiosis, differentiation, the first sub-phase of separation-individuation, takes place. The infant starts to explore her/his environment through locomotion. From 10 to 16 months, the infant enters the next phase, of practicing, in which there is further exploration and a mutual “cueing” between mother and child. Mother now conveys a “mirroring frame of reference”. There is now the shift from the symbiotic order to a more autonomous functioning. At 18 months there is a gradual internalization through ego identification. Rapprochement is the final sub-phase, during the second 18 months in which the child begins to verbally communicate. There is more autonomous functioning, and the emergence of representational thought. The child is more aware of the mother and now actively seeks her. Thus, the preceding phase is now replaced by a more active approach behavior. If mother rebuffs the child during this phase, Mahler asserts that this can sow the seeds for depression in later life. Finally, if the symbiotic and the subsequent sub-phases of separation-individuation are successfully experienced, the child reaches the point of true identity, that of differentiation between the self and object representations,
and the capacity to internalize the object representations independent of the state of need. Maturation then proceeds in a routine fashion (Blanck & Blanck, p. 57-59).

Daniel Stern (1985, 2000), in his study of pre-verbal infants, has made the assumption that some senses of self exist prior to self-awareness and language. Therefore, he says, they may exist in pre-verbal form, yet these senses have been relatively neglected in developmental research:

And that is exactly what we wish to study. Accordingly, it must be asked, what kind of a sense of self might exist in a preverbal infant? By “sense” I mean simple (non-self-reflexive) awareness. We are speaking at the level of direct experience, not concept. By “of self” I mean an invariant pattern of awarenesses that arise only on the occasion of the infant’s actions or mental processes. An invariant pattern of awareness is a form of organization. It is the organizing subjective experience of whatever it is that will later be verbally referenced as the “self.” This organizing subjective experience is the preverbal, existential counterpart of the objectifiable, self-reflective, verbalizing self.

(Stern, p. 7)

Stern suggests that theorists who have subscribed to the stage theory of human development have failed to realize the importance of the relatively organized subjective experience of the infant. Observations of infants is not the only source of information about the intrapsychic experience of infants; theorists must study adults also:

This infant is the joint creation of two people, the adult who grew up to become a psychiatric patient and the therapist who has a theory about infant experience. This recreated infant is made up of memories, present reenactments in the transference, and theoretically guided interpretations. I call this creation, the clinical infant, to be distinguished from the observed infant, whose behavior is observed at the very time of its occurrence. Both of these approaches are indispensable for the present task of thinking about the development of the infant’s sense of self. The clinical infant breathes subjective life into the observed infant, while the observed infant points towards the general theories upon which one can build the inferred subjective life of the clinical infant.

(Stern, p. 14)
Stern describes the developmental progression of the sense of self as the primary organizing principal in the human lifespan. There are different senses of self, beginning with the emergent self from birth to two months. This stage distinguishes itself by being in the domain of “emergent relatedness” in which the infant’s integrative networks are forming, but are not ready to organize into a single subjective perspective. The infant, for example, engages in gazing, but cannot organize or internalize the objects of her/his gaze.

Concluding Remarks: Language and Socio-emotional Development

Major theories of infant language development and socio-emotional development have been briefly reviewed. Certain threads seem to be surface throughout the review: 1) the idea that both language and socio-emotional development may have its genesis in biologic maturation: Chomsky, Skinner and the Behaviorists, and perhaps, in a sense, Piaget with his focus on intellectual growth; 2) the idea that early development is a social phenomenon—Vygotsky, Bloom, Bruner: language is a social interaction, based on experience; emotional growth depends on social pressures (Erikson) and can only be understood in a social-historical cultural context (Vygotsky); 3) the idea that early development may depend on the inner, intra-psychic experience of the infant—that language may be viewed as a communication device from the baby’s point of view (Locke) or Selma Fraiberg’s assertion that language may be magic, implying that there is something special coming from inside the child; the psychoanalytic object relations tradition of Mahler who stressed the importance of the mother/child bond to avoid serious emotional delays.
If a child is emotionally traumatized during this critical developmental period of infancy, what happens in her/his later development? In order to understand the ramifications of such traumatization, a review of current trauma literature will be presented next.

**Psychological Trauma**

Psychological trauma has been defined by a number of writers in the field (Vankoneu, 1993; Herman, 1992; Terr, 1991; Van der Kolk, 1987; McDougal, 1978) as a mental result of a sudden external blow or of events that disorient and render persons helpless and unable to cope in an ordinary way with everyday life situations. It appears as if their defense mechanisms break down. These events may be so catastrophic that they overwhelm ordinary human adaptation and create disconnection and sometimes dissociative patterns that prevent persons from having normal social and work relationships. Through the developmental stages, persons literally split off from the original trauma but react to stress with the emotional intensity of the original trauma, often-times without a conscious awareness of their own history (Van de Kolk, 1987). If the trauma occurs in childhood, emotional and cognitive development can be so affected that the person carries a developmental lag into adulthood. If the trauma occurs prior to language acquisition, in infancy, the developmental deficiency may be so great as to cause adult behavior that manifests itself in constant projection/introjection, splitting, and hallucinations. The infant has no means of expressing her/his feelings save through early body movements, so as an adult, when stressed, s/he returns to the early traumatized infantile state and can only establish equilibrium through primitive defenses. That type of psychic suffering in infancy, at the pre-symbolic phase of development is virtually indistinguishable from physical suffering (McDougal, 1978).
Trauma Theories

A preliminary review of trauma literature reveals sparse information about the effects of psychological trauma on infant language development. Linda Share (1994) in her book, *If Someone Speaks, It Gets Lighter: Dreams and the Reconstruction of Infant Trauma*, reviews trauma literature in detail and notes that in classical psychoanalytic literature, the reconstruction of traumatic memories from the pre-verbal period are rarely written about. In her chapter on infant and childhood trauma, Share cited several theorists who had written about early trauma. Kris (1956), she said, felt that the nature of psychic trauma involved either shock (a series of blows) or strain which is cumulative as it involves an accumulation of tensions (Kris, 1956, in Share, p. 42). Strain trauma becomes a way of life within a family, as in an on-going sexual abuse situation. Phyllis Greenacre (1949), Share reported, focused on pre-genital traumas as a product of overstimulation, while William Murphy (1958), suggested that sensory perception had something to do with trauma: 'sensory and affective perceptions are focal points around which many traumatic experiences may be telescoped and condensed (Murphy, in Share, 1994, p. 46).

Share continued her review by citing Masud Khan's (1964) view of trauma as cumulative: he suggests that the mother is the organizer of a protective shield which acts as an 'auxiliary ego' for the helpless infant. The shield's purpose is to protect the child, so that anything that might hurt the child shifts to the mother. Cumulative trauma emerges when there are breaks in the mother's shield, and the mother's unconscious is passed on to the child.

According to Share, Michael Balint (1969) coined the word "traumatogenic object" as he emphasized the close and intimate relationship between the traumatized child and the perpetrator. The "traumatogenic objects" were the perpetrators. Michael Forman (1984) said that the fixation derived from traumatic experiences is the source of pathology in later character neurosis, and Sandor Ferenczi, and W. R. D. Fairborn suggested that there is a need for a child to protect the parent object (in Share, p. 50).
Bernard Bail and Annie Reiner (1993), Share reports, in their discussion of strain trauma and the development of the body ego, suggest that the child gives up her/his mind if s/he is not seen or understood by the parents. Thus, the child suffers a psychological death (Ibid.).

Share cites various theorists who postulate various consequences of psychic trauma. Khan (1964) felt that there were three significant effects of cumulative trauma on ego functions and ego integration: 1) Precocious ego development wherein there are only certain parts of the personality that function, so the personality is prematurely developed; 2) There is inadequate development and differentiation of the self instead of a unified personality. It is here that dissociations emerge and genuine love does not develop; 3) There is intensive involvement in both an internal fantasy world and in an external world. Disturbances here are in relation to bodily self-development, and the need for stimulation is chronic (in Share, p. 52).

Fodor (1949, 1957) viewed life as a continuity that does not begin with birth but is 'split' by birth, resulting in prenatal amnesia. So birth represents a change from one life to another. If there are any traumatic disruptions that accompany birth, a child might begin life with a neurosis (in Share, p. 89). Otto Rank (1926) also emphasized the fact that the birthing process in and of itself is traumatic, and children constantly struggle with this in their lifespan development (in Share, p. 88).

Incest, also has been found to be a major contribution to early trauma. In their article, The shattered self—A psychoanalytic study of trauma, Ulman and Brothers (1988), review the literature of trauma and speak explicitly about incest as a traumatic event because "the unconscious meaning of incestuous experiences shatters central organizing fantasies of self in relation to self-object that cannot be fully restored." (p. 65)

Christine Courtois (1988) has challenged the traditional trauma theories, and has called for a feminist focus as she asserts that there is a 'woman's reality'. This perspective emphasizes subjective knowledge of the individual and seeks to validate women's
experience (in a man's world). When she speaks of trauma related to incest, she says that a victim's experience is central and must be accepted and validated. Feminism offers, she says, a conceptualization of symptom-formation as a creative adaptation to highly negative circumstances rather than pathology. Symptoms are viewed as survival skills that allow victims to cope with the trauma and its aftermath (p. 119). She also cites Figley's (1985) traumatic stress or victimization theory that defines trauma as "an emotional state, a discomfort and stress resulting from memories of an extraordinary catastrophic experience which shattered the survivor's sense of invulnerability to harm." (Courtois, p. 120) Courtois also notes that child abuse trauma is very rarely mentioned in developmental literature, although it is well documented that trauma can cause severe developmental problems relating to self-esteem and identity formation.

Judith Herman (1992), seems to reinforce this when she says that a "secure sense of connection with caring people is the foundation for personality development." (p. 52) When that connection is shattered, the traumatized person loses a sense of self. Trauma survivors experience a numbing, a freeze in their personality structure and are often in a state of constant hyperarousal and fixation.

**The Effect of Infant Trauma on Early Language Development**

Major theories of early language development and trauma theories have been discussed. Most language theorists agreed that the seeds of language are sown in infancy. Santrock felt that language is a creative enterprise and is characterized by infinite generativity and a rule system. Lenneberg and others suggested that language was a maturational process and that there is a critical period in language development at 18 months of age, after which it is difficult to learn semantic language with proficiency. Chomsky emphasized physiology and genetic engineering in language development by asserting that the brain is pre-wired for language. Behaviorists such as Skinner said that language is a learned skill which is reinforced and shaped by the environment, while Bruner, in his social-interaction theory stated that language is a joint achievement by
child and parent working together. Friedlander felt that language is a whole process of learning to listen, and it is this receptive process that is the heart of a child's mental development. John Locke seems to be the first theorist to query about the emotional aspect of language development, when he speaks about pre-natal experience as an important precursor of verbal language development—what does the baby hear, how does the baby feel? —What really does go on inside the baby? Another contemporary linguist, Pinker, reiterates earlier statements about infants coming equipped with language skills and feels that there is a maturational timetable. Selma Fraiberg enters another variable in linguistic query as she implies that children are filled with linguistic incantations that are magical by its very nature.

In terms of trauma theory, we have seen that most trauma theorists concur that if there is a childhood trauma, emotional and cognitive development can be affected, and this, in turn, can be carried over into adulthood. Share’s notations that the reconstruction of traumatic memories from the pre-verbal period are very rarely written about clearly articulate a problematic review of linguistic research as it relates to trauma theory in infancy. Share says that some of the basic theoretical understandings of trauma include the suggestion that the nature of psychic trauma is shock or strain, and that trauma involves dramatic changes in sensory perception. Trauma is also cumulative. When the mother cannot protect the child, the child retains the memory and the traumatic memory becomes a fixation in the child’s developing personality structure. Share also suggests from her review of the literature that there might be grave consequences of psychic trauma, such as premature personality development or dissociated states or lack of bodily self-development. Other trauma theorists spoke directly about incest trauma and the resultant disturbed sense of self and identity problems that they have encountered in adult clinical cases.

There was little, if any, literature describing the influence of psychic trauma on language development in infancy. There were some researchers who implied that socio-
emotional issues may be important. McArthur, and Adamson (1996), in examining joint attention in preverbal children, underscored the importance of interaction between children and caregivers for the emergence of conventional language. They said there is a period of joint attention during which time infants begin to allocate attention to both objects and social partners at about nine or ten months of age. This continues for several more months and precedes the transition to symbolic commands (p. 482). Fajardo (1987) expressed concern for the developmental outcome and quality of life for premature infants raised in a stressful environment, and suggested that verbal stimulation is important in language development. Van der Kolk and Fisler (1995) speak about sensori-motor organization of traumatic experience referring to research observations that show that trauma is organized in memory on sensori-motor and affective levels. They report client descriptions of traumatic experiences that are initially organized without semantic representations (p. 513). One might conclude by these observations the possibility of trauma occurring before speech, and the body is used to represent the resulting affect because there are no words.

John Nelson (1994) speaks of neurological development and its effect on cognitive processes and the possibility of predisposition to affective disorders and learning disorders should there be traumatic interference. He says as the fetus develops, the brain centers are sensitive on a deep level. At birth, the chemical ACTH is released by the pituitary gland which signals the adrenaline system to release adrenaline into the system--this activates the body's defense system. The ACTH and adrenaline have an immediate effect on the brain as it stimulates it to produce large amounts of proteins vital to learning. These hormones, he says, promotes the growth of new synapses that link neurons, and in a way, this organizes the brain to survive birth and subsequent life in the world (p. 176). The hours of labor enervate the pathways that will shape a person's experience throughout life. Imprinting takes place, which is a kind of rapid learning that establishes social attachments early in life. Nelson refers to Grof's work when he then
suggests that traumas specific to this birthing stage may predispose a person to psychosis or severe emotional disorders (p. 177). One might wonder about how a paucity of those proteins that are vital to learning might effect early language development as well?

John Locke (1993) seems to think that, for the most part, infants’ sound-making movements for most of the first year of life are relatively unaffected by "potentially distinguishing ambient experiences" (p. 179). Babbling, he says, are "primitive actions of the vocal tract articulators". He continues by proclaiming that the gestures of babbling are so "robust" that they survive retardation, neonatal brain damage and congenital deafness. He also stresses that babbling is important for the acquisition of spoken language, and it can be play (p.179). He suggests that play may stimulate the brain, and babbling as play helps the brain to mature, and uses as examples sick animals who cannot play, and says that their brain develops more slowly. Locke associates delayed babbling with delayed language in children: a persistently sick or hungry child is unlikely to babble often, and ultimately finds h/her self in linguistic trouble (p.213). In addition to helping the brain to mature, babbling is important for speech in other ways, according to Locke: infants who babble tend to have more parental attention, and those who babble freely may be playing and much more free of fear. One might wonder here—if an infant is psychologically traumatized, and his/her imagination blunted (according to trauma theory), can h/she play, make sounds? Locke seems to indicate that if something interferes with babbling, or the infant cannot play with his/her sounds, language acquisition will be delayed. He doesn't really speak about what those interferences might be, or about emotional trauma except to allude to the importance of sociability and bonding with the parental figures.

Only very brief direct references were found in the literature describing the effect of psychological trauma on infant language acquisition. Harrison (1971) cited the case of a 20-month old child who had had a cranial nerve paralysis as a result of an accident. Her mother felt responsible for the injury, and her mother also had multiple sclerosis.
One year after the accident when the mother had to start using crutches, the child became almost catatonic and lay on her mother's chest. The girl was then 2 1/2 and lost her language. Harrison related this loss to her physical trauma and to the possible internal feeling of fear of abandonment by mother, due to her illness, and quite possibly introjected feelings of mother's guilt.

In her article, *Why social interaction makes a difference: Insights from abused toddlers*, Susan Braunwald (1983) speaks about how experiential input to language acquisition may relate to the process of making the transition from prelinguistic to linguistic communication (p. 237). From her observations of two abused children in a therapeutic daycare unit and her subsequent clinical and language interventions, she contrasted these children's language development to those children with normal language development. Both of these children were severely emotionally traumatized in early infancy and both of them had severe language problems, and no adequate parental support/caregivers. Braunwald's task, as she saw it, was to work with them with language in a supportive environment in order to create a more solid matrix of social experiences which would help them learn symbolic communication. She noted that one of the boys did not develop a language structure until he had achieved a certain level of psychological functioning (p. 257). She also noted that in order for him to do that, it was critical for him to have supportive caregivers with whom he could communicate.

It is important to mention here that Braunwald made the assumption that both of these children were emotionally and physically abused prior to language acquisition, and that she felt those early traumatic experiences resulted in their subsequent language delays. She also emphasized the need to continue to study the effects of abuse on infants' language learning, but is unclear as to how to do it, without further traumatizing the infants. She, instead, chose to do two case studies to illustrate her point, and to work with these youngsters to help them learn to communicate.
Conclusion/Questions for Discussion

The first question that needs to be asked here is: Why is there such a dearth of literature on the subject matter of infant trauma and language acquisition? In the above review of both language and trauma theories, certain assumptions have been made about abused children: that, of course, their language will be delayed, but those children are usually identified after age three.

There does not seem to be a thread that links trauma and language delay, so the next question is how might such a literature be developed? Once confidentiality issues were resolved, researchers might be given access to the Department of Welfare and/or the Department of Social Services' records of substantiated sexual assault and abuse reports of children under age two.

Perhaps another means of identifying the population would be clinical case studies of both older children and adults who are in treatment. One way of doing this is for researchers to increase their own psychological understanding of the impact of trauma by working with personal transference issues, including somatic countertransferences as Penny Lewis (1984) suggests: when the therapist "embodies" her/his client's trauma. The therapist becomes the empty vessel, and through this "taking-in" of the trauma can help the client by mirroring in movement what had been repressed in the body's cells, remembering that there were no other ways that an infant could express her/himself except non-verbally. So, movement might be an intermediate language that can be used in the identification process, along with other non-verbal modalities, such as art—painting, sculpting, or making music.

Along with this question of identifying a population for further study, researchers need to find some way of looking at the "unsaid", "unseen", part of language development presented by the individual child, including the social, emotional, and spiritual aspects of the child's life. Just what is the "magic" that Fraiberg talks about? What would happen if a child is so traumatized that language becomes fundamentally
associated with pain and terror? Is that Black Magic? Would the child be afraid to speak, afraid of the danger of language?

Locke asserted that we needed to start looking at language from the child's point of view. Braumwald, by her case studies, has taken a closer look at what can happen when a child is abused. There appear to be problems with language acquisition. She doesn't really define what they are, except to say that there are processing problems and psychological deficits that need to be attended to before full speech takes place. In fact, she says, there has to be a social environment with adequate care-giving. Bruner emphasized that also. Chomsky spoke about the physiological aspects of language, that the child is biologically pre-wired for language, and Nelson wrote about neurological maturation, and spiritual and emotional influences on the child's physiology of speech.

An area that appears to be missing from this research is the use of imagination. Dissociation seems to be a central defense for those persons who have been traumatized. Parts of the psyche are split and fragmented. Is this fragmentation carried over into speech, and following that, does something happen to the thinking processes that precludes the development of imagination? According to language theory, imagination begins with the development of language. An examination of trauma theory tells us that people who have been traumatized not only have blunted affect, but also a lack of imagination. If the trauma has occurred prior to language acquisition and the early defense mechanisms are not built up, there is a major assault on the inner life of the child before the development of more sophisticated and healthy defenses. So if the child is so traumatized that s/he cannot speak, how can s/he possibly use the imagination in a conscious way to build up the ego defenses?
Indications For Further Study

It would appear that presently there are no adequate designs to study the question of the relationship of pre-verbal trauma to the acquisition of language. I believe that such a study must include the following components:

1. Population identification—perhaps drawn from two populations, children under three, and adults. The first group of children under three would include children who have been identified by DSS (Department of Social Services) as having had severe psychological trauma and a control group of other children under three who have had no trauma history. The second population would include adults who had been traumatized before three and a control group with no trauma history before three.

2. Investigators might use a number of instruments which should include more qualitative measures, interviewing, cognitive measures, emotional measures, and more phenomenological measures, such as including on the team expressive therapists who are skilled in diagnostic observation (e.g., movement therapists, etc.) These instruments would be used on children and on the adults.

I further believe that linguists, mental health workers, teachers, spiritual leaders, and expressive arts therapists should examine this question collaboratively, for it seems, upon review of the literature, each of these theorists has acknowledged a piece of the puzzle, but all the pieces need to be more integrated. This will be discussed in greater depth later in the dissertation.

Behavioral manifestations of language delay and early traumatic sequelae often present as dissociative pathology. Because of this, an understanding of the history and current thoughts on dissociation is in order. Therefore, an overview of the professional literature on dissociation and current treatment models will follow.
Dissociation: An Overview

Introduction

This study concerns itself with the healing process involved in dissociation. Contemporary literature about dissociation is vast. This part of the review cannot hope to cover all aspects of this subject, but will offer an overview in order to give the reader a frame of reference for this current research which may impact on the adult recovery process of four specific persons who have been diagnosed with a dissociative disorder and who have been traumatized before full language development/production.

Definition of Dissociation and Dissociative Disorders

Dissociation can be formally defined, according to the Chambers Dictionary (1993), in psychological terms as “the splitting off from consciousness of certain ideas and their accompanying emotions leading to fragmentation of the personality into independent identities as in cases of split or multiple personality” (p.488). This chapter, however, will focus on contemporary psychiatric/psychologic literature’s definition of dissociation as experienced through the nomenclature of a group of psychological disorders known as the Dissociative Disorders in the official American Psychiatric Association’s diagnostic manual, Diagnostic Criteria from DSM-IV (1994). Two of these disorders will be the specific focus of this literature review: Dissociative Identity Disorder (DID) formerly known as Multiple Personality Disorder and Dissociative Disorder Not Otherwise Specified (DDNOS). The DSM-IV describes Dissociative Identity Disorder as a mental disorder that presents with the following criteria: a) the presence of two or more distinct identities or personality states (each with its own pattern of perceiving or relating to and thinking about the environment and self); b) at least two
of these identities or personality states recurrently take control of the person's behavior; c) the inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness and d) the disturbance is not due to the direct physiological effects of a substance...(p. 230). Dissociative Disorder Not Otherwise Specified (DDNOS) is a category reserved for persons who experience dissociative symptoms such as a disruption in the usual integrated functions of consciousness, memory, identity and environmental perceptions, but who do not meet the criteria for any specific Dissociative Disorder (p. 231). For the purposes of this study, the other specific Dissociative Disorder will be designated as Dissociative Identity Disorder, for oftentimes, persons who have been diagnosed with either DID or DDNOS fluctuate between these two diagnoses within the course of treatment, according to most writers in the field (Kluft, 1996; Ross, 1996; Steinberg,, 2000).

Corroborative psychiatric diagnostic definitions of dissociation may vary according to cultural variants. Many researchers in the field agree that dissociation is a basic and universal component of the human psyche (Ross, 1996; Kluft, 1996, 1999; Van der Kolk, 1987; Greaves, 1993; Wright, 1997; Phillips & Frederick, 1995; Chu, 1998; ). Clinical researcher Stanley Krippner (1997b), in his discussion of cross-cultural studies and dissociation, notes that "so-called 'dissociative' phenomena have been given varied labels and interpretations in different eras and locations, as well as in diverse historically and geographically situated interchanges among people" (p. 6). Some are philosophical in nature as he refers to a philosophic inquiry by Braude (1995) who asserts that the term, "dissociation" can be used if a state system of a human being, such as traits, skills, or alternate personalities, is separated from other parts of the human being
by either phenomenological barriers (e.g. anesthetic) or epistemological barriers (e.g. amnesia) produced by someone who is not aware of establishing the barrier. Braude, in this way, rules out suppression of what someone is aware of (Krippner, p. 6; Braude, pp.120-121).

Other definitions, Krippner says, are theoretical and explanatory as noted, for example, in Brown’s (1994) contention that there is a neuro-physiological basis to dissociation (p.113). Krippner also suggests that Hilgard’s (1994) assumptions about dissociation are intriguing: For example, Hilgard states that subordinate cognitive systems exist, and that there exists some hierarchical control and an overarching monitoring and controlling structure. Under special circumstances, he says, these interacting systems may become somewhat isolated from each other (Hilgard [1994, p. 38], in Krippner, p. 7). Spanos and Burgess (1994), according to Krippner, proffer a theory of sociocognitive formulation of dissociative disorders, in which individuals learn to construe themselves in ways that are created, legitimized, maintained, and altered through social interaction (p. 137, in Krippner, p. 7). Other definitions, suggest Krippner, are operational, depending on standardized test scores or responses to semi-structured interviews (Krippner, p. 7).

For the purpose of this study, this writer will use Krippner’s definition as the general root definition of psychological dissociation as evidenced by participants in the study. Krippner’s definition is descriptive rather than theoretical or philosophical. He says that the word, “dissociative” is

an English-language adjective that attempts to describe reported experiences and observed behaviors that seem to exist apart from, or appear to have been
disconnected from, the mainstream, or flow, of one’s conscious awareness, behavioral repertoire, and/or self-identity. Dissociation is a noun used to describe a person’s involvement in these reported dissociative experiences or observed dissociative behaviors. Dissociation contrasts with “association”, the binding or linking together of concepts and memories, a notion prominent in the writing of John Locke, Edward Hume, and other British empiricists of the 17th and 18th centuries.….. I use the term “self-identity” to describe a person’s definition of him/herself, encompassing his or her body, gender, social roles, values, and goals. (p. 8)

From the above definitions and descriptions of the words dissociation and dissociative, I would support Krippner’s views simply because it is difficult to distinguish between phenomenological subjective self-reports and behavioral observations. Krippner suggests that, in part, dissociative phenomena are the outcomes of diverse beliefs and practices that can differ substantially throughout various cultures. He says, for example, a patient who is suffering from a fugue state and loss of identity in a mental hospital may be experiencing “uncontrolled dissociation”, whereas in many tribal communities, a tribal practitioner, whose identity presumably has been changed or replaced by disembodied “angels”, “saints”, or “spirits” maybe engaging in “controlled dissociation” (p. 9).

Narratives or descriptors of an individual’s experience, says Krippner, may shift quickly, sometimes within minutes. A person, for example, who is being treated for posttraumatic stress disorder in a group therapy situation may be quite focused on group process, when suddenly, s/he has a flashback. If s/he cannot control the dissociation that
usually accompanies this process, h/she may experience this flashback in which s/he imagines her/himself in a different location. The experience has now changed from one of controlled dissociation to uncontrolled dissociation (p.9). Krippner’s definition seems to focus on splits in conscious awareness, behavioral presentations, and/or self-identity (p.10). So it seems that the ability to control dissociative experiences involves a conscious process of mental and physical awareness of an earlier memory. In this case, there is no real split in consciousness. However, when there is no conscious awareness, the dissociation is uncontrolled and becomes what is known in traditional psychiatric literature as a pathological defense to past traumatic events.

My own interpretation of Krippner’s observations has led me to conclude that uncontrolled dissociation can produce certain distortions in the way one experiences oneself and therefore may inhibit healthy identity formation. So, perhaps more of a working definition of dissociation and the dissociative disorders for this study would be to simply view the participants as having gone through such a severe identity crisis that they have had to store or hold certain traumatic events in other parts of their brain or body. Thus, in this situation, when flashbacks or early memories arrive, they might appear as initial traumatic feelings in the unconscious and behavioral changes would take the form of what would seem to the observer to actually be a “different” persona. This would be what Krippner would call “uncontrolled” dissociation, when literally one part of the person does not know what the other part is doing. There is no stabilizing center for the person to return to. There are only certain feeling states that do not seem able to establish a central connection to, i.e., in Krippner’s terms, the Self, the real identity.
History of Dissociation

According to Ross (1996), the concept of dissociation began prior to history with the ecstatic experiences of shamans (Eliade, 1964), and appears to be a universal and fundamental component of human psychology. Ross suggests that these early shamanistic practices illustrated by trance and possession states found in most cultures throughout history are the psychological foundations of DID and other dissociative disorders. In the western culture, he asserts, demonic possession is an historical precursor of DID (p.4). He also notes that many contemporary cases of DID have not been successfully treated with exorcism (Ibid.).

Wright (1997) says that the narrative of dissociation within the Western cultural tradition is the story of possession, mesmerism/magnetism, hypnosis, PTSD, and MPD whose name was changed to DID in the DSMIV (p. 41). She speaks of possession as being one of the oldest identified forms of dissociation, and defines it as either a part or the whole of the body behaving as the possessing identity. Some forms of possession, she says are voluntary and sought by persons who are trained to enter into alternative states of consciousness by means of varying techniques. These persons include spiritualists and mediums who have existed from ancient through modern times. In contrast, involuntary forms of possession that occurred against a person’s will were considered pathological and treated by exorcism (cites Ellenberger, 1970, The discovery of the unconscious, NY:Basic Books). The belief in demonic possession played an important part in the belief systems of the Judeo-Christian cultures of the Middle East and Europe and the rites of exorcism among the major faiths of Judaism, Islam and Christianity were similar. There were cases of collective and individual possessions
reported through the 1700’s and less frequently noted through the 1800’s. The Western psychiatric community has reported some alternate states of consciousness that met the criteria for demonic possession (cites, Ross, 1989; van der Hart et al., 1993, p. 41).

Up until the mid-1700’s, exorcism was the primary treatment for demonic possession (Wright, 1997, p.42). In 1770, physician Franz Anton Mesmer (1734-1815) introduced the technique “animal magnetism” or hypnosis for healing and exorcisms (Crabtree, 1993; Wright, 1997; Braude, 1995). Mesmer believed in the healing power of magnets, but eventually proposed that magnets were not really the curative agents.

Instead he postured that the physician has powers analogous to those of magnets. The physician is a channel of universal ‘magnetic fluid’ into the body of the patient to heal disease. He suggested that illness was the result of an imbalance of this fluid within the body and recovery was predicated on the restoration of this balance. Mesmer said that the physician/magnetizer could restore this equilibrium by channeling, storing and transferring this fluid to others (Braude, 1995, p. 9-10). Mesmer, according to Wright (1997), was able to replicate Father Johan Joseph Gassner’s (1727-1779) healing and exorcisms by both creating and banishing convulsions as well as other symptoms of possession, without appealing to supernatural explanations. Finally, Gassner’s activities were curtailed by the Roman Catholic Church and belief in possession was diminished. Mesmer’s work became short-lived as scientific opinion in the 1780’s declared that the effects of animal magnetism were produced solely by the imagination. Scientific inquiry was, at that time, limited to the observance and study of physical phenomena (Wright, p. 43).
Although magnetism had fallen into ignominy by the end of the 18th century, it seemed to expand to other parts of Europe and even to reach America, fueled by both scientific and popular interest (Wright, p.43). Marquis de Puységur, for example, a colleague of Mesmer, expanded Mesmer’s work and, according to Crabtree (1993), was credited with the discovery of magnetic sleep which he defined as being “awake while asleep”. Puységur said that there were distinct characteristics of magnetic sleep: First, there is a Sleep-Waking consciousness called somnambulism. There is both a magnetic and natural somnambulism which involves a “sleep of the exterior senses”. The former is artificially induced and the later occurs naturally. Second, an essential feature of magnetic sleep involves establishing an intimate rapport or special connection to the magnetizer which allows the unconscious to make room for suggestion. The person who is in this type of artificially induced magnetic sleep is highly suggestible if this rapport is maintained. Third, there is a lack of memory and divided consciousness. The inability to recall what happened while in magnetic sleep is typical. He thereby concluded that “the demarcation is so great that one must regard these two states as two different existences”. Finally, paranormal activity seems to increase during trance (somnambulism). A person’s sixth sense seems to be activated where one may be more receptive to mental communication and clairvoyance (Crabtree, pp. 39-45).

Puységur continued to explore magnetic sleep and noted that its effects could be healing both physically and psychologically. He, thus, was the first to use magnetic sleep as an adjunct to psychotherapy, and maintained that there is a second consciousness accessible while a person is in trance or magnetic sleep. The recognition of divided consciousness is the keystone of magnetic therapy (Crabtree, p. 46, 84).
This concept of dual consciousness proffered by Puységur was intriguing to researchers. While in a deep hypnotic sleep, patients would manifest what seemed to be a new personality, which would be different than the ordinary one. Other indications of the dual nature of consciousness would be automatic writing; posthypnotic suggestions; and automatic or ‘non-volitional’ responses obtained from hypnotized subjects (Wright, 1997, p. 44). James Braid (1795-1860), who was credited with the spread of magnetism to England, would later, in 1842, rename animal magnetism, ‘hypnotism’, and called it a psychologically induced psycho-physiological state which induced analgesia (Crabtree, 1993, pp. 142-43; Braude, 1995). Thus, hypnosis was providing a new model of mind as a double-ego, a conscious entity that was completely unaware of a subconscious one, endowed with hidden, discerning and creative powers (Wright, p. 44).

According to Wright there was a rekindling of interest in hypnosis in the mid-1800’s as two trends would bring dissociative phenomenon to the forefront of scientific and popular thought. The first was the spiritist movement in the U.S. in 1847 which also spread through Europe during the 1850’s. Apparently, this was partly a reaction to intellectualism of the Enlightenment era. This was the age of ‘spirit mediums’ who included dissociative phenomena such as automatic writing and drawing and voluntary spirit possession in their practice. They became popular as writers and spiritual counselors during this time. The second trend was an increase in the scientific study through hypnosis of various dissociative psychopathologies. The medical diagnostic category for dissociative experiences in this period was ‘hysteria’ whose symptoms duplicated those of possession and the early magnetic diseases. Consequently, hypnosis
and automatic writing became the primary techniques for studying both mediums and hysteric (Wright, pp. 44-45).

During the same time, a split in hypnosis theory arose in France between the Salpêtrière School headed by Jean-Martin Charcot (1835-1893), a neurologist and the Nancy School headed by Hippolyte Bernheim (1840-1919), a professor of internal medicine. Charcot established the differences between organic and hysterical forms of convulsions, paralyses, and amnesias. He pointed out the often traumatic origins of hysteria and posited a neurological basis for it and believed only hysteric could be hypnotized. Bernheim, on the other hand, believed that there was a continuum of hypnotic susceptibility which everyone possessed to a disparate degree. He used hypnosis on a variety of patients, suffering from different ailments and suggested that the success of hypnosis is due to “suggestion”, which he defined as “the aptitude to transform an idea into an act”. Bernheim concluded that the hysterical behaviors of Charcot’s patients were artifacts created by suggestion (Wright, p. 45).

The concept of dissociation during this time was medically oriented towards the study of hysteria. According to Wright, the first medical use of the word “dissociation” can be attributed to an American physician, Benjamin Rush. However, Wright contends, that the concept of dissociation was probably used first by Moreau de Tours in 1845, and adopted by other researchers in various forms throughout the West: Charcot and Janet in France, Breuer (1842-1925) and Freud in Austria, and Morton Prince (1854-1929) in America (Wright, p. 46).

The 19th Century medical models of dissociation were broad-based and included conversion disorder, somatization, somnambulism, and some forms of
obsessive-compulsive disorder. Everything was included under the term, *hysteria*. Some scientists like Breuer, Janet, and Prince saw the splitting of consciousness and the isolating of traumatic memories and unacceptable impulses in dissociated parts of the psyche to be the mechanism underlying paranormal phenomena, mediumship, possession states, and wide-range of psychopathologies (Ross 1996, p. 5).

Hilgard (1977/1986) maintains that the beginnings of the concept of dissociation are generally ascribed to Pierre Janet in 1889 in his book *L'Automatism Psychologique* (p. 5). Janet, Hilgard says, refers to this concept in his Harvard lectures, *The Major Symptoms of Hysteria*, in 1907. He believed that systems of ideas are split off from the major personality and exist as a subordinate personality which is unconscious, but capable of becoming conscious through hypnosis. According to Hilgard, Janet was the first to introduce the term *subconscious* in reference to cognitive functioning that is out of awareness but could on occasion become conscious. Janet preferred to use this term rather than the term *unconscious* that had been used prior to Freud (p. 5). Janet believed that each dissociated state is a conscious state. In healthy individuals, he says, there is no doubling of consciousness or personalities. A healthy person is capable of integrating diverse perceptions into a new memory and then allow that memory to merge with the person’s self perception or unitary consciousness (Wright, 1997, p. 47). In pathological cases, says Janet, a dissociation of personality takes place and a part of the personality splits off to become an autonomous subconscious personality (Erdelyi, 1994, p. 5). Therefore, in contrast to Freud and a number of other researchers, Janet believed that healthy people did not experience a subconscious process (Wright, p. 47).
Morton Prince (1854-1929), a Boston neurologist, is credited with establishing the modern American tradition of psychopathology and psychotherapy during the last decade of the 19th century. He founded the Journal of Abnormal Psychology in 1906 and the American Psychological Association in 1910. A contemporary of Janet and Freud, he was intrigued by Janet’s experiments with dissociation and understood that different conscious personality states may co-exist simultaneously and saw that it appeared in some cases that while one personality was in control, the other one was listening. This led him to ask the question, in a 1924 lecture at Clark University: “How may selves have we?”. He came to the conclusion that personality is the psycho-physiological collation of traits. In other words, personality comprises many different components. It is not a stable thing. It exhibits “many alterations under changing conditions” (Prince, 1975, pp. 190-191; p. 211). He also was concerned only with the neuro-biological structure of the mind and not the dynamic forces, and was the first to use the term, co-conscious instead of subconscious, because he believed that each different personality subsystem might be invested with consciousness. So, for Prince, the hidden aspects of dissociation were described as co-consciousness, which could explain the notion that there were other parts of the personality who watch and are aware when another is in control. (Prince, 1975; Hilgard, 1977/1986; Erdelyi, 1994).

For Sigmund Freud (1856-1939), dissociation was an active defense phenomenon, with subsystems of ideas, wishes and memories that threaten the integrity of the whole personality. These subsystems arise when these memories are suppressed or repressed and they are split off from consciousness, the ego. Freud initially proffered two personality subsystems, the ego and the id, and subsequently added a third, the superego.
(Erdelyi, 1994, p 5). In sum, the ego was the conscious part of the personality, the id represented the unconscious, primary processes of the personality, and the superego was the mediator or the conscience of the personality. All of these subsystems in some way dynamically influenced each other sometimes in a conscious way; at other times in an unconscious way. Freud introduced the dynamic conception of dissociation which distinguished him from Janet in that these subsystems were moving and malleable parts of the integrity of the whole personality system.

Freud was later to change his views, well after Breuer and he published Studies on Hysteria in 1895. The book consisted of case histories of women who had met the criteria for DID/DDNOS (according to DSM IV) and also, for many, reported histories of childhood sexual trauma. Freud believed at that time that the predominant cause of hysteria was adult sexual seduction of a child (Ross, 1996, 1989; Wright, 1997). In the scheme of the trauma-dissociative model of psychological treatment, sexual trauma was a key focus during the period between 1890-1910 and trauma and dissociation were the mainstream themes in both Europe and the U.S. (Ross, 1996).

Meanwhile, a contemporary of Freud, Carl Jung (1875-1961) introduced some new thoughts on the concept of dissociation. He was influenced both by Freud and Janet in terms of dissociation, but felt that the unity of consciousness is an illusion. He introduced the idea of complexes: persons are made up of complexes which are autonomous groups of associations that have a life of their own —i.e. fragmentary personalities. Jung regarded the manifestation of subpersonalities as constituting hysteria, or in a larger sense, neurosis. A neurosis is a dissociation or fragmentation of the personality due to the existence of these complexes (Erdeyli, 1994, p. 6). Jung was
considered to be more out of mainstream psychiatry at that point and soon professional differences ruptured Jung and Freud's relationship. Jung continued with his own research outside the realm of the psychoanalytic model.

In sum, the psychopathology of dissociation in the late 19th century was well-documented, beginning with Janet's belief that dissociation occurred because of a defect or deficit in ego strength. Also the relationship between trauma and dissociation was well understood, and there was a body of clinical, experimental, and theoretical literature on DID, trauma, dissociation, hypnosis and the paranormal. Janet and Freud, according to Ross (1996) were not interested in the paranormal and there were other researchers who had no interest in trauma. Jung was interested in all of the components (Ross, p. 5).

Interest in dissociation declined in the early 20th century leading to its virtual disappearance until decades later. According to Ross (1996), Wright (1997), Chu & Bowman (2000), and other researchers, there were three main factors that contributed to its decline: Freud's repudiation of the seduction theory; the creation of the term schizophrenia by Bleuler in 1924; and the rise of behaviorism.

Within a few years after Freud's studies on hysteria, he discarded the seduction theory, ridiculed hypnosis and shifted from the dissociation model to a theory of repression of traumatic events. By disowning childhood sexual abuse, Freud disallowed the possibility of treatment of dissociative symptoms within a trauma model, so dissociative diagnoses became irrelevant to mainstream clinical practice. The fundamental issue here was not DID or dissociation, but it was the endemic nature of child abuse, and society's need to deny its reality (Ross, 1996, p. 6; Wright (1997).
Second, in 1924, according to Ross, Bleuler created the term, *schizophrenia* and said that hysteria is a grouping of different personalities each succeeding the other. Through similar mechanisms in schizophrenia, different personalities exist side by side. Bleuler decided that schizophrenia should be called *split mind disorder*. Bleuler’s clinical descriptions of schizophrenia, says Ross, are often descriptions of the DSMIV’s DID. Thus, many DID patients were transferred over to a biomedical organic brain theoretical model, the model of schizophrenia that dominates contemporary psychiatry. Patients who would have been diagnosed with a dissociative disorder and treated on the basis of childhood trauma, were now diagnosed with hysteria and prescribed psychoanalysis for their sexual fantasies or they were diagnosed with schizophrenia and assigned to biomedical treatment which included pharmaceutical therapy (Ross, 1996, p. 6).

Third, during that time, the rise of behaviorism with its focus and emphasis on the maintenance of correct external behaviors, did not allow for consideration of internal states of consciousness. Also, during years between 1920-1950, there was not much academic interest in DID, and this continued even as late as 1970’s and early 80’s (Ross, p. 6).

However, there was a resurgence of clinical interest in dissociation in the 70’s and 80’s, Ross remarks. The reason for this, he and other researchers say, is probably the women’s movement which supported more open acknowledgment of childhood physical and sexual abuse (Ross, 1996, p. 6; Wright, 1997; Chu & Bowman, 2000). Ross cites two cases of MPD (now DID), which gained notoriety. One was Chris Sizemore (1989), also known as Eve (*Three Faces of Eve*, Thigpen and Cleckley, 1957).
in 1957 and was one of the most widely read cases of MPD in psychoanalytic literature. She was told that she was probably the only person “on the planet with MPD (DID)”.

Ross continued by saying there was still a dearth of psychiatric literature on severe, chronic childhood trauma which was considered clinically peripheral. He claims it is not possible to understand dissociative disorders without understanding childhood sexual abuse (Ross, p. 7). The other case was Sybil (Schreiber, 1973). Both cases were published as books and subsequently made into movies (in Ross, p. 7).

Another reason for the revival of interest in the dissociative disorders was the Vietnam War and its accompanying malady of combat-related Post-traumatic Stress Disorder (PTSD). Interest in trauma grew as clinical treatment for PTSD gained attention when the traumatic life-altering experiences of soldiers returning from the war could no longer be denied (Ross, p. 7; Chu & Bowman, 2000, p. 9).

Finally, the dissociative disorders were given their own section in the DSM-III (American Psychological Association, 1980) in 1980, including the nomenclature of MPD (Ross, p. 8; Wright, p. 50). This “official” recognition of dissociation within the psychiatric community made scientific study of the disorders possible as grant monies became available and a number of journals on dissociation and related disorders emerged as credible sources of scientific literature (Wright, p. 50-51; Ross, p. 8). The current DSM-IV (American Psychological Association, 1994) now includes five disorders within the dissociation category and has replaced the term “multiple personality disorder” with “dissociative identity disorder” (DID) (Wright, p. 51).
Current Research

According to Chu and Bowman (2000), during the last two decades of the 20th Century and currently, extraordinary changes have occurred in the study of trauma and dissociation. The first modern studies of the dissociative disorders appeared in the scientific literature in 1980. This coincided with an upsurge of interest in trauma, and, in particular, interest in the welfare of children and child maltreatment and its after-effects, including post-traumatic and dissociative responses (p. 6). Clinical treatment, research and training about trauma and dissociation burgeoned during the 80’s as both the professionals and the public began to understand the vagaries of trauma paradigms and became more sophisticated about treatment. Strong reactions against public allegations of abuse by childhood trauma survivors started in the 90’s and by the middle of the last decade, many professionals who have specialized in the treatment of dissociation have found themselves besieged by “false-memory” advocates in courtrooms and in clinical and academic settings. As the new century has arrived, the controversy continues, though somewhat muted in its intensity as the treatment of dissociation has become more moderated by professionals’ experiences with trauma survivors and the false memory backlash (p. 6).

Advancement in the Field of Dissociation

Progress in the formal clinical diagnosis of dissociation has made many strides in the past two decades. These have included more sophisticated research in treatment methods, diagnostic instruments such as the Dissociative Experiences Scale, the Structured Clinical Interview for DSM Dissociative Disorders, and trauma-focused journals such as the Journal of Trauma & Dissociation, and its predecessor, Dissociation, devoted to the study of dissociative disorders. Diagnosis of dissociation in children and adolescents has also improved with additional testing instruments such as the Adolescent Dissociative Experiences Scale and Child Dissociative Checklist. Guidelines for treating
dissociative disorders in children and adolescents are currently being written (Chu and Bowman, 2000, pp. 10-11).

In addition, overall treatment of dissociative disorders has become more integrated with traditional therapies. The usefulness of hypnosis in treatment has been further clarified, and cognitive approaches/techniques have multiplied with the advent and application of new techniques such as Eye Movement Desensitization and Reprocessing (EMDR) (Chu and Bowman, pp. 11-12).

*The Evolution of Treatment*

Chu and Bowman have divided the evolution of treatment into three parts: The First Generation: The Early Years to the Mid 1980’s, The Second Generation: Growth—The Late 1980’s to the Early 1990’s, and The Third Generation: Conflict and Maturation—The Mid 1990’s to the Present.

*The First Generation*

Early in the 1980’s, an increasing number of clinical practitioners were beginning to realize that many of their patients were suffering from the aftereffects of childhood trauma. Previously, clinicians had been bewildered by symptomatology that appeared to be dissociative and post-traumatic responses to overwhelming and shattering childhood experiences. These patients were often difficult to treat successfully. Treatment strategies needed to be devised that would support healing these persons with such primal narcissistic wounds. The scientific literature was scarce, as were resources on how to treat these patients. Finally, a treatment paradigm based on clinical experiences and introductory research was developed by psychiatrist Ralph Allison and a yearly course was taught by psychiatrists Richard Kluft and Bennet Braun at the American Psychiatric Association meetings. Thus, a first generation treatment model began to emerge (Chu and Bowman, pp. 12-13).

Early treatment models emphasized the importance of abreaction of traumatic experiences as a critical component of the primary treatment phase. The rationale for this
was that this aggressive abreacting would lead to a working through of the trauma and, in the case of dissociative disorders, would lead to a reintegration of split-off parts of the personality. In many cases, report Chu and Bowman, patients did benefit from this treatment, but others did not do as well (p. 13).

In 1983, the first annual meeting of the International Society for the Study of Multiple Personality and Dissociation (later renamed the International Society for the Study of Dissociation) convened, and clinicians began to discuss treatment issues surrounding the dissociative disorders and trauma. In addition to the standard therapies of the time (e.g. psychodynamic, cognitive therapies, hypnosis, etc.), some innovative treatment practices were proposed for the treatment of dissociative disorders. These included identifying alter personalities, and helping these parts to negotiate with each other in the personality structure (Chu and Bowman, p. 13).

**The Second Generation**

The late 1980’s to the early 1990’s engendered a period of new growth as an increasing number of clinicians became more knowledgeable and skilled in the treatment of trauma-related disorders and especially the dissociative disorders. Specialty programs were opened throughout the United States and Canada and became centers for trauma treatment and research in the study of dissociation (Chu and Bowman, p. 14).

During this time, it became clear that using treatment strategies which encouraged abreaction was not helpful to many persons with dissociative disorders. In some cases patients either failed to improve or became more symptomatic. Chu and Bowman asserted that breaching of the dissociative barriers which held early traumatic memories by abreaction could cause patients to become more overwhelmed as they were flooded by past experiences. There are major ego deficits in these patients which have interfered with their learning vital social skills and basic trust, which, in turn affect moods, impulse control and the ability to tolerate being alone. When faced with the
sudden re-experiencing of past memories as happens in abreaction, these patients sometimes would self-mutilate, take drugs, alcohol, overeat, etc. (p. 14).

As a result, Chu and Bowman (2000) and Kluft & Foote (1999, p. 1) maintain, the second generation of treatment models focused on the development of a stage-oriented approach. This approach encompassed an initial stage of ego-supported therapy designed to improve basic coping skills and to stabilize patient symptomatology, affirm safety and develop affect tolerance and impulse control before abreaction of the trauma could happen. This often was a lengthy process, but a necessary one, to produce a safe climate in order to tolerate the strong affects associated with re-experiencing the original traumatic material. Acceptance of stage-oriented treatment for child abuse was gradual because it appeared to involve more lengthy clinical intervention. However, by the mid 1990s, it became part of the standard care of traumatized patients (Chu and Bowman, pp. 14-15).

The Third Generation

The mid 1990s to the present has become a period of conflict and maturation in the treatment field. In early 1992, parents of trauma patients who were accused of abusing their children, psychologists who were involved in memory research, and biologically-oriented psychiatrists organized to form the False Memory Syndrome Foundation. This group asserted that many clinicians were using techniques that were suggestive and unproven which resulted in vulnerable patients developing false memories of early childhood abuse. They contended that there was no scientific evidence of ubiquitous traumatic amnesia and that misinformed therapists were ruining lives and shattering families by leading non-traumatized patients into falsely believing that they had been victims of childhood abuse. In addition, some psychologists and biologically-oriented psychiatrists carried out systematic attacks on the validity of the DID diagnosis, especially with those patients who had declared that they had been abused by satanic
culs, and on the use of hypnosis and guided imagery in therapeutic treatment (Chu and Bowman, p. 15).

This false memory conflict continued to be discussed in the psychiatric literature and in North American courtrooms where clinicians were sued and prosecuted for their work and where some were even attacked at their homes and offices. In attempting to address the false memory issue, clinical researchers were able to subsequently lend support to the validity of recovered memories in a considerable number of dissociative patients (Kluft, 1995; Chu and Bowman, 2000, pp.15-16).

Currently, there is some evidence that this controversy is waning as treatment strategies and dialogue are becoming more sophisticated. During this third generation of trauma treatment, models have been developed to include more sophisticated evaluations, better differential diagnoses, and treatment that is more focused on helping patients develop a more reasonable sense of their personal history rather than uncovering more trauma. Clinicians are now able to better recognize the complexities of differential diagnosis surrounding the nomenclature of a genuine dissociative disorder from a factitious or malingered clinical presentation. As such they have begun to integrate more multiple views of trauma and dissociation (Chu and Bowman, pp. 16-17).

**Current Treatment Models**

Current treatment models appear to be multi-dimensional and varied, depending more or less on individual clinical philosophies and patient needs and developmental deficits. There are, however, definite guidelines for the treatment of Dissociative Identity Disorder issued by the International Society for the Study of Dissociation (ISSD, 1997, as cited in the Journal of Trauma and Dissociation, 2000) which provide a structure for ethical clinical treatment. These guidelines were the outgrowth of the FMSF controversies previously cited. In general, these guidelines suggest the use of screening tools such as the Dissociative Experience Scale, Dissociation Questionnaire, and informal office interviews as part of the initial evaluation for those patients who are at
risk for a dissociative disorder. Other more formal structured interviews are now available. Once a diagnosis is formed, a more comprehensive treatment planning is prepared, oftentimes including persons from a variety of professional disciplines, as well as medical consultation, etc. An outline of psychotherapy for DID which includes integration as an overall treatment goal, a framework for outpatient and inpatient treatment and specific guidelines for group therapy, pharmaco therapy, hypnotherapy as well as therapist conduct, etc. is written in the guidelines. Specific protocols are set up which speak to the veracity of patient’s childhood abuse memories. Therapists must retain a neutral stance when memories surface, and allow the patient to determine their meaning in the context of their own narrative and experience. There are also cautionary statements which urge clinicians to treat the patient’s spiritual and philosophical issues with respect and further urge clinicians not to impose their own values on patients (pp. 117-130).

As there are a myriad of specific modalities which have surfaced over the past few years, only the major therapies will be summarized here. These include: Hypnotherapy; Psychodynamic Therapy; Ego-State Therapy; Cognitive Restructuring; Expressive Arts Therapies; and EMDR.

Hypnotherapy

According to many researchers in the field, hypnosis as an effective treatment is well-documented. It has been a curative agent for many types of mental disorders for over two centuries of clinical practice, especially for the dissociative disorders (Deabler, Fidel, Dillenkoffer, & Elder, 1973; Beueler, 1979; Scagnelli-Jobsis, 1982; Wadden & Anderton, 1982, as cited, in Whalen & Nash, 1996, p. 192).

Peterson (1996) refers to clients with dissociative disorders as having a core existential crisis. It is essential, therefore, she says is that the cognitive restructuring of
these patients be based on this core crisis. Hypnotherapy, in order to be effective, must revolve around symptom alleviation, not merely “digging” into old memories. The core body feeling of terror and existential angst must be honored and processed. Hypnotherapy, if used in this way, permits the patient to be in control of what happens in the trance state. Hypnosis is the focused attention to a selected part of the internal or external environment. It is also used to help patients to learn certain hypnotic techniques. This may give them more control over their feelings and behavior. Trance states, she says, provide patients with a safe interior space in which they can learn to self-regulate these feelings, learn how to contain them and distance themselves while processing traumatic memories (pp. 450-459).

Phillips and Frederick (1995) proffer a four-stage model of hypnotherapeutic treatment for traumatic and dissociative conditions. This is known as the SARI Model. Before beginning hypnotherapy with a dissociative patient, Phillips and Frederick state that it is necessary to discuss these four stages of treatment: safety and stabilization; accessing traumatic material; resolving traumatic experiences; and integration and new identity.

To briefly summarize: During Stage I (Safety and Stabilization), the clinician uses hypnosis as an ego-strengthening device wherein the patient will work at establishing a therapeutic alliance with the therapist, emotional self-regulation, family and interpersonal issues, somatic and post-traumatic issues; any addiction problems, and any self-destructive issues. This is the stage of establishing a safety zone for the patient and may take a long time.
Once safety is established, the clinician uses hypnosis to enter into Stage II (Accessing Trauma Material). The patient, with help, will be able to begin to reconstruct the traumatic material in empowering ways, and there will be alternate uncovering sessions with ego-strengthening ones. If the patient is having difficulty, h/she returns to the prior stage.

Stage III (Resolving Traumatic Experiences) involves working through the traumatic material and cognitively connecting sensory, visual, behavioral, and affective trauma to conscious awareness. Once again ego-strengthening techniques continue throughout this process and if there is destabilization, the patient returns to Stage I.

Finally, Stage IV (Integration and New Identity) involves the development of a new identity: internal maturation; there may be ongoing processing and the working through of traumatic material. There is in this phase a continued focus on reconstructed history for empowerment of the patient and a focus on integrating what has been safely remembered and reassociated (Phillips and Frederick, pp. 36-60).

Psychodynamic Therapy

Psychodynamic Therapy, according to Barach and Comstock (1996) serves the purpose of bringing the disparate parts of the human psyche together. The psychodynamic approach is designed to help the patient gain mastery over her/his mental life, and is well-suited to persons experiencing a chronic state of identity confusion. The researchers contend that other forms of therapy mainly focus on dissociative behaviors and management techniques where as psychodynamic therapy focuses on creating internal changes which enables the patient to function as a whole human being. This approach helps a person to alter a continued reliance on dissociative defenses. The patient
is encouraged to redirect her/his attention to possible connections between certain ways of behaving and emotional affectations, and is instructed to associate these to things which are previously unrelated. In effect, says Barach and Comstock, the therapist invites the patient to move the current picture aside to view the whole picture. The therapist does this through psychodynamic techniques such as interpretations, questions, empathic reflection, and confrontation. The goal, they say, of psychodynamic therapy for DID is the resolution of the resulting deficits of having been traumatized by reducing the patient’s need for dissociative defenses, so the dissociative aspects of the mind (alters) tend to integrate spontaneously (pp. 413-415).

_Ego-State Therapy_

Watkins and Watkins (1996, 1997) developed ego state therapy as an extension of understandings and techniques that have evolved out of the study of severe dissociation. They base their therapeutic technique on the assumption that dissociation is an extreme maladaptive splitting of the personality on a continuum, ranging from normal to an intermediate zone of adaptation or defensive separation (p.447). In sum, they believe that in dissociation, there is a differentiation or splits in personality states which they call ego states. There are three processes that are included in the development of ego states: normal differentiation, introjection of significant others, and reactions to trauma. In normal differentiation, boundaries within the ego states are flexible and permeable. In dissociation, normal differentiation does not occur, and ego states become more sharply differentiated from one another. The separating boundaries become less permeable. They use the term “ego state” to explain and cover all those distinct patterns of behavior and experience which range from simple behaviors in normal adjustment through
intermediate behaviors represented by more neurotic defenses to the more severe
dissociations represented by DID (pp. 432-436).

Ego state therapy, according to Watkins and Watkins, involves building trust and
rapport among all the dissociated aspects or ego states of the personality. The ego state is
not a thing or a process, they contend; it is, rather, a “part-person”, and must be respected
as such. They assert, the therapist must be able to separate out only those ego states
germene to a presented problem that the patient seeks to resolve. Therapy continues with
communicating with the ego states or “parts” of the personality with the therapist
encouraging each part to understand that the resolution to any emotional conflict resides
within the individual. They believe that when the ego states begin a process of internal
communication and collaboration, dissociation is reduced and boundary permeability is
increased (pp. 439-443).

*Family Systems Approach*

Schwartz (1995) introduces the concepts of systems family therapy to the
intrapsychic realm of human development and especially to the treatment of those
persons with a dissociative disorder. According to Schwartz, by introducing a family
systems approach, he offers clinicians and patients alike a new understanding of people’s
subpersonalities. This, in turn, is useful in connecting to the core resources within
persons. He asserts that the traditional view of the unity of personality oftentimes leads to
a poor self-concept because people often believe that the many mood swings and
thoughts they experience may really constitute who they are. For example, if one says, “I
am angry, or I am jealous”, it may describe the whole of oneself, and one can be totally
overcome and overwhelmed by that feeling and all its implications. There seems to be no
room for anything else, and if that is all that one is, one may feel contempt for oneself (p.11).

In describing the term “subpersonalities”, Schwartz refers to the work of Roberto Assagioli (1965/1975, in Schwartz, 1995), an Italian psychiatrist who has been credited by some to be the first Western thinker to discover multiplicity of mind, writing about subpersonalities in the early 1900’s. Assagioli’s ideas developed into a full school of psychotherapy called psychosynthesis. Schwartz says that the ideas of subpersonalities were very similar to what his clients were saying about their parts and their Selves. He suggested that “… the followers of psychosynthesis were more interested in helping people to get to know individual subpersonalities than in helping them to understand and to change the internal system….and similarly more interested in helping people to achieve the full potential of their subpersonalities than in helping them to solve problems and heal syndromes…” (p. 4).

Schwartz also credited Carl Jung (1962, 1968, 1969, in Schwartz, 1995), who, in his middle age journeyed inside of himself to experience what Assagioli called subpersonalities but what Jung classified as complexes, which are generally negative, and archetypes which are positive. He also used such terms as persona, shadow, anima, to further describe them. Jung, he felt, went further than Assagioli, to state that these parts of the self, or subpersonalities, were derived from a collective unconscious. He developed an interaction with them through a process called active imagination. Both Jung and Assagioli, continues Schwarz, believed that in addition to subpersonalities, each person contains a Self or Center that is different from the parts. This Self is both a state of mind to be achieved and a place which is non-judgmental and has a clear perspective
According to Jung, this Self is a passive, observing state. According to Assagioli, a person can evolve to a point at which the Self shifts and becomes the active manager of the personality (pp. 4-5).

Schwartz was also influenced by object relations theory proposed by Melanie Klein in the 1940’s. She asserted that our internal experience is shaped by introjected ‘objects, holographic-like representations of significant people in our lives (Klein, 1948; Gunthrip, 1971, in Schwartz, 1995, p. 12). Taken together, Schwartz was influenced by Assagioli, Jung and Klein to develop his family systems model. Other Jungians refined the active imagination process and developed an approach called voice dialogue wherein parts of the self could interact with each other and get to know each other (Hillman, 1975; Johnson, 1986, Watkins & Watkins, 1997).

Jung took this a little further when he said that a complex has “a tendency to form a little personality (1935/1968). It has sort of a body, a certain amount of its own physiology. It can upset the stomach, it upsets the breathing, it disturbs the heart — in short, it behaves like a partial personality… I hold that our personal unconscious, as well as the collective unconscious, consists of an indefinite, because unknown, number of complexes or fragmentary personalities (p.80,81, in Schwartz, 1995, p. 12)”.

As a result of his research, Schwartz concluded that if persons are naturally multiple their extremes may only represent a small parts of themselves rather than pathology at its core. So, “multiplicity transports us from the conception of the human mind as a single unit, to see it as a system of interacting minds” (p. 16, 17). So interaction is the key to Schwartz’s therapy. Multiplicity/dissociation needs to be
understood by viewing it as a systemic principle, a system defined as “any entity whose parts related to one another in a pattern”. Small systems are subsystems of a larger system (p. 17). Consequently, he advocated working with the various dissociated aspects or parts of the personality using the family therapy or systems intervention model.

*Cognitive Restructuring*

Catherine Fine (1996, 1999) offers a cognitively based model for treatment of DID. She believes that DID patients need to learn to problem solve and the Socratic method of asking the various parts of the personality to find a solution to a particular problem will help to conceptualize the problem, make it concrete, so old behaviors can be brought into a new context and replaced by new ones. Calling her method tactile integration, she has taken into account the affective, cognitive and perceptual struggles of the DID patient (Fine, 1996, p. 404). In dissociation, cognitive schemas may be separated and information held in different parts. Fine’s cognitive model calls for a temporary suppression of the affective part of treatment while helping the patient to cognitively restructure his/her dissociated life experiences through reconnecting, uniting and processing it through the use of cognitive techniques such as mapping, outlining, finding schemas or themes. Through this process, the patient learns to contextualize and provide structure for reframing dissociated thoughts/parts (pp. 404-409).

*EMDR*

In recent years, Eye Movement Desensitization and Reprocessing (EMDR) has been used extensively with trauma victims and used increasingly for the processing of traumas in DID patients (Kluft, 1999). However, Paulsen (1995) has cautioned its use for DID patients. EMDR is a clinical protocol that facilitates emotional processing of contents of the neural networks in the brain. Basically, the process involves engaging the
patient in lateral eye movements while the brain’s neural network containing the traumatic material is activated and the information is “catalyzed” (Paulsen, p. 32).

Paulsen says that EMDR has an intriguing relationship to dissociation in that it seems to act as a dissociation finder, so that clinical intervention has to be a measured one to insure that there will be a minimum amount of neural “flooding” without proper affect resolution (p. 34).

Expressive Arts Therapies

The literature that focuses specifically on the use of the expressive therapies as a clinical treatment tool for DID is sparse. However, a close review of those therapies clearly indicates their strength and impact in supporting personality realignment and healing through creative involvement of the psyche.

The expressive arts therapies are a therapeutic outgrowth of the creative arts. As defined in this study, the creative arts refers to the dynamic inclinations of our psyche to engage in an aesthetic act of moving some-thing (e.g., emotion) from the inside of ourselves and expressing it outwardly. It is akin to giving birth to one’s thoughts and feelings. This “giving birth” may manifest itself in the visual arts, in writing, in music, drama, or in movement. Artist/therapist Ellen Levine (1995), in referring to the arts, regards creativity as this internal sense of "vitality" that we have when we are born, and depending upon our life experiences, we either use it or not. Shaun McNiff (1992) and Paolo Knill et al. (1995) share this sense of movement when they speak of the use of the imagination and metaphor as soul-making. McNiff asserts that creation is "interactive", implying that there is a dynamic team of "players" inside of ourselves who are propelled by the soul's "instinctual process" to heal the self of any conflict (p.1). Knill et. al. (1995)
voices a vision of the creative arts as a unitary dynamic entity as the arts generate movement among all forms, and he calls this process Intermodal Expressive Therapy. Stephen Levine (1992) also speaks of the movement and dialogue that creativity brings to the developmental stages of life as he discusses its recursive nature, the dance between innocence and experience through each developmental life stage. Carol Beeman (1990) describes creativity as both a process and a product as she says that the creative process guides the psyche wherein the creative person attempts to find and maintain psychological balance (p. 40).

Creativity, within this context, is defined as a process that implies movement within the psyche that promotes some kind of interior change. The creative arts as defined above can be one way of expressing this inner energy and making something new. It appears that the arts may share a common language and that is inspiration, literally a breathing-in of a vital force that moves persons to express this energy in various art forms. A poet and an artist, for example, may experience this energy as an inner push, a cry from within the soul to breathe-out, expel something. If one cannot write, draw, verbalize, or dance what is happening inside of oneself, the energy is simply pushed back down into the psyche, and sometimes one is "stuck", and different kinds of feelings may become repressed. In psychological terms, this becomes part of a repression barrier that, for some people, thickens, until the feelings cannot be accessed. Rothenberg (1990) believes that inspiration refers to an intrinsically dramatic experience which may combine with thoughts to embody and represent unconscious conflicts (p. 39, 42).
Some expressive arts theorists (Arnheim, 1986; Moreno, 1988, 1995; Adler, 1992; Lewis, 1993; Lorenzetti, 1994; Politsky, 1995) have suggested that the arts therapies are multi-dimensional, and are interrelated as they stimulate all the senses. In terms of psychotherapeutic intervention, the arts can help people discover their own metaphors, or images, and stories to break down in the mind that repression barrier and access feelings that have been locked within the psyche. Because the creative process involves the whole person in its interior dialoguing, they believe that the arts therapies can and should be used as a primary treatment mode just as any other type of therapeutic intervention.

Questions which might arise from the preceding paragraph are, how are the creative arts therapeutic and specifically how can they effect change in disordered dissociative patterns? It may well be that the arts are a bridge between the exterior and interior life. The arts may enable persons to delve deeper inside the psyche and to learn more about life’s existential mysteries such as one’s personal identity. Since the dissociative disorders are directly related to problems of identity formation, the use of the more expressive therapeutic modalities may be effective tools in the healing process.

From my understanding of the expressive therapies literature, the creative process that underlies the art that moves the psyche towards inner realization of traumatic memories is also the source of ultimate healing (Jung, 1966; Chodorow, 1977, 1991; Moreno, 1988; McNiff, 1988, 1992, 1995; Adler, 1992; Levine, 1992; Serlin, 1993; Knill et al., 1995; Politsky, 1995; Marcow-Speiser, 1995; Cohen, et. al., 1995). The above cited theorists, with the exception of Jung (deceased), are expressive therapists and artists who use metaphor as a means of helping clients process trauma-related psychic injuries. Metaphor in this context is an image that is a manifestation of the inner life (McNiff,
This inner life appears to be a life that transcends the normal, and the inward journey is a creative or flowing process leading to change. Healing occurs as one engages her/his own internal image of what is troubling her/him. The engagement is multi-faceted in that the person may use different art modalities to process the problem. One can, for example, begin with a mental image and give it a visual form by drawing or painting it. Then, using movement of some kind, one may experience that image in the body and can give it form again with sculpture, or words (writing, poetry, drama, etc.), or create music. All of these modalities can work together to help the person conceptualize the problem and then bring it into some sort of present-day life context. This, they assert, will help ground the person in her/his everyday life experience (Levine, 1992; Knill, et. al., 1995; Politsky, 1995; McNiff, 1995).

Kane (1989), referring to trauma survivors, spoke about the role of imagination in the healing process, citing Jung’s assertion that the “loss of imagination and denial of the feeling function are a product of abandonment of the incest taboo...where the connection with the body has been lost through trauma, so too has imagination” (p.1). She contends as does Jung that true imagination is grounded in images arising from the unconscious. The imagination, she says is the real and literal power of the soul to create the image. In order for healing to take place, it is necessary to go back to true imagination, images that arise from nature, that are retrieved from our primal sources/energies in the unconscious (p. 25-26).

Returning to the creation of images or metaphors, it is necessary to acknowledge the value of primal sounds and somehow give them form by encouraging the patient to embody them. Chodorow (1977), Adler (1992), Serlin (1993), and Marcow-Speiser
all stress the sacredness of authentic movement, movement that can be akin to a vibratory romance with the soul. They say, it is a dance or movement that arises from the inner sound current within our body. It is the organic process of Self-Movement, and integration, a coming together of the lost parts of oneself. The dance becomes the “embodiment” of the sound and consequently, the soul. Dance or movement is the body’s natural, and primary way of communicating an internal process. Sound moves through the body, and the body reacts through movement of some kind to give expression to the pain. The visual arts, in addition, give form as do poetry, song, and the written and spoken word as survivors tell their stories.

Ward et al. (1997) would seem to agree as to the importance of going back to nature and using metaphor and imagery in the healing process. He says that creativity is rooted in existing knowledge (p.18-19). Gibbs (in Ward, et al., 1997) states that “we metaphorically conceptualize our experiences through very basic, bodily experiences that are abstracted to form higher metaphoric thought (p. 357)” They both seem to be talking about embodied knowledge and embodied cognition, which would further imply that the adult who had been traumatized early on would need to work though her/his issues in the imaginal realm as Kane (1989, op.cit. ) has suggested. The imagination is used in order to learn how to embody the trauma, give it form and expression in a creative product and then take it in again to integrate the experience and find words to express the pain.

In writing about treatment of dissociative patients, Barclay (1997) suggests that many of our concepts, or understandings are metaphoric in nature, thereby our understanding of what is true arises out of these concepts (p.305). It would seem, then, that metaphors can be true or false depending upon one’s understanding of one’s own
story or narratives and the concepts that emerge from them. He focuses on metaphor as it pertains to the narratives produced by dissociative persons. If, as he suggests, that metaphor lies at the root of narrative structure (p. 306), then the metaphors which may serve as a crucial function in patient narratives can be a focal point in therapeutic intervention. So the key metaphors determine the way in which a person experiences dissociative phenomena as well as the experiences that produce those phenomena, such as childhood sexual abuse. Particularly, he adds, key metaphors in persons’ descriptions of dissociative experiences can seem to have innumerable emotional and cognitive effects. Narratives contribute directly to the structure of what is customarily called the self. One’s narrative structure is crucial to the understanding of one’s experience (p. 307).

Finally, Cohen (1996) and Cohen and Cox (1995) contend that art-making in its many levels of expression is critical for persons who experience dissociation. Relying solely on verbal communication with these patients limits other possibilities for internal discovery and growth and may retard their ability to be able to conceptualize their early traumatic experiences. Persons who have severe dissociative disorders engage in much artistic expression and produce a considerable amount of visual art, poetry, music, and sculpture primarily to communicate what they have not been able to say in words. Consequently, their metaphors have been given form through the art and it is the work of the expressive therapist to choose the modality(ies) that will best help the patient and therapist understand the narratives involved in the dissociative experience and help to piece together the different aspects of the whole person.
Summary/Conclusions

Some of the major theories of the concept of dissociation have been reviewed as they pertain to the psychiatric nomenclature of the dissociative disorders, most notably Dissociative Identity Disorder (DID) or Dissociative Disorder Not Otherwise Specified (DDNOS). The history of dissociation, its development and influence on what the early psychiatric literature has called Multiple Personality Disorder has been reviewed as well as its relationship to early psychological trauma induced by childhood abuse.

The evolution of the recent scientific study of the dissociative disorders shows a marked progression in treatment within the past two decades, as the psychiatric community has begun to understand and acknowledge the complexities involving treatment. The first generation of treatment in the early 80’s involved more uncovering of traumatic events through abreaction which did not always help in the healing process for many patients. Treatment strategies were integrated within the more mainstream therapies such as hypnotherapy and psychodynamic therapy. Scientific research began more intensely in the second generation in the late 80’s, early 90’s when treatment centers for the dissociative disorders were opened in a number of places in North America. Treatment models began to surface which included a developmental stage model of treatment and abreaction was not the goal, but rather cooperation and ego-strengthening among parts of the dissociated personality. The third generation of treatment in the 90’s to the present, brought with it a time of both conflict and maturation as the False Memory Foundation was formed by both lay and professionals who felt that trauma therapists were “planting” childhood memories of abuse in their patients. The result, they said, was damaging and fracturing to families. It was during this time, in the
mid 90’s that more scientific research was being done and professional organizations like the International Society for the Study of Dissociation (ISSD) wrote formal guidelines for treatment of the dissociative disorders. Training programs were set up to help clinicians learn to use safe treatment techniques. Treatment was now more focused not on the importance of uncovering old memories, but on utilitarian means of helping persons to form a stable identity structure. Some major current treatment modalities were discussed. Their usefulness in the process involved in reassociating split off fragments of the personality were underscored.

Once again, the literature on this subject is vast and beyond the scope of this paper. However, the reader has been introduced to the concept of dissociation as it is used within the framework of this thesis and how it applies to the subjects of this study. It has been noted that treatment of DID is varied and complex and some conclusions that I have arrived at based on the literature are multi-varied. In discussing dissociation, especially the primary splits, it appears to have occurred in people who have been traumatized early in their development. Parts of the personality appear to split off, holding the traumatic memory or the feelings associated with it. To the onlooker, some of these parts or self-fragments appear to be almost separate persons. The more traditional treatments and understanding of this phenomenon is well understood. I, however, feel that traditional researchers have oftentimes failed to use a more interdisciplinary approach of looking at dissociative phenomena. I think this is where the interdisciplinary studies seem to offer a more global understanding of the dissociative disorders and implications for training educators and mental health professionals as well. The strength of interdisciplinary studies is its willingness to embrace divergent viewpoints and make room for cultural
differences. As has been noted in this review, the whole concept of dissociation seems to evolve around cultural perspectives. Many cultures regard dissociation as a normal part of their lifespan and embrace what we call mental illness as an opportunity for inner growth and spiritual enlightenment.

It is this opportunity for inner growth and spiritual enlightenment that well may be an important part of the healing process for those who experience dissociation as a severe identity problem. Psychological trauma experienced before full language production may be precipitous of a language delay sufficiently residual for certain affects to split off into different personality fragments. This review has spoken so far about language and trauma and the probable connections to dissociative experiences resulting in a compromised and confused understanding of a coherent unified Self.

Because of my own background experience of inner fragmentation, it was incumbent for me to understand my metaphorical narratives. My goal was to work with these using different art forms and movement in order to first give these split-off parts form and then concretely work through the feelings that were unearthed and embrace them. This was a compelling process that consistently moved me to understand the concept of a unified Self or what I consider to be a core identity without severe dissociative experience. The indubitable question was my relentless companion: “What does it mean to be a whole person, to not dissociate?”

As noted in the introduction, healing, for me became a spiritual process that led to the lessening of what has been described in the literature as severe dissociation and fragmentation. I, therefore, wished to examine some of the literature revolving around healing as a spiritual experience in search for this coherent Self. Consequently, I include
an overview of Western and Eastern thinkers who consider psychological healing and spirituality in the section that follows.
Psychological Healing as a Spiritual Process: An Overview

In the attempt to understand the vagaries inherent in the healing process of those persons who are labeled with a dissociative disorder, there remains a need to define for the individual that which is a natural and healthy process which leads to personality integration. Consequently, further examination of the literature here includes an overview of some of the major Eastern and Western practitioners and thinkers who view psychological healing as a spiritual process.

The healing of the psyche is a powerful, transformative and, for many, a spiritual process. Spiritual awareness may provide understanding of the existential issues which threaten healthy emotional development.

Historically, many practitioners and thinkers East and West have had questions as to what kind of process leads to deep psychological healing. In the West, there have been four major models of psychotherapeutic intervention during this century according to Lueger and Sheikh (1989): behaviorism, psychoanalysis, humanistic, and transpersonal. In the East, generally speaking, there are few therapeutic models; the models are based mostly on the ancient spiritual traditions. In this paper, some of the Eastern traditions concerning Hindu and Buddhist philosophy and their psychology of healing will be discussed. The first three forces of psychotherapy in the West, behaviorism, psychoanalysis, and humanistic will be considered in relation to their influence on the development and emergence of transpersonal psychology: an organized attempt to include spirituality as a necessary part of the psychotherapeutic process. I will also examine and speak of the differences and similarities regarding the importance of spirituality in the healing process, both East and West.
**Eastern and Western Ways of Knowing**

Before Eastern and Western healing practices can be understood, it is necessary to be aware of the fundamental differences in both the Eastern and Western perspective or outlook on life. According to Kelman (1960) the East is characterized by its subjectifying attitude; the West, its objectifying one. The East is interested in consciousness itself; the West is cognitively interested in the objects of consciousness (p.72). The guiding principle of the East is correspondence and identity; in the West, unity in variety. The East is concerned with life essentially in its intuitive and aesthetic immediacy and it produced the world’s religions. The West is interested in theory and inferred factors in nature and produced science. For the West, he continues, wisdom is that which can be conceptualized and reality can be explained in terms of theories. The East tries to establish immediate contact with the Real; communion with that is wisdom. The Western form of the absolute is a deity or abstraction, so even in union there is still a distinction between the divine and human—a dualism persists. The Eastern absolute is the Real—The subject and all otherness are identical as in the absolute and the Real. The subject meets and experiences itself as it empties consciousness of its contents. There is a final awareness which is a state of pure lucidity when one is aware without being aware (p. 73).

Kelman says that the concept of time differs as well. The West tries to define it explicitly; in the East, there is no concrete time, only the present. Reality resides in the individual, not in historical process or linking those processes. He further explains that the East’s life rhythms arise from nature. They are organic. The West is dissociated from those. In terms of language, the West is more active in the use of verbs, doing, and
conforming to abstractions in language, and using phonetics. The East uses intuitive aesthetic language [e.g. Chinese characters]. The western mind-structure is used to conceptualization which blocks communicating and experiencing being on which the East is focused (p. 73,76).

Walsh (1989) suggests that Eastern descriptions of human nature and potentials sometimes run counter to basic Western assumptions and beliefs. He describes, for example, the Hindu psychological perspective on the nature of the mind as he quotes from the Bhagavad Gita (Hindu Bible):

Restless man's mind is,
So strongly shaken
In the grips of the senses
Gross and grown hard
With stubborn desire
For what is worldly.
How shall he tame it?
Truly I think
The wind is no wilder.
(Pabhhavananda & Isherwood, 1944, in Walsh, p. 544)

So, the human mind is “restless” and less under control than is usually appreciated, according to Eastern thought. Walsh indicates that these ancient claims have found support in recent Western studies of cognitive processing which suggests that “pseudothinking” is more the rule than the exception and people are constantly being misdirected by rational thinking. In fact persons’ minds are so out of control that usual
perceptions, identity, and consciousness are so distorted that they are not aware of the distortions. Therefore, Walsh suggests, that the Eastern psychologies might be akin to one of Freud’s (1917/1943, p. 252) earlier observations that “man is not even the master of his own house...his own mind” (Walsh, 1989, pp. 544-545).

Freud, he says, impacted on the Western world by declaring that what the world has regarded as “normality” is actually a culture-wide form of neurosis. Eastern psychologies proclaim that what we call normality is actually psychosis. The West’s usual definition of psychosis is a state of consciousness that is so out of control that it provides a distorted view of reality in which the distortion is not recognized (p. 545).

Both East and West thinkers acknowledge that the adult ego state with its concomitant limitations may be a necessary developmental life stage. The problem that seems to surface is that most people do not recognize, correct and develop beyond this conventional stage, even though the Eastern psychologies offer a transconventional developmental stage as their etiology (Walsh, p. 545).

When discussing the relationship between Eastern and Western psychological thinking, Walsh (1989) states that the West and East focus on different developmental levels. Western psychologies map psychopathology in greater detail. The Asian psychologies, for example, describe levels of development and well-being beyond those recognized in Western models, other than the transpersonal models. The East says almost nothing about early development, the dynamic unconscious or severe pathology. The East and Western psychologies may be partially complementary in that the Asian focus is on the advanced stages of development and state of well-being while the West focuses on the details of psychopathology and early development (p. 547). Walsh cites the work of
Western transpersonal theorist, Ken Wilbur, who offers an integrative paradigm of Eastern and Western thought which he calls a “full spectrum” theory. Wilbur traces development from infancy through adulthood on into the transpersonal, transconventional stages and then through the various stages of enlightenment. Thus, he says, Buddhist and Hindu psychologies may offer broader models to extend the scope of Western models (pp. 547-548).

In summary, Eastern and Western thinking appear to have divergent views as to the nature and substance of the exterior and interior world. One (the East) represents a non-linear view of the world, while the other (the West) a linear and dualistic view. How do these different views effect psychological healing, and what is the place of spirituality in the healing process?

*Healing as a Soul-Centered Activity*


I believe that each of us may facilitate healing as we are sensitive to our connectedness, as we acknowledge our ability to participate in the creation of realities, as we focus on the here and now,...as we strive for harmony and balance. The spiritual perspective on healing I am describing thus takes us back to an awareness of the original meaning of the verb *to heal*. That is...
'Heal comes from the same root as whole and holiness'. (p.41)

As an adjunctive statement, she cites Brooke Medicine Eagle (1989, p.60, 62) who says:

This holiness is the essence of healing, which means to manifest wholeness in spirit and bring it into our bodies, our families, our communities, our world. We heal by beginning to consciously embody...and manifest that wholeness of Spirit......[true healing] means coming into resonance with one law:

*You shall be in good relationship with each other and with all things in the Great Circle of Life.* (Ibid.)

Elkins (1995) emphasizes the importance of the spiritual dimension and focuses on the soul as the central organizing construct for psychotherapy. He urges psychology to return to its roots as “the study of the soul”. He says that psyche means soul from its Greek root word, and logos means study. The word psychopathology literally means suffering of the soul, again from its Greek antecedents (p. 1).

Historically, Elkins asserts that Carl Jung (1933) was the first psychologist to stress the importance of the soul and to make it a major psychological construct. Jung, he said, made spirituality the center of his therapeutic work and said that in order for anyone to be cured or healed, it was necessary to develop a spiritual orientation to life (in Elkins, 1995, p. 1).

Contemporary Jungian analyst, James Hillman, Elkins (1995) suggests, has called for a re-visioning of psychology from the perspective of soul. He reports that Hillman believes that the soul is one central organizing construct that can give boundaries and focus to professional psychology. Elkins calls for a Western approach to having a psychology based on soul which would return us to our Western roots in ancient Greece:
...a psychology based on soul would draw upon the traditions of Western culture and would use language and constructs more familiar to Western psychologists. A psychology with roots in ancient Greece one that is more indigenous to Western culture would, it seems to me, have a better chance of entering the mainstream of Western psychology than would its eastern counterparts (p. 2).

He continues by speaking about soul as belonging to humanity, the universal dimension of the human being. The soul does not have its haven in religion because it really has its origins in ancient Greece as the definition of psyche. The soul is the door to the imaginal world, so we have to disband our linear notions of understanding and realize that soul is more primordial, mythic and poetic: “The soul can be felt, touched, and known, but never defined” (Elkins, p. 3). Elkins indicates that since the soul cannot be defined in operational language, we must find some other way of defining it. He suggests that personal experience may help in establishing a common understanding.

The Hindu literature of India also proclaimed that there was an individual soul or Atman which was in its core identical with Brahman, the universal ground of all existence (Ramaswami & Sheikh, 1989 a, p.93). Embracing that Hindu belief, Kirpal Singh (1990), an Eastern Sikh scholar and practitioner of the 1970’s, would appear to support Elkin’s commentary about experience when he talks about personal inner experience of the soul and the importance of the soul in healing:

As long as we do not have an inner experience of the soul, we remain in utter darkness...Bookish knowledge becomes a headache....On the contrary, self-knowledge satisfies the innate craving and hunger of the soul for peace and happiness...When once a person is able to open the pages of the soul, and see the
great and immense possibilities lying hidden therein, there dawns in him a new kind of awakening and new light, shadowless and uncreated. This is called regeneration or rebirth or resurrection. It puts an end to his otherwise endless sufferings, tribulations, wants and miseries...The soul thus freed from worldly ties comes into its own, knows its truly Divine nature...(pp. 93-94)

Elkins (1995) additionally speaks about Western spirituality as tending to be more masculine and heroic: questing, overcoming, ascending, transcending, transforming. But these are animus functions, he says, things of the spirit. This is half the polarity; balance is called for with a deeper, more feminine “soulality” (p. 4).

Wright (1995) and Borysenko (1993), both women scholars, would tend to agree that the feminine brings balance to what traditional Western literature has largely minimized. Wright suggests that Western dualistic thinking has provoked cultural miasms such as “male against female, mind or spirit against body, and logic and rationality against intuition and emotions.” In the East, she says, the mind-body split does not exist and the concepts of male and female are complementary rather than contradictory (Wright, p.1). Borysenko implies that there are feminine qualities attached to what the trauma literature has called the Internal Self-Helper (first used by Allison, 1999), the enduring part of the self that seems to be devoid of all the disabling emotions. This inner helper seemed to be wise, compassionate and loving. These descriptions seem similar to some of the ancient spiritual texts like the Upanishads in India which speak about the Self. The Katha Upanishad, she says states:

The Self ... is not born. It does not die. It is neither cause nor effect. This Ancient One is unborn, imperishable; though the body be destroyed, it is not
killed...Smaller than the smallest, greater than the greatest, this Self forever
dwells within the hearts of all. (Borysenko, pp. 70-71)

Corresponding to Wright’s observation of the importance of the feminine, Elkins
(1995) says that soul is associated with the feminine. It derives its etiology from the
feminine Greek noun, psyche, and the Latin feminine noun, anima or spirit. In addition,
the word psychopathology, taken from its roots is the suffering of the soul.
Psychotherapy, then, can be perhaps more of a feminine act — the art of nurturing and
healing of the soul. Therapy becomes a container for soul-making. Soul to soul contact is
necessary for healing in the Western tradition. The psychotherapeutic methods for doing
this are simple: narratives, sharing our stories and soul food — whatever speaks to the
soul. Thus, he says, “psychotherapy from the perspective of soul means that the soul is
placed at the very center of the therapeutic endeavor (pp. 6-8).

In summary, I have reviewed some of the literature that regards the concept of
the soul as an integral part of the psyche’s healing process. Western theorists, Becvar
(1997), Elkins (1995), Wright (1995), and Borysenko (1993), all have suggested that
there is an underlying principle within each person that is enduring, compassionate and
loving. Because soul is a factor that is universal, it needs to be the underlying construct
in therapeutic intervention. The Hindu philosophy of Singh (1990) would support the
universal experience of soul, and for the Hindu that soul is divine. True healing occurs
when soul meets soul inside of the person. The healing practice or methodology rests
within the person’s soul and is concerned with meditation (this will be discussed in
another section of this review). According to Hindu philosophy, there are no constructs;
soul just is.
If healing is a soul-centered activity, what are some of the methodologies or practices that can transform or alleviate individual suffering? What follows next is an examination of some of the major Western and Eastern psychotherapeutic traditions.

*Healing from the Western Perspective*

Lueger and Sheikh (1989) briefly summarize the history of psychotherapeutic models that were precursors to the renewed interest in incorporating spirituality into clinical practice. They say that there are basically four models or forces of psychotherapy: psychoanalysis, behaviorism, humanistic, and transpersonal. During the first half of century, psychoanalysis arose as the first force and then behaviorism emerged becoming the second force. Those two dominated the field until the 60’s when humanistic psychology (the third force) emerged with Carl Rogers (Client-centered Therapy), Abraham Maslow (hierarchy of needs, Self-actualization Theory), Frederick Perls (Gestalt), and Rollo May (Existential). The humanistic movement emphasized individual freedom and ability of human beings to develop and determine their own destiny. They refuted the earlier deterministic philosophies of the behaviorists. The fourth force, transpersonal psychology emerged in the 80’s out of the need to recognize the importance of spirituality and transcendental needs as essential aspects of human nature (p. 198).

Central to the humanistic approach is an emphasis on the self as the organizing principle and emphasis on insight into the phenomenology of experience which encompasses existential, client-centered, Gestalt and experiential therapies. (Lueger and Sheikh, p. 218) Kurt Goldstein (1940, in Lueger &Sheikh, 1989) stressed the unity, organization and coherence of the human personality. He said there were four basic
precepts of the humanistic approach: 1. human beings function as organized wholes—the whole person equals the sum of all one’s parts plus an emergent quality; 2. human beings have one basic motive — self actualization, the drive by which a person is moved; 3. the normal person seeks to equalize orgasmic tension. There is a tendency towards order and centeredness. The balance of needs and drives, rather than a reduction of tension, guides the person forward; 4. the person must cope with stressful situations/environments; a developing person must “come to terms” with limits and demands of the environment (p. 219).

In existential therapy, the goal of healing is authenticity by which the client seeks to increase sensory awareness in the present. By losing more and more of one’s mind, one can experience with all of the senses the reality of oneself (Lueger and Sheikh, p. 221). Existential therapy is distinguished by this sense of reality and concreteness, and dynamisms always take their meaning from existential situations in a person’s environment (Scotten, 1981, p. 9). Authenticity is the end result of a person’s internal wakening, as s/he begins to shed the phony self.

*Transpersonal Psychotherapy*

It is the fourth force, Transpersonal Psychotherapy which has moved beyond the personal and personality. This model expanded the domain of psychological thought to encompass the spiritual dimension of human beings (Lueger and Sheikh, p. 225).

From the transpersonal perspective, Eastern and Western approaches to healing and growth are seen as complementary—the transpersonal perspective seeks to integrate ancient wisdom and modern knowledge. Stanislav Grof and Ken Wilbur, they say, have been the most influential in attempting to give direction to the transpersonal perspective.
Grof (1980, in Lueger & Sheikh, 1989) observed four major levels of human experience: 1. abstract or aesthetic experience dealing with impressive perceptual changes in the environment; 2. psychodynamic experience pertaining to significant memories, emotional issues, conflicts from the past; 3. perinatal experiences or experiences dealing with birth, aging, pain, agony, disease or death; and 4. experience of a transcendent, transpersonal, archetypal or mystical nature. Grof is closely aligned with Eastern philosophy; he also says that different systems of therapy and healing deal with different layers of experience (p. 227).

Ken Wilbur (1977) presents his own paradigm or overview of the entire spectrum of consciousness. Consciousness for him is a continuity with unity at one pole and dualism at the other. Wilbur suggests that most psychological or spiritual systems deal only with one segment of this continuum. But the ultimate aim of psychotherapy is to lead the client towards unity rather than to allow her/him to remain fixed or stuck at any point along the way (in Lueger & Sheikh, 1989, p. 227).

Walsh and Vaughan (1980) described four major dimensions of the transpersonal model of the person: consciousness, conditioning, personality and identification. Consciousness is the essence of being human; ordinary consciousness is seen as a defensive state of diminished awareness. In order to grow, it is necessary to let go of these defenses and remove the obstacles that bar us from recognizing our limitless potential. According to transpersonal theory, most persons are tightly wrapped in conditioning; but it is possible to be liberated. The goal of transpersonal therapy is to let go and release ourselves from the constant state of conditioning. Letting go means letting go of attachments that have played a pivotal role in our suffering. The transpersonal
model also states that there is more to us than our personality. In other words, there are other aspects of our being that we have not touched. Health is seen, from the transpersonal perspective, as primarily a process of disidentification from the personality rather than a modification of it. So one of the goals of transpersonal psychotherapy is to nurture the aspects of oneself that disidentifies with the whole and to recognize her/his own identity with the total self (in Lueger & Sheikh, 1989, p. 228).

Another transpersonal theorist, Boorstein (1997) speaks about psychotherapy and spirituality as paths that are clearly interrelated:

...as psychotherapy increases one’s capacity for witnessing the contents of one’s mind, so meditation increases ego strength by increasing one’s capacity to be aware of changing mind states without being overwhelmed by emotional responses. Also, spiritual practices can lead to an intensification of concentration and calm, which facilitates traditional psychotherapy. One can also view the spiritual ascent as requiring certain amounts of emotional energy. Unresolved early conflicts and traumas can keep this emotional energy from being available for the spiritual ascent. Therefore, traditional psychotherapy may be the crucial step to help a patient with his or her spiritual aspirations. (pp. 17-18)

He implies that healing is about developing compassion. A therapist can do this through engaging in some of the meditation practices that spiritual traditions offer. The spiritual traditions specifically emphasize working on the problems of love and compassion and the development of moral values: Buddhism, for example, speaks about Right Speech, Right Action, etc., the Judeo-Christian traditions revere the Ten
Commandments. Both Buddhism and Christianity emphasize the development of compassion and forgiveness (p. 19).

Boadella (1998), speaks about transpersonal psychology as having nine roots or mainstreams beginning with Carl Jung who took over the concept of the numinous and related it to an archetype whose referent was the essential qualities of our experience (from Dionysus the Areopagite who first used the term in the 5th century AD.) Jung spoke about the persona [the outer person], the shadow [repressed unconscious], and the archetype of the self which was seeking individuation (p. 6).

For the purposes of this study, only some of the major trends that Boadella sees in contemporary transpersonal practice will be discussed. Boadella cites Stanislav Groff’s (1985) work in perinatal psychology and altered states of consciousness as an important contribution to transpersonal theory and healing. Groff’s holotropic therapy is based on a multi-dimensional model of man who is opened to trans-egoic (beyond ego) levels of experience (in Boadella, 1998, p.8). He also credits Robert Assagioli, (1965), an Italian practitioner, with establishing a method of integrating various levels of personality dysfunction within the human being. Assagioli’s method was called psychosynthesis which left behind psychodynamic insights. He concentrated on the integration between spirituality and daily life (in Boadella, p. 8),

Francisco Varela and collaborators, Eleanor Rosch and Evan Thompson (1991), in their work, call for a ‘transformative re-embodiment’ of consciousness, as they stress the importance of cognition in the healing process: “...enactive cognition as an embodiment form of active knowledge integrating neuro-scientific understanding of human behaviour with direct life-experience coupled with pragmatic self-reflection
founded in the tradition of spiritual awareness” (Varela et. al., in Boadella, p. 9).

Transformative potential calls for a meditative element whose aim is to deepen our interpersonal awareness and global mindfulness. It is a call for the re-embodiment of psychotherapy by connecting “our reflective consciousness to its spiritual developmental foundations, in sensory-motoric, somatic-emotional, interactional, imaginal levels of experience” (Varela et. al., in Boadella, p. 9).

Varela et. al.’s work would seem to support the advent of movement therapy early in this century with a therapy developed by Rudolph Steiner called ‘eurhythmy’. 

Eurhythmy was a movement practice intended to rebalance the body, and re-tune the emotions and revitalize the spirit. Gerda Alexander, from Denmark, also developed her own form of movement therapeutic exercises called ‘eutony’ (in Boadella, 1998, p.12).

Many U.S. contemporary dance-movement therapy practitioners have embraced this theory of healing through embodiment. [Smallwood], Chodorow (1977), Adler (1992), Serlin (1993), and Marcow-Speiser (1995) all stress the sacredness of authentic movement, movement that can be akin to a vibratory romance with the soul. It is a dance or movement that arises from the inner sound current within the body. It is the organic process of Self-Movement, and integration, a coming together of the lost parts of oneself. The dance becomes the “embodiment” of the sound and consequently, the soul. Dance or movement is the body’s natural, and primary way of communicating an internal process.

A more recent development in the transpersonal movement is the contemplative psychology of Han de Wit (1991). This is a spiritual psychology of development with specific practices that are recommended to attain that development. De Wit uses a tripartite model: mind, communication, and behavior. He sees contemplative psychology
as unifying two traditions of academic psychology of religion as typified in university studies, with the subjective, first-person psychology of the meditator or the spiritual practitioner (in Boadella, 1998, p. 10, 11).

The literature about Western practitioners and thinkers who believe that the psychological healing process is a spiritual one is vast as has been noted. In the West, the reader has observed that psychotherapeutic forms of healing evolve from the more traditional behavioristic and psychoanalytic models towards a humanistic structure which appeared to pay more attention to the possibilities of an inherent unity of body and mind. As the humanistic psychologies began to explore the individual’s search for meaning, more questions arose about the cosmic influence on healing and about the interconnectedness between the individual and larger cosmos, and the courage of the heart, which the Greeks considered to be part of the essence of the soul (Boadella, 1998, p. 6). Finally, the West began to seek other ways of helping those who were so afflicted by existential concerns. Turning to the East for more answers and also to the great mystical traditions of their own faiths and cultural traditions, they sought to bring West and East together through a transpersonal model.

What had the East to offer the West in terms of psychological healing? Why this renewed interest?

*Healing from the Eastern Perspective*

Walsh (1989) suggests that the implications of the Buddhist and Hindu psychologies are not merely theoretical, but are also personal and practical. The trained mind is capable of all levels of well-being which includes a well-developed state of consciousness that is rooted in the depths of love, compassion, joy and clarity. These
attributes go far beyond those available to an untrained person. The Buddhist and Hindu psychologies provide road maps for attaining these high states of consciousness. These are maps whose validity can be experimentally tested in one’s own experience. This is the difference, they say, between contemplative knowledge and conceptual knowledge (pp. 546-547).

According to Walsh (1989), Eastern psychologies proffer an understanding of religion that is essentially different from the traditional Western views. He says that at the heart of the great religions, particularly in the mystical sects, is a common core which has been described as perennial wisdom, perennial philosophy, or transcendent unity of consciousness. This perennial wisdom provides road maps or strategies for inducing transcendental states. Perennial wisdom is the inner comprehension which comes as a result of deeper philosophical and psychological analyses of perspectives, insights, understandings and world views as provided by those transcendent states. Indian philosophers in the East conduct and describe human experience in multiple states of consciousness, whereas the West observes things and describes them in one state of consciousness. There are world views that are linear (West) and world views that are multi-dimensional (East) (p. 547).

**Buddhist Psychology**

If the Eastern perspective has a worldview that is multi-dimensional, then perhaps there may be some therapeutic technique which will enable persons to solve some very complex problems that may arise in their daily living. In their article on Buddhist psychology, Ramaswami and Sheikh (1989a) speak to the issues of psychological healing from a Buddhist viewpoint. Buddhism, they say, arose from the teachings of a man
named Gautama Siddhartha. Known as the Buddha after his enlightenment, he was born more than 500 years before Christ in India and nurtured in a Hindu family. Buddhism has retained some Hindu concepts, but the Buddha’s evolutionary ideal was that people could attain enlightenment through their own efforts. His “eightfold path”, a series of ethical techniques “for the psychological maturation of human beings consists of the following: right views, right resolve, right speech, right action, right livelihood, right effort, right mindfulness, and right concentration” (p. 91).

Ramaswami and Sheik (1989a) cite the work of Joy Manne-Lewis (1986), who analyzed the constructs pertaining to the Buddha’s attainment of enlightenment. She refers to them as the ‘axioms of the psychology of enlightenment’:

1. There exists a state of enlightenment.
2. Enlightenment is attainable by a person.
3. There is a method for the attainment of enlightenment.
4. There are discrete, ordered stages leading to enlightenment.
5. Enlightenment is both a cognitive and an affective state.

(Lewis, in Ramaswami and Sheik., p. 92)

These are close to the psychological concepts introduced by the Theravada (Hinayana) school of Buddhism. This school is noted as being closer to the Buddha’s original teachings (Ramaswami and Sheik, p. 92).

Most conventional Western psychologies would tend to view the development of a personal identity as a developmental matter which begins in childhood and progresses as each life stage is passed through. The basic concept of identity appears to reside in the notion of an individual self, a self which is concerned with the external world. In
referring to the Buddhist traditions, Roshi (1983), says that there is an *absolute self* in addition to the individual self. *Satori*, or enlightenment or full integration of the personality can only be developed through the realization of the absolute self (in which there is no self left to experience), and then, “when this unification breaks up, to realize the individual self which objectifies the absolute” (p. 72). When one affirms the individual self without knowing the absolute self, one approaches problems as if they were outside of oneself. Therefore, a person has only a one-sided perspective of the self. Since one then only experiences the world as external to oneself, one is never unified with it, and is consequently, always seeking the world or objects. Roshi explains that *satori* means that there is only one center of gravity in the universe, and one is sitting in that center of gravity. What one ordinarily calls the absolute or ultimate reality must really become one's own experience. When one has the experience of the absolute, there is no need to pursue things outside of oneself. He illustrates his point by saying: “When you are embracing your friend, you are not seeking your friend or yourself. This is absolute self” (p. 73). He continues by talking about the experience of fulfillment:

...Separating from that embrace, you now recognize the experience of fulfillment. Having experienced God or Buddha as none other than yourself, you separate and worship Buddha, you pray to God. Two lovers embracing each other experience absolute self, but when they separate, then respect for each other arises. There is nothing mystical about these two activities whose endless repetition is the basis of human life. All that is lacking is the true wisdom to realize this function (Roshi, 1983, p. 73).
So, the concept of self or identity is not a concept at all in Buddhism; it is enlightenment, or being totally in the present. Western concepts of self, say Ramaswami and Sheikh (1989a), can be traced back to either Plato or Aristotle or to the early Christian philosophers, St. Augustine and St. Thomas Acquinas. Both of these traditions affirm the existence of an individual soul. The Hindu literature of India also proclaimed that there was an individual soul or *Atman* which was in its core identical with *Brahman*, the universal ground of all existence (p.93).

The Buddha, they said, departed from the predominating Hindu view of self by denying the existence of a permanent soul or self (p. 93). The combination of mental and material or physical qualities constitutes the individual (p.93). They said this was a psychophysical complex that produces individuality. These physical and mental elements that constitute the individual are always changing and are only extinguished when one does not desire to exist any longer. The only continuous thread is the continuity of consciousness over time (pp.93-94). There are only mental states. There is no “I” behind thoughts, emotions, memories sensations and perceptions. “Yet without them there is no sense of “I”. The “I” derives its existence from these mental states” (p. 94).

In Buddhism, the idea of a separate self is illusion and is original sin. It is the cause of suffering and evil (Ramawami and Sheik, 1989a). Mental states are perceived as objects by the self which looks at them from a distance, outside of the self. According to Radaswami and Sheikh, Buddhism says that “this division of mental contents into a subjective self and objective mental states is a great error. All mental states are subjective and not objects of a subject, since the self is but a series of mental states” (p. 94).
How does this Buddhist philosophy regarding the concept of self or lack thereof relate to psychological healing?

*Mental Health in Buddhist Psychology:*

According to Ramaswami and Sheikh (1989a), the Buddha is often considered to be the Supreme Healer. He embodied all the qualities of the ideal doctor—detachment and compassion, and devoted his life to the alleviation of human suffering (p. 104). In the Buddhist view, meditation is the path to optimal health, both physical and mental. The Buddhists speak of setting right the mental currents; if that happens healing occurs. How does meditation heal? It helps to eliminate emotional toxins such as anger and lust and this brings about psychological and therefore physiological harmony. Lack of control and restraint are often the root causes of illness, mental and physical. They are the cognitive and motivational components of mental illness: “Mental disorder is caused by the presence of unhealthy factors and the absence of healthy ones...biological and situational factors, one’s karma and the psychological status of the previous mental state, all act to determine one’s mental state....the singular goal of Buddhist psychology is to increase the presence of healthy mental states and eliminate unhealthy ones altogether” (pp. 104, 106).

Ramaswami and Sheikh assert that in Buddhism, psychology cannot be easily separated from psychotherapy (p. 107). Meditation is not only a tool for exploring the mind but it is also a tool for transforming it and for achieving the optimal psychological functioning. This resembles Western psychotherapy. Both aim at changing people’s feelings about themselves, but the goals of some Western psychotherapy are narrow, that is, helping the person with social adjustment [society], social norms, etc. The goal of
Buddhist psychology is “the maximization of human happiness and the unfolding of the human potential”, but does not speak of societal adjustment. Being mindful in the present is what is required (p.108).

Ram Das (1983), in a panel discussion with two colleagues, Kornfield and Miyuki, supports the above opinion when he says: Spiritual growth “concerns the identification with the ego structure, and on that issue there is quite a gap between what is known as the psychological growth movement in America and the spiritual movement.” The psychological world is primarily interested in adjustment, and in happiness and pleasure. Psychology treats unhappiness as a negative condition and happiness is positive. The Buddha said that everything is suffering (p.35).

Odajnyk (1998) speaks about another form of Buddhism, Zen, and talks about Zen meditation as a way for individuation and healing. He says that western psychotherapy and meditation may be complementary in the healing process in that meditation may bring to the surface psychological problems, but does not directly address them. Psychotherapy can address them and bring the person to “normal” functioning but meditation can move the person beyond the normal to a state of more profound relief (p. 133).

In this essay, Odajnyk states that while he agrees that a combination of meditation and psychotherapy is the best way to approach psychological and spiritual growth, he believes that Zen meditation alone may accomplish the work of alleviating unhealthy symptoms and provide, in addition, an experience of individuation or wholeness (p.134). He says that after an experience of Zen meditation, many people report that they feel better physically and mentally even though they do not know why. They feel more alert
and less conflicted and confused. They also feel that they have a better understanding of their emotional problems (p.134).

In summation, the psychology of Buddhism appears to rest on the absence of a separate self, the impermanence of all things, and the fact of sorrow (Ramaswami and Sheikh, 1989a, p.120). Human beings suffer because of self-delusion. The Buddha proclaimed the cure is to reach a higher state of being, wherein self-delusion, attachment, and desire is eradicated by self-knowledge. All psychological pain is caused by false knowledge and covetousness and physical illness may also be attributed to these factors (p.120). Meditation is one way to transform and transcend this suffering, both on a psychological and physiological level. For example, the effects may be: “reduced energy metabolism, greater cortical alertness, limbic inhibition, and a deautomization of the attentional mechanisms involved in perceptions and cognition” (Ramaswami and Sheikh, 1989b, p. 462). The fruits of these effects promote a deep understanding of the underlying human condition and promote a lifestyle which is more harmonious and balanced as meditation becomes a singular focus on self-knowledge and self-awareness. Therapy based on Buddhist principles is likely to use cognitive restructuring, behavioral techniques and insight-oriented methods to effect a complete healing. This cure would involve a fundamental change in consciousness, and an awakening to an enlightened state where there was no fear nor desire (Ramaswami and Sheikh, 1989a, p. 120).

Hindu Psychology

Sudhir Kakar (1982), a practicing Indian psychoanalyst, examines a wide range of healing and spiritual practices in India. He devotes a whole chapter to one of the sects called Santmat (“the Path of the Saints”) advocated by the Radha Soami Satsang from
the perspective of healing. The sect's implied promise, he says, is to remove all suffering, mental and otherwise. This promise has attracted many thousands to this path, not only from India but also from many other countries. Kakar alludes to a certain difficulty which has been precipitated by the existence of a gulf that divides Freudian psychoanalysis from the practical psycho-philosophical schools of self-development and self-integration in India. These schools are generally grouped together under the common label, *mysticism*. As an Indian practicing psychoanalysis in his native country where there is such an absorption in the mystical traditions, he finds that he must consciously reflect on the conflict between his intellectual orientation of psychoanalysis and his own cultural/spiritual traditions (p. 119). He explains that too many of his colleagues have refused to engage themselves in the mystical model of man and thus have retained the narrow-mindedness of Western parochialism in the human sciences, especially since the contemporary mystical paradigm is generally perceived as a non-Western product emanating from the Hindu, Buddhist, and Sufi traditions (pp. 120-121).

The mystical paradigm, he says, has ignored the psychoanalytic claim to have discovered the "'true', unconscious meaning of mystical aims and practices"(p. 121). He says that the mystic would say there are four levels of knowledge of man arranged in ascending order: "the shrewd level of common sense, the rational one of the scientist, the imaginative level of the artist, and the spiritual one of the mystic. It is meaningless, if not foolish, to make statements about one level from the viewpoint of the other."

Kakar intimated that the psychoanalyst would doubt whether there was spiritual knowledge at all except as a transformation of emotions (p. 121).
Kakar speaks about the Radha Soami sect which had its origins in 1861 by a mystic, Shiv Dayal Singh or Soamiji in the city of Agra. This sect was very much in the mainstream of Indian devotional mysticism emanating from discourses, poems, and songs of medieval saints such as Kabir, Nanak, the founder of the Sikh faith. The two main parts of the faith rest on the notion of guru bhakti—the devotion to the guru, and a devotional practice known as the surat shabd yoga. The guru is referred to as the Satguru or True Master, the incarnation of the divine. The Satguru can take a devotee to the highest realm of transformation where s/he is united with God or the Supreme Being and redeemed from the cycles of birth, life, and death. The Satguru must, however, be a living one, just as Christ and the Buddha were living Masters during their time in history. The seeker must discover the living guru in her/his own time and do devotional practices to receive the grace which helps her/him progress on the inner journey. The second feature of this faith is the spiritual practice itself, the surat shabd yoga. This literally means the joining (yoga) of the spirit or soul (surat) with the Divine Sound or Word (shabd). According to the practices, a spiritual current of sound, emanating from the highest realms of creation, the dwelling place of the Supreme Being, resonates in every human being. With proper guru devotion (bhakti) and the practice of surat shabd yoga, the individual soul can become attached to the sound current which pulls the soul up through different “mansions of the soul” until it reaches the highest realm of consciousness. The key to this inner journey is the Satguru who is the guide who leads the disciple through the inner mystical regions (pp. 123-124).

To its followers, this faith is the real teaching of every saint simultaneously at all times in history. Christ, Buddha, Krishna, Kabir, the Sufi saints and Sikh gurus have all
spoken of and taught precisely the same journey as the road to self-transformation (p.125). These teachings are identical with those of Santmat.

In terms of psychological healing and solving life’s problems, this method of meditation and devotion offers a system of psychological and physiological practices “by which a person can deliberately and voluntarily seek detachment from the everyday, external world and replace it with a heightened awareness of inner reality; and, finally, there is a shared conviction that this inner world possesses a much greater reality than the outer one” (p.136). This is done, Kakar explains, through a process of idealization and identification with the Guru. This is similar to the process in psychoanalysis whereby the patient needs a temporary idealization and identification with the analyst in order to take further steps in attaining more self-autonomy through self-exploration. The difference between the two healing traditions is that idealization and identification are “tactile and temporary” in psychoanalysis; in Santmat, they are “strategic” and intended to be permanent:

...the...group activities such as the Satsang and its philosophy as expounded in the ...literature, by senior disciples, and by the guru himself, all propel idealization to its culminating point, where the guru can be experienced as God, and take the identification to its logical conclusion, where the disciple has the feeling of complete unity with the guru. (p. 146)

Therapeutic value is to be experienced through daily meditation and remembrance of the physical form of the Master. This singular focus of concentration, according to Kakar, “further cements the idealization and internalization of the guru since he is daily experienced as the benevolent protector against the anxieties that arise during the
meditative process” (p. 146). The Master, then, becomes, in fact, the “psychological powerhouse” who moves forward the inner processes of the disciple. The disciple must strive for a psychological symbiosis which is vital for her/his reemergence and rebirth. This active seeking for symbiosis with the Master is consistent with the Hindu view that solutions to problems are relational, that problem resolution resides in dyadic communication (p. 147).

These processes which lead to identification with the Master, says Kakar, are the basis for the disciple’s own healing transformation. The disciple, in a childlike ennui, surrenders to the divine in the Master, and somehow s/he is better able to understand the nature of her/his personal problems. The way of the infant is the only way to approach the divine, according to Hindu beliefs; childlike surrender is a way of detaching oneself from one’s biography, and the mystical path provides the resource in the person of divine guidance. Healing comes from within as an eternal process; it takes the commonly-held view of what psychoanalysts see as the “infantilization” of the seeker and his search for the ideal parent, one step further, and says that there is no ideal parent; there is only the Absolute (p. 150).

Thus, according to the literature, healing from the Eastern perspectives of Buddhism and Hinduism is personal and practical and is firmly rooted in the practice of meditation which is considered to be the therapeutic technique of self-surrender and self-knowledge. Meditation offers the individual sufferer an inner kind of contemplative knowledge rather than the more outer conceptual knowledge of the West. An integrated personality from the Eastern perspective is simply one who is fully contained and held in
the unity of the cosmos or universe. There is no “I” or “Thou”; there is only the Whole or the Divine Matrix.

Summary/Conclusions

The literature of some of the major Eastern and Western practitioners and thinkers who view the psychological healing process as a spiritual process has been reviewed. Suffice to say that the literature is vast from both traditions, and continues to evolve. Only some of the major thoughts on this matter have been reviewed. These include Western and Eastern psychotherapeutic processes as they pertain to spiritual thought. Judeo-Christian and native aboriginal practices and philosophy have not been included here, for the literature is too broad for the scope of this study.

The literature revealed certain basic disparities between Eastern and Western thinking which included divergent ways of knowing. Eastern thinking is non-linear, non-conceptual, non-compartmentalized and focuses on a multi-dimensional perspective of being-in-the-world. True Reality lies within the person, not outside. Western thinking is linear, rational, scientific, conceptual and one dimensional according to some sources (Walsh, 1989; Kelman, 1960; Ram Das et. al., 1983; Ramaswami and Sheikh, 1989a, 1989b).

Given these different perspectives, what is psychological healing and how does it take place, and, indeed, is it a spiritual process? Some of the major trends of thought in Buddhist psychology and Hindu thought as illustrated by a particular sect have been discussed. I have also examined a few of the major Western models of psychotherapy and have discussed how certain psychological perspectives on healing changed or evolved during this century, resulting in the emergence of a fourth force, Transpersonal
Psychology. Transpersonal Psychology has sought to incorporate and integrate both Eastern and Western thought and speaks of healing beyond the scope of traditional Western thought. The work of Vaughan, Walsh, Wilbur, Grof, and others value and declare the importance of the spiritual dimension of personality in the healing process. Transpersonal psychology concerns itself with the idea of personal identity as union with the total Self, and encourages the use of Eastern practices such as meditation along with psychotherapy to produce healing.

The concept of soul in both the Eastern and Western traditions was examined, as was the concept of identity in the formative healing process. For the East there is no such thing as personal identity; the individual soul merges with the Absolute, Atman (Hindu), where there is total unity. That is total healing wherein one is not only functional but whole. In the Buddhist tradition, there is not the absolute or God; there is just the Self, the here and now; enlightenment means one is totally in the present. The method for achieving this enlightenment is meditation — for the Buddhist, it is sitting and emptying the mental contents of the mind; for the Hindu Santmat sect, it is sitting in remembrance and focusing on the Guru inside who takes the soul to higher levels of consciousness. Functional healing of the psyche takes place simultaneously as the soul merges with the Divine inside.

For the West, the practices were initially concerned with bringing the unconscious (trauma) to consciousness and cognitively restructuring behaviors to alleviate suffering. Various techniques or methodologies were used in this endeavor. Psychoanalysis used free association, dream interpretation and analyses of the unconscious drives that produced maladaptive behaviors. Once the unconscious trauma was uncovered, an
individual could change the behaviors to adjust to the larger environment. The West has offered primarily a psychology of adjustment that focused on behavioral changes that would help a person function in every day activities. With the development of Humanistic psychology, practitioners said there was more. Maslow, Rogers, May, Perls and others, all spoke about concentrating on the here and now, being totally present and authentic. Viktor Frankl, an existentialist, said that in order to alleviate suffering, one has to touch the spirit, so healing must have something to do with soul. Interest in soul and the word authenticity emerged as an important theme. Simultaneously, Carl Jung, in his departure from Freud, called for a greater understanding of soul in the healing process, and said that no one could really be cured unless there was a belief in something greater than oneself. From there, modern writers like Becvar, Moore, and Elkins spoke about healing as a soul-centered activity. The transpersonalists from there continued the quest of making the healing a soul-journey that culminated beyond human consciousness into a cosmic consciousness, and embraced the idea of the necessity of going into altered states of consciousness to view the human condition (Washburn, 1994; Wilbur, 1996).

For me, healing from these divergent viewpoints seems to remain a mystery. It would appear that the literature has given some support for the idea that healing is a spiritual process. It would also appear that both East and Western ways of thinking about this matter may be complementary to each other, perhaps bringing together the cognitive mental aspects of the Western mind with the more intuitive aspect of the East. Some women thinkers like Wright and Borysenko, for example, would entertain a more
formal dialectic of introducing the feminine principle in healing, which may produce balance.

**Concluding Remarks: Literature Review**

This study involves an interdisciplinary way of approaching the subject matter of the healing of dissociative disorders that have their origins in pre-verbal psychological trauma. The major literature concerning developmental language and trauma theories, the concept of dissociation and current clinical treatment models for persons diagnosed with a dissociative disorder and the concept of psychological healing as a spiritual process has been reviewed.

It was found that some of the underlying assumptions and theories that exist in the professional literature of the above named domains are multi-layered and varied and may involve intercultural understandings and practices. There appears to be a dearth of literature directly linking language acquisition skills to early trauma. The basic assumption, as has been cited, is that psychological trauma can cause language delay. Because of this language delay, it is difficult for persons who were traumatized early on, to emote feelings associated with the trauma. It has been noted that the use of imagination is one of the first skills infants use in developing language skills. Trauma theorists have noted that those persons who had been traumatized early on have blunted affect and lack of imagination. Early language theories have largely neglected the subjective world of the infant but theorist/practitioner, Daniel Stern (1985, 2000) has suggested that there is a subjective world of the infant and this can be accessed. The literature concerning dissociative treatment modalities has revealed that there is access. It is my opinion that those feelings/reactions to early traumatic incidents may be
dissociated from the infant’s consciousness and remain there until h/she is taught to use these imaginal skills. This may occur within treatment modalities like the expressive arts, hypnosis, EMDR, etc. to help access these split-off feelings.

The literature also reveals that persons with a dissociative disorder (DID, DDNOS) have severe identity fragmentation and little, if any, stable ego formation. The bringing together of these fragmented parts of the self to form a unitary identity, according to clinical practitioners, is the goal of therapeutic intervention. Concomitant with this is the question of how does healing take place for those who were traumatized before full language production?

Upon examining the literature of those practitioners/thinkers who believe in healing as a spiritual process, the reader is reminded of still another domain that needs to be explored as it pertains to those who have serious identity issues. It has been noted in this review that there are cultural disparities in the perception of dissociation and psychological trauma and the healing process. Consequently, the reader is introduced to both a brief summary of some Eastern and Western ways of knowing and treatment for psychological trauma. For the West, the idea of identity formation is more linear and it is for all practical purposes, psychological; for the East it is non-linear and mostly concerned with the oneness of the Soul-Self. The process is spiritual in nature.

I believe that final personality integration occurs when there is a balance in the psychic energies. Could this be the fulcrum — where East meets West inside? There appear to be many questions left unanswered. The West thinks the East is mad; the East thinks the West is mad. The world is illusion, the East says. Self-knowledge is all there
is, and this is the prerequisite for healing. Is self-knowledge the same as merging with the Divine inside of oneself?

There remains now a need to define what are the necessary ingredients to form a healthy personality integration with self and society and how to make that happen. The next section will focus on a contextual analysis of the recovery process of the author and four participants all diagnosed with a dissociative disorder. Their process will be examined correlative to the supporting interdisciplinary literature contained in this part.
PART THREE: METHOD AND FINDINGS

Introduction

The last section focused on the professional interdisciplinary literature that has concerned itself with this dissertation study: language development, trauma, dissociation and healing as a spiritual process. In Part three, I focus on a short history of the methodologies I have chosen, on my process of discerning and using these methodologies, the pilot autoethnographic study, and the participants' experiential descriptions of their process and the resulting emergent personal and corporate experiential themes. I conclude with a reflective summary synthesis on the summary findings.

Research Design and Methods

This study is based on autoethnographic (Patton, 2002), heuristic and phenomenological research methods (Moustakas, 1990, 1994; Patton, 2002) that support experiential inquiry and a design utilizing grounded theory (Seidman, 1993; Moustakas, 1994; Strauss & Corbin, 1998; Willig, 2001; Patton, 2002).

As noted in my introductory remarks on methodology, I use autoethnography as a basis for choosing the participants in my study and as a starting point for understanding my own lived experience. It is this initial, intuitive understanding of my own dissociative history that will hopefully inform the interactive thematic components of the participants' lived experience of dissociation and subsequent recovery.

As noted previously, autoethnography involves the study of one's culture and oneself as part of that culture, and its many variations (Patton, pp. 85-91). I have chosen to regard dissociation as an experience that may be culturally specific to early trauma
survivors. As such, my method includes the use of autoethnography as my own lived experience of dissociation.

Patton cites researcher Goodall (2000) who calls this ‘new ethnography’ “creative narratives shaped out of a writer’s personal experiences within a culture and addressed to academic and public audiences”. What distinguishes this method from other ethnographic research is self-awareness about and respect for one’s own experiences and introspections as a primary source of data (in Patton, p. 85).

Patton concludes that this method is both groundbreaking and confusing because so many divergent descriptive phrases have emerged. He says that Ellis and Bochner (2000), in a comprehensive review of this method, cite a great number of phrases that have emerged to support this form of qualitative inquiry including but not limited to: first-person accounts, personal narratives, personal experience narratives, self-stories, narratives of the self, lived experience, first person accounts, ethnographic memoir, etc. Ultimately, they infer that autoethnography has been used more and more as the term of choice in describing studies that involve procedures for connecting personal experience to the culture (in Patton, p. 85).

Therefore, I tell my own story as it pertains to the cultural milieu of dissociation and dissociative behaviors. I do this, both as a researcher, and as a participant. As researcher, I structure my narrative based on the philosophy of infant developmental theorist/practitioner, Daniel Stern (1985, 2000). As participant, I share with the reader my recovery/healing process as a trauma survivor. Thus, my lived experience becomes the phenomenon for further study as I transition to examine this process in others who have had similar experience. Consequently, after telling my story, I needed to find additional
methodologies that were in concert with the qualities inherent in my lived experience—to go outward, and then inward again to examine the quality and essence of other lived experiences of a dissociative nature. I turned to heuristic inquiry and phenomenology as a way to amplify and to understand the dissociative experience.

Heuristic research, according to Moustakas (1990, 1994) requires that the researcher be totally involved as a co-participant in the process of discovering the nature and meaning of the participants' experience. For him the heuristic process is autobiographical in that with every question of importance, there is a social and sometimes universal significance. His aim is to understand human experience in the context of persons' stories as explained through self-dialogues, stories, artwork, poetry, etc.

Heuristic inquiry's focus, then, is on intense human experiences, and is concerned with: 1) meanings, not measurements; 2) essences, not appearances; 3) quality, not quantity; and 4) experience not behavior (Patton, 2002, p. 107). There are orderly steps that the heuristic researcher engages in. These involve a creative process that leads to what Moustakas (1990) and others have called “definitive exposition” of experiential essences. They are: 1) immersion, wherein the researcher is fully absorbed in the mysteries inherent in the narratives and still remains engaged in a meaningful research experience; 2) incubation, or a period of waiting for the thoughts to develop or to gel; 3) illumination, an “aha” experience, wherein there is the moment of clarification much akin to either an inner spiritual or intellectual revelation; 4) explication, the moment of explanation or elucidation of the idea; 5) creative synthesis, the summary or integration
of all the gathered information and includes the researcher’s intuition and implicit understandings (Patton, pp. 108-09; Moustakas, 1990).

According to Patton, there is another heuristic approach called Qualitative Heuristics that was developed at the University of Hamburg. This German alternative tradition has four basic rules of heuristic inquiry: 1) The researcher should be open to new concepts and be amenable to change preconceptions of the data that are not in agreement with them; 2) The topic of research is preliminary and may change during the course of the investigative process. It is only fully known after being successfully examined; 3) The data is collected under a standard of a good number of studied variations. This variation of samples avoids a one-sided representation of the subject matter; 4) The analysis is aimed at the discovery of similarities (p. 110).

My understanding of Moustakas’ later work (1994) is that he seems to incorporate or integrate heuristics with an approach which he calls “transcendental phenomenology”. This methodology is centered primarily on philosopher Edmund Husserl’s idea that knowledge based on intuition and essence precedes empirical knowledge (p. 26). According to Willig (2001), Husserl felt that it was possible to transcend presuppositions and biases to experience a state of pre-reflective consciousness which allows the researcher to describe phenomenon as it presents itself. The method used to gain entry involves three phases: 1) *Epoche*, in which the researcher suspends all suppositions, assumptions and judgments and/or interpretations and allows her/himself to be fully present and aware of the presenting phenomenon; 2) *phenomenological deduction*, in which the researcher describes the phenomenon in its totality, which includes all the physical features (size, shape, color, texture, etc.) as well as the experiential aspects such
as thought, feelings, so that the researcher becomes consciously aware of what makes the experience what it is; 3) imaginative variation, in which the researcher attempts to access the structural components of the phenomenon, i.e. how this experience is made possible. The goal here is to be aware of the circumstances related to or connected to the phenomenon without which it could not be what it is. Lastly, these textured and structural descriptions are joined together to arrive at an understanding of the essence of the phenomenon (p. 52).

Willig asserts that there is a different focus and emphasis between transcendental phenomenology and the use of the phenomenological method in psychology. The phenomenological method in psychology is more concerned with the variety and changeability of human experiences rather than unearthing or identifying essences. Transcendental phenomenology examines essences. It requires the total contemplation of the phenomenon which involves introspection and attention to one’s own experience. Phenomenological analysis of a particular experience requires the researcher to get inside someone else’s experiences (p. 53). Strictly speaking, she explains, interpretative phenomenological analysis accepts the infeasibility of the researcher gaining access to participants’ inner life, for that type of exploration is always colored by the researcher’s own life experience (p. 54). Therefore, in order for the researcher to unearth meanings contained in the texts and transcripts, steps must be taken to identify themes and integrate them into meaningful clusters, first within and then across cases. So, first the researcher works with transcripts of semi-structured interviews using open-ended and non-directive questions to encourage participants to amplify their experience rather than to check whether they agree or disagree with particular statements, etc. The texts are
worked with in an open form of annotation, different from the open coding used in
grounded theory. Secondly, themes that characterize each section of the text are
identified and labeled, usually in the right margins. Thirdly, structure is introduced into
the analysis by listing the themes and thinking about them. The themes form natural
clusters of concepts that the researcher reflects upon in order to grasp their essence as
described by the participants. Finally, the researcher produces a summary table of
structured themes along with quotations that illustrate each theme (pp. 56-58).

There are limitations to the interpretative phenomenological method, Willig
asserts. This analysis relies on language. However, language may construct rather than
depict reality. The same incident can be described in many ways. Language, she says,
can never express experiences in a simple way; it can add meaning, which resides in the
words themselves and therefore makes direct access to someone else’s experience
impossible. An individual, for example, can talk about a particular experience within a
specific context in a transcript or diary entry. It may be described within context but the
researcher still does not know about the experience itself. Language precedes and shapes
experience (p. 63).

Willig’s statements about language and the interpretative model caused me to
reflect further on the feasibility of using this model, especially since I was investigating
early trauma. In reflecting on my own process, I am aware of having had no language to
describe my experience, so it could hardly be shaped. My experience had no form; it was
only the art or the use of body movements ("body language") that could describe it. I
had to learn to talk and to name my experience in the vernacular so others could
understand. My art conveyed an underlying language that evoked feeling or emotion in
others. That prompted questions about my experience and also questions about the participants' lived experiences whereby verbal expression was limited. I had to find my own meaning and words. I had to develop my own narrative through learning the language, learning how to make sense out of visual or bodily metaphor and apply it in the "real" world, the external environment so that the clinical infant could survive. The adult needed access to the feelings and learn appropriate words to describe the feelings so that she could feel heard. My question remained: Did the other participants go through a similar process? I did not think that the more objective method of interpretative phenomenology would give me these answers.

So, I returned once again to Moustakas’ later work (1994) in which he speaks more of the transcendental phenomenological method coupled with his basic heuristic methodology. It is in this later work that Moustakas seems to insist that the researcher be totally co-present with the study participant and that self-knowledge and “pairing” is the way that the researcher experiences someone else:

I must first explicate my own intentional consciousness through transcendental processes before I can understand someone or something that is not my own, someone or something that is apprehended analogically. My own perception is primary; it includes the perception of the other by analogy (p. 37).

So, for Moustakas, phenomenology has become the first method of knowledge because it is concerned with “things” themselves, and eliminates anything that could be construed as a pre-judgment. Presuppositions are set aside and things are examined in a fresh way:

As far back as I can remember, I have sought to know the truth of things through
my own intuition and perception, learning from my own direct experience and from awareness and reflections that would bring meanings to light...I have always wanted to encounter life freshly, to allow myself to be immersed in situations in such a way that I could see, really see and know from my own visions and from the images and voices within (p. 41).

Moustakas’s method of collecting data in his later writing is the phenomenological interview which involves an informal, interactive process utilizing open-ended questions and comments. Although the researcher may have questions prepared in advance to elicit response, they may be varied or not used at all. The interviewer, according to Moustakas is responsible for creating a relaxing and comfortable environment for the participant (p. 114). Data is analyzed through contextual analysis.

At this juncture in my exploration of methodologies, the differences between heuristic inquiry and phenomenology seemed rather negligible and at the same time complex. Patton (2002) seemed to shed light on my queries when he stated that heuristic inquiry is derived from but different from phenomenology in four major ways: 1) Heuristics emphasize connectedness and relationships; phenomenology supports more detachment in analyzing experience; 2) Heuristics lead to representations of essential meanings and depiction of intrigue and personal significance that underlies the search to know; phenomenology focuses on more authoritative descriptions of the structures of experience; 3) Heuristics finishes with a “creative synthesis” (as noted previously) that includes the researcher’s understandings; phenomenology offers a distillation of the structures of experience; 4) In Heuristic inquiry, the research participants remain a vital
and visible part of the research process and are treated as whole persons. They retain their essence as persons; in phenomenology, persons are lost in the process of descriptive analysis, and it ends with the essence of the experience (p. 109).

I finally decided that I needed to use both of these methods because they seemed to fit into my basic exploratory style as the researcher-observer (phenomenological objectivity) and as the participant (heuristic subjectivity). This seemed to clear the way forward to find another method that would support a theoretical construct should one emerge from the data analysis.

Consequently, in addition to the aforementioned methods, I utilize the grounded theory methods of data analysis as explicated by Strauss and Corbin (1998). Grounded theory, they say, is theory derived from data that is systematically gathered and analyzed through the research process (p. 12). Grounded theory refers to research that examines person’s lived experiences which include all their social behaviors and cultural influences that have shaped their lives, internally and externally. Strauss and Corbin maintain that analysis is the “interplay between researchers and data” (p. 13). Analysis can be seen as both an art and a science. The creative and critical thinking research skills of the researcher are essential in order to obtain a true picture of personal experience. It is important for the researcher to describe what is heard without interpreting it and then to conceptualize and order the data into certain shared themes. The theory will emerge by itself from the data presented through thematic analysis of its content.

Thus, grounded theory’s focus is on the process of generating theory rather than looking at a particular theoretical content. It emphasizes specific steps for making constant comparisons, comparing research sites, doing theoretical samplings and testing
of the emergent concepts with additional fieldwork. The analysis continues to be an interplay between the researcher and data, so that grounded theory offers as a framework a set of "coding procedures" to provide for and maintain certain standards and rigor (Patton, 2002, pp. 125, 127). So, grounded theory is both systematic and creative, fostering a generative sense of something new, an emergent thought or idea that underlies what has been observed.

In sum, apart from the initial autoethnology which focuses on a cultural relationship (dissociation), the subsequent three methods reflect and support the way in which the data is to be analyzed. In review, phenomenology focuses on the content of consciousness and the individual's lived experience of the phenomenon under investigation. Interpretative Phenomenological Analysis emphasizes objectivity in description and documentation of the lived experience but does not attempt explanation (Willig, 2001, p. 52). Heuristics (Moustakas, 1990, 1994; Willig, 2001; Patton, 2002) focuses on the essence of lived experience as shared by both the researcher and the participant. Finally, Grounded Theory (Willig, 2001; Patton, 2002) examines data in an objective way and is concrete versus the more intuitive subjective process of heuristics. It begins with basic description, moves to conceptual ordering, and ends with theorizing — intuiting ideas or concepts based on description of the data.

Building on my understanding of these three methods, I have chosen to incorporate all three into my study in the following way. First, data has been collected consisting of personal narrative, journal notes and self-dialogue, and artwork, etc. of my (researcher's) recovery process and of fieldwork notes and interviews with four persons with corresponding histories. The pilot study data was used as a platform to structure the
interview guide. I stayed away from subjective interference by keeping that data out of the study. The four persons who have gone through their own recovery process have been interviewed in a series of three in-depth interviews, based on an adaptation of Seidman’s (1993) three-interview system of data collection. These interviews included open-ended questions as a guide for participants to reflect on the meaning(s) of their lived experience of pre-verbal trauma and subsequent dissociative pathology. Each interview was from one to one and a half hours in length. The first interview focused on their life history pertaining to the original trauma and the resultant developmental issues engendered by this early experience. The second interview focused on recovery and their life in the present, and the final interview was a reflective synthesis of the other two. The interview guide and process will be discussed in more detail under the section, Participant Choice.

Secondly, all interview data after the pilot study were analyzed by using the following methods: 1) Transcription: all interviews were transcribed and sent to the participants for review and amendments as needed in the margins of the text. Three were returned with comments and additions and one person gave me permission to use the transcript as it was because she had misplaced it and explained that there were too many stressors in her life at that time to try to find it; 2) Coding and Content Analysis: I read and reread the transcripts, highlighting main ideas, themes, words and concepts in the margins in each transcript and made a summary sheet for each with categories and general themes; 3) Cross-Contextual analysis: After examining the themes within the context of each person’s narrative, I then did a summary analysis of the contextual similarities and/or differences among all four persons to determine if there were
universal themes and/or beliefs that are held by this population. Because heuristic inquiry is concerned with subjective, lived experience, my analysis here purposely included thematic expressions from each participant to exemplify and amplify their experience.

Finally, after discovering and labeling these universal themes, I wrote a summary synthesis of the findings.

So, these steps appear to reflect an overlapping use of phenomenological, heuristic and grounded theory methods. What is pivotal in this study is the differentiation between objective and subjective data. I use objective and subjective means of data collection. I use description (phenomenology, grounded theory), and documentation of lived experience (phenomenology) to objectively identify and to understand the external phenomena under investigation (pre-verbal trauma, dissociation, healing/recovery process). I incorporate the more subjective, intuitive aspects of the heuristic method by focusing on the essence or the core meanings of the lived experience.

I use all three methods in the data analysis by focusing on: 1) the objective aspects of grounded theory and phenomenology which includes finding themes through individual narratives, labeling, coding, and finding similarities/differences among participant stories, etc.; 2) the more subjective heuristic methods which include focusing on both content and contextual analysis that involves inner nuances, thoughts, textures, environmental influences, etc. Finally, I use all three approaches in writing my conclusions based on a synthesis of both what was observed (description) and what was inferred by the subjective narrative sharing and the core or essential emergent underlying themes that both describe and explain the lived experience. The purpose here was to see
if a theory might emerge that is grounded in both the objective and subjective presenting data (Grounded Theory). The following table illustrates the use of the methodologies:

**STEPS IN DATA ANALYSIS**

<table>
<thead>
<tr>
<th>Steps</th>
<th>Method</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Data Collection</td>
<td>Phenomenological</td>
<td>Objective — collection includes description and documentation of lived experience</td>
</tr>
<tr>
<td>Objective and Subjective</td>
<td>Grounded Theory</td>
<td>Objective — collection includes basic systematic description from fieldwork notes and narratives</td>
</tr>
<tr>
<td>collection of data to identify and understand the external phenomena under investigation, i.e. pre-verbal trauma, dissociation, healing/recovery process;</td>
<td>Heuristic</td>
<td>Subjective — collection includes focused awareness of core essences contained in narratives by both researcher and participant; involves intuitive sharing of both interior and exterior descriptions, feelings, textural postures of lived experience</td>
</tr>
<tr>
<td>Three 1-1/2 hour taped interviews, transcribed for each participant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Data Analysis</td>
<td>Phenomenology and Grounded</td>
<td>Objective — finding themes through individual narratives, labeling, coding, finding similarities/ differences, etc.</td>
</tr>
<tr>
<td>Individual and cross contextual analysis of presenting data from transcribed interviews and field notes; objective and subjective</td>
<td>Theory</td>
<td>Subjective — focusing on both content and textural analysis; involves inner nuances, thoughts, texture, environmental influences, etc.</td>
</tr>
<tr>
<td></td>
<td>Heuristic</td>
<td></td>
</tr>
<tr>
<td>3. Findings and Conclusions</td>
<td>Phenomenological Heuristic and</td>
<td>Findings and conclusions based on synthesis of what was observed and what was inferred — objective and subjective narrative sharing and description of emergent theme(s) that both describe and explain the lived experience</td>
</tr>
<tr>
<td></td>
<td>Grounded Theory</td>
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</table>
Precedents for Methodology and Research Design

There are few studies using the qualitative research methods as described that have examined the healing process involved in dissociative pathology from the patient’s perspective. However, there are precedents for this kind of study. Schneider (1997) uses heuristic methods to examine the process of self-healing as she compares her own healing to a shamanic process. Bowman's (1994) study of the psychological experience of healing from childhood trauma is a heuristic study of six persons who were trauma survivors. The study attempted to elucidate what their experiences were and what modalities were helpful to them in their healing journey. Machell (1999) offers a phenomenological exploration into the inner worlds of five people diagnosed with a dissociative disorder. Interviews were audiotaped and analyzed for themes. In a more recent ethnographic study, Somer and Nave (2001) used phenomenological methods to explore the healing process of five former DID patients. Their objective was to explore and to understand dissociative experience from the patient’s perspective and to offer a more scholarly appreciation of this experience (p. 316).

Having discussed the methodology and its process, I now turn to a summary narrative discussion of what I would call the “pilot” study which became the basis for the choice of participants. This, I refer to as the researcher’s process, a study of my own experience of dissociation and subsequent healing.
PILOT AUTOETHNOGRAPHIC STUDY

Researcher’s Process: Healing Through the Arts:

A Case Study of Infant Trauma

Introductory Remarks

As noted in the literature section, researcher Daniel Stern (1985, 2000) places emphasis on the subjective world of the infant as important and vital in clinical intervention. When alluding to therapeutic intervention, he says that the infant is a joint creation of two people, the adult who grew up to be a psychiatric patient and the therapist who has a theory about infant experience. According to Stern, within the therapy hour, the adult becomes the “recreated infant”, the only one who can express or reenact the memories. He calls this creation, the clinical infant as differentiated from the observed infant, whose behavior is observed at the time of its occurrence. Both of these approaches, he says, are necessary when thinking about the development of the sense of self. The clinical infant, he says, breathes subjective life into the observed infant, so that memories can be processed and the subjective life of the observed infant can be acknowledged (p. 14). It is my opinion that healing and recovery is predicated on a profound acknowledgement of the infant’s subjective experience. The patient’s narratives and metaphors, therefore, become an integral and vital part of treatment. This may be especially true for those persons who have been traumatized before full language production.

Consequently, in this chapter, I will review my own narratives associated with early traumatic experiences, and how I became an example of Stern’s term, the clinical infant. I will demonstrate how the adult (the clinical infant) was able to access previously
unexpressed pain associated with those early memories and illuminate the subjective
world of the observed infant through the use of metaphor and narrative as experienced in
the therapy room.

Pre-verbal psychological trauma and later clinical diagnosis of a dissociative
disorder has led me to experience a healing process through the intermodal use of the
creative arts. I now share with the reader my subjective experience of this state which
the mental health professions have labeled dissociation. I call this experience, “sacred
splits”, an extensive identity crisis, originating in infancy, [perhaps as early as the
womb]. A chronic fear created a split that was so debilitating that so many inner, what I
have called, “characters” (ego-states) emerged, each trying in her/his own way to protect
the body that held them, so that the body could move around in this strange environment
called the world, the conscious reality that you, the reader, and I experience in the
present.

Integration took place through a process of modified abreaction using several
processes: 1) working with metaphor using the creative arts, such as movement, the
visual arts, sculpture, poetry, writing, photography; 2) body and energy work; 3) trance
work which helped to contain powerful abreactions and gave me control; 4) reliance on
my spiritual path as the underpinning of all my work. My therapist and I had this mutual
implicit understanding that my inner work was a spiritual process, not solely a
psychological one. This kind of work was very different for me from earlier inner work
which had encouraged abreactive work through more outward aggressive discharge
which did not leave me in control of anything.
Because the trauma had occurred prior to language acquisition, my "ego-states", "alters", or "introjects" were initially very primitive responses to questions that a therapist might have. In short, I could not speak, nor could I use my voice. The trauma and along with it, my voice started to emerge through my art, and I had to put form to this before I could make words. These parts of myself appeared on paper in the form of the sadist or perpetrator, mother, child, etc. in totally different handwriting(s). The "baby" appeared physically in sessions by expressing the self in primitive movements, and self-harming gestures. When the voice came, it came speaking in rhyme—it was only after a few years that other parts came out with actual voices within the sessions. The healing came because there was a witness who was a "living companion" in the process—a therapist who understood or was willing to understand the inner process as a spiritual one, that somehow we were connected, and she and I were cognizant of this Oneness.

**Introduction**

*From the outside looking in*
*the gates are locked,*
*you see,*
*as the piercing pieces*
*of precious lives*
*steal away*
in the night —
*falling light*
*makes tiny*
*glimmers in*
*the sea —*
*calm fools*
*bear witness*
to the sky falling
*in......*

*dds, 1994*
This poem was written by me as I peeked through the cross-bars of a heavy black wrought-iron fence overlooking the Aegean Sea at sunset. I was on a small Greek Island where I had been working as a clinical therapist and administrator of an inpatient program. My job had just been terminated due to financial problems at the center. Job stresses attenuated and reactivated earlier traumatic experiences (to be discussed in later paragraphs). I had begun to lose time and to have flashbacks of these experiences via artwork that propelled me into crisis. A friend had come from the U.S. to bring me home. Somehow, I really couldn’t tell her or my colleagues the depth of the anguish I was experiencing. Poetry was the only release, and I am not certain that I even understood that then. She took my car keys, and I walked outside, heading for the road, hoping that maybe I would be run over by an on-coming car. I saw the fence and held onto it. The poem emerged — simple and direct. It was as though something inside of me knew what others could not see or feel.

Healing of the psyche after intensive traumatic experiences can be a powerful rejuvenative force and a soul-making process for persons who have been so fragmented in early childhood. I discovered in my midlife here on an island far from home that I had lived two lives, or many segmented ones, as I, in crisis, began to write, draw, paint, and sculpt my way into my unconscious in an attempt to bear witness to the angst of separation within myself.

My friend brought me back to the states to a woman’s trauma unit of a private psychiatric facility. I was fifty-three years at the time of my hospitalization and presented initially as very articulate though depressed. I was actively dissociating and had some memory loss. I seemed to know where I was and expressed a need to be in a
safe place, where I could finally "let go" and be "mad". In fact, I must have been forewarned. I had prepared myself for this crisis a few months before: I had written my will, gave a friend power of attorney and also wrote up a health care proxy that authorized my daughter and another friend to make decisions for me in case I was incapacitated.

This was my first hospitalization, although I had had a "breakdown" that interrupted my graduate schooling in social work. At that time I took a leave of absence and was treated for a clinical depression. Hospitalization was averted then when a friend took care of me, and I sought clinical counseling. This current crisis, however, precipitated more intense feelings of constant suicidal ideation, accompanied by fantasies of cutting myself with knives. While overseas, I had gone into the nursing office at the center and tried to find valium with the idea of overdosing. I then gave some very strong anti-malaria pills to a colleague, for fear that I might use them.

In the hospital I found it difficult to speak about family history. I described myself as a lonely child, almost an only child of a middle class German-American family. I was the middle child with a brother five years my senior and another brother seven years younger. I was virtually mute as a child, did not speak, nor could I interact with others in social situations. When I was alone I would usually rock back and forth and have conversations in my mind. People frightened me, and I could not make eye contact and many times would withdraw into a corner somewhere where no one could see me. My childhood, in short, was bereft of sensory and social stimulation, with a father, who either had temper tantrums and raged or withdrew completely from family activities, and with a mother who was like the "virgin-mother-martyr", a good German housewife,
who supported the vagaries of my father’s labile temperament. My father, I said, always grinned like a cheshire cat ready to pounce, and had a strange "habit" of exposing and playing with his penis in front of me.

My narrative continued as I explained that an "excessive shyness" had followed me throughout my life, and I knew something was profoundly "wrong" with me, but didn't know what. I was a good student in school, but had trouble with reading and concentrating, but, always, according to some of my teachers, performed beyond my ability level determined by normed test scores. I graduated from college, became an elementary teacher in order to conquer my shyness and learn how to speak. I subsequently married, had three children about a year apart in age, became a homemaker and also became very involved in civic and church activities. In my late thirties, I decided to go back to school for a Master's degree in social work, after having had a traumatic experience with a psychotherapist that prompted an internal feeling "to do therapy" better than what I had experienced. I also was determined to learn how to think more clearly and to become more articulate around my peers, which had always been problematic for me.

After graduate school, I made a major move with my family to an island community and started a new job with an agency as a child therapist. This move, combined with a series of losses, ill health, and marital difficulties, seemed to precipitate one crisis after another. In the hospital, I did not talk much about my divorce. After twenty-five years of marriage, my husband left, just after his mother died and as the children were leaving home. A few years later, I had lost my home, my mother, and became quite ill, and then left my job as a clinician in the treatment center overseas,
hoping that a change of venue would prompt a healing process. That appeared to back-fire when all my childhood and adult traumatic memories surfaced once again as I began to dialogue with a colleague about my life. The colleague suggested I start drawing. I sat down one evening and drew about twenty pictures. It looked as though a child had drawn these, and it opened up a part of my unconscious that I didn't even know existed. The more I drew, and the more I wrote, the more I started to dissociate in ways that were impossible for me to handle. I said to the hospital therapist: "Everything caught up with me", so here I am".

Treatment

So my own more provocative inner journey began in the hospital; my work really began when I let go of the need for integration as I watched myself disintegrating. An early journal entry proclaimed: "This is a journey through madness, not a journey of madness. All my pieces are dissolving. I am vomiting them up...there is no pain...just compulsion, numbness, acceptance, surrender to the process or the madness".

I was fortunate; I found a therapist in the hospital who was cued into the transcendental qualities of psychosis. For me, the problem of my disengagement was a spiritual difficulty, not an organic disease that must be treated with modern medical methods. I viewed my treatment as an ongoing spiritual process akin to what the literature has referred to as a Shamanistic journey into the deeper, disorganized parts of the psyche. This refers to the practices of indigenous cultures where the requirements for one to become a medicine man/woman is to go through a process of psychic disintegration and then a reintegration with the psyche. (Eliade, 1964; Harner, 1980; Crabtree, 1993; Krippner, 1997c).
Though I was, in my words, "out of it" (dissociated), I had many internal strengths to draw upon. My intelligence, sense of humor, and intuition would become valuable tools to enable me to enter into an inner dialog, necessary for my healing. An external support system consisting of close friends and my spiritual community (I was following an Eastern meditation path) was there if needed. Because my paintings contained material that seemed to indicate very early trauma before full language production, it seemed reasonable to use the creative arts as a modality to help myself through the healing process. I felt later that I had unwittingly orchestrated my own soul journey through the media of art — paintings, poetry, sculpture, movement and journaling. I brought my journals into the treatment room, along with the art.

The focus of the balance of this chapter will be a demonstration of my healing process as I move through the traumatic memories/narratives of early pre-verbal traumata into adulthood. The thematic context and content of this journey presents itself as the evolution of the psyche through my artwork, as I court what I would call a shamanistic process or cycle of "soul" growth: 1) Birth/Rebirth; 2) Abuse/Chaos; 3) Dismemberment/Splitting or Dissociation; 4) Remembering/Reintegration/Healing/Rebirth.

Birth/Rebirth

One of my early pictures was that of a large phallus that seemed almost perfectly crafted and totally symmetrical (fig. 1). It did not appear to be a representation of something ugly that one would expect to see from a child who had been molested. This phallus played a dominant role in my fantasy life. Phallic imagery presented itself no matter where I went. I could not even look at a man without this presentation. Upon further reflection on the beginning process, I could see that this first drawing became the enduring theme for the anticipated healing journey. In a sense, then, this phallic symbol represents my birth and rebirth. The traditional symbology of the phallic image was somewhat confusing for me in the beginning as I viewed the picture. The picture was
quite vital and flowing and very positive. It certainly did not initially evoke negative emotions. The phallus is an archetypal symbol of creativity and fertility according to Jung who based his theory on early cultural mythologies. Some of this topography embraced the notion that the symbol of the pole or pillar was phallic: a striving vertical thrust towards an upper spiritual realm. This, according to Edinger (1975), may signify the central axis which is the connection between the human and transpersonal experience (p.221). Archetypes, Jung and his followers said, are the unconscious contents of the collective unconscious and have been defined in the literature as suprapersonal symbols which are universal in nature (Jung, 1959, 1965; Edinger, 1975; Kruger, 1982; Wehr, 1987; Hillman, 1989; Kast, 1992; Kalsched, 1996; Stein, 1998:). Thus, the phallus, though by its physicality is a male appendage, has a universal significance, just as the archetypes of Mother and Father. However, this was not my interpretation then. I simply allowed the imagery to come.

At the time I drew this picture, other evocative material emerged from my psyche that depicted early abuse. This seemed to contradict the quality of the positive phallic image. After I drew the picture, I sat down at the typewriter, and many strange words seemed to "leap" out at me. Part of this "transcript" follows as a split-off sadistic part of me speaks to another part, the baby:

...daddy sweet mouth, let me piss all over you that does excite you little tyke, doesn't it— sweet jesus, little tyke in your crib i'll be with you always little one—open wide your mouth and enjoy the delights open up your tiny legs and let daddy's river flow into you — feels good —.

I started to choke and wanted vomit. I felt extremely isolated and alone. I was certain that there was poison inside of me and called this 'the devil's delight in the middle of the night'. The sadistic voice continued on the page:
...pitchfork on your tongue little tyke.....eat sweet jesus, eat, the fire of light in your eyeball nothing will save you little tyke, you are mine, suck my nipple of delight...

As these words continued to literally "dance" before my eyes, I started to somaticize my feelings, felt dizzy and wanted to go to sleep. The 'baby' part of me spoke on the paper, revealing the terror and angst that had compromised my emotional growth:

...picture talks picture talks, picture comes every night....mutilate, cut it out, cut cut, cut--rid the poisonous waste that sealed my fate--

...suck suck suck--baby rock baby rock baby choking baby choking suck suck suck baby choking.....

...so much blood so much blood, wanna go home wanna go home, please let me go home....

Looking back at the phallic symbol I drew and then at the writing, I could not reconcile the two. On a conscious level I had a positive feeling about the picture. Unconsciously, something else seemed to be happening. I felt as though someone else had drawn the picture because there appeared to be a strong internal psychical disconnectedness and fragmentation of my person. In retrospect it would seem as though I entertained a positive instinct within me which was reflected in the positive image of the phallus. I believe that perhaps my psyche was saying to me, "You are undergoing this journey, but it's ok, there is going to be a positive outcome". Though the verbal psychic material is suggesting abuse, the picture stands out as Light, not darkness;
it is quite possible that I had been victimized by my father, but something would be regenerated through this trauma. There appeared to be a need for transcendent healing, for it seemed that that level of abuse and disconnectedness or dissociation was connected to the Self and not to the ego.

Given the history of my father's continuous habit of phallic display, it was not surprising that I should have some compromising internal conflicts and emotions. It would appear that certain introjections took place causing a primary split between the "good" father and the "bad" father as illustrated by two phallic images I had incorporated into my mind's eye. However, this was not apparent at the time, and I later realized that the first image I actually drew was not an ugly penile projection, but a strong and vibrant one.

Once again, in retrospect, perhaps unconsciously this phallus became the archetype of a "good" father. I believe, however, that my father never seemed to be embodied in his "male-hood". He could not make the inner connections within himself on a soul level to embody his own creativity i.e. penis, so the phallus became something to "play" with outside of himself, and it became, unbeknownst to him, a weapon of rage directed towards me who could not fight back. Somehow, I think I became the recipient of this rage and could only see this ugly, tubular "thing", which, in my winsome child eyes, became like a loaded gun. This was most evident in an instance in later childhood when he was unconsciously playing within himself in front of me. I kept screaming inside, 'Daddy' don't do that, Daddy, that's ugly'.

In attempting to make more sense out of this experience, I am reminded of an early dream Carl Jung (1965) had in which a phallus presented itself as a primary symbol for his own transformation:

...I had the earliest dream I can remember, a dream which was to preoccupy me all my life. I was then between three and four years old.
The vicarage stood quite along near Laufen castle, and there was a big meadow stretching back from the sexton’s farm. In the dream I was in this meadow. Suddenly I discovered a dark, rectangular, stone-lined hole in the ground. I had never seen it before. I ran forward curiously and peered down into it. Then I saw a stone stairway leading down. Hesitantly and fearfully, I descended. At the bottom was a doorway with a round arch, closed off by a green curtain. It was a big, heavy curtain of worked stuff like brocade, and it looked very sumptuous. Curious to see what might be hidden behind, I pushed it aside. I saw before me in the dim light a rectangular chamber about thirty feet long. The ceiling was arched and of hewn stone. The floor was laid with flagstones, and in the center a red carpet ran from the entrance to a low platform. On this platform stood a wonderfully rich golden throne...Something was standing on it which I thought at first was a tree trunk twelve to fifteen feet high and about one and a half to two feet thick. It was a huge thing, reaching almost to the ceiling. But it was of a curious composition: it was made of skin and naked flesh, and on top there was something like a rounded head with no face and no hair. On the very tope of the head was a single eye, gazing motionlessly upward.

It was fairly light in the room, although there were no windows and no apparent source of light. Above the head, however, was an aura of brightness. The thing did not move, yet I had the feeling that it might at any moment crawl off the throne like a worm and creep toward me. I was paralyzed with terror. At that moment I heard from outside and above my mother’s voice. She called out, ‘Yes, just look at him. That is the man-eater!’ That intensified my terror still more, and I awoke sweating and scared to death...(pp. 11-12).

Jung (1965) remarked that this dream had haunted him for years. Only much later did he realize that what he had seen was a phallus, and still many more decades before he
understood this to be a ritual phallus. For him, the phallus represented what he would call an archetype, a symbol of a “subterranean” God who really had no name. Apparently, Jung began to have conflictual religious thoughts about Christ that began with this dream, and with his mother’s warning about the “man-eater”—the phallus seemed to represent the “dark Lord Jesus”, the Jesuit’s disguise, which appeared to be confusing to him, since the phallus itself emitted light. He alluded to the paradoxes he experienced in the faith of his youth. For him there seemed to be a profound difference in the characteristics of the person of Jesus (i.e. love and kindness) and the behaviors of some of the Catholic priests who had terrified and “even alarmed” his father (pp. 12-14).

I now see certain parallels in Jung’s experience and mine. My strange fascination and fear has haunted me as well. I have had a great deal of difficulty reconciling, as Jung did, what appeared to me to be the unkind behaviors manifested in the outward practices of religion with what I thought was the “Christ’s” message of love and kindness. So, the experience for him and for me represented the beginning of a journey that included a quizzical dalliance with the archetypal powers of darkness and light. For me this translated as a struggle between goodness and evil and became more intense as I grew into womanhood. His narrative became his own, and the phallus a transpersonal guide. My narrative became my own, and the phallus, the metaphor of light and darkness, representing the confusion I felt over the relationship with my father. In a sense, he could be like Jung’s “Lord Jesus”. He was gentle and kind and had an inner creativity. However, his sexually provocative behavior towards me somehow created an unholy split: what, indeed, was good; what was evil?
Abuse/Chaos

Consequently, for me, there existed a profound confusion between what I would call the archetypes of good and evil. My healing journey appeared to be a re-birthing process emanating from this phallic symbol, once real and whole, and then distorted by abuse followed by a chaotic interior life. Because I had introjected the "good" phallus, though unconscious of this, I was able to establish a framework within myself to allow the inner process to complete its cycle towards rebirth and healing.

My pictures subsequent to the phallus started to portray more of my affective reactions to earlier abuse and how that impacted and dominated every waking hour. My initial abuse is provocatively displayed in figure 2 which, on the surface, reveals victimization and infant sexual abuse.

I remember at the time that it was very hard for me to finish this picture. In my journal I wrote this was because of all "the penises and the sodomy...it's like everything inside of me pushes, pushes, to have it out, but the other part just wants to run away". My verbal description of the picture at the time was quite graphic:

...someone fucking baby, no name—sodomizing her and going into her vagina...the other creatures are being sodomized by something/someone else—the child is being burned up again — helpless as she watches this being done and the ropes, trying to tie it all down...something's not working, the man is stepping over the rope and is fucking her anyway...

Again in this process there appears to be a dichotomy between what I am feeling and the archetypal presentations contained in the drawing. As part of my research, I took these drawings to Jungian analyst and researcher, Russell Holmes (1997). The following interpretations are his as he viewed my process through the drawings. In this particular drawing,(fig.2), he said, it seems as though my whole family history is contained in this
one picture, with mother in the corner on "fire" with her rage, and father, in brown, all "tied" up in the mother-world. It appeared that both parents did not know what was going on, for mother and father have no facial features. I, as the child, he noted, was the only conscious being in the picture, the only one with eyes. In a sense, I was going to liberate the whole family by rising to what was going to be my life task: i.e. learning to speak about the evolutionary aspects of child abuse and how it impacts on the psyche. So, my task then became aligned with what has been called the primary archetypal shamanistic journey as the soul has to descend into the chaos of the underworld in order to be redeemed and to be made whole (Eliade, 1964; Edinger, 1973; Harner, 1980; Krippner, 1997c).

During this period, I reflected on the complexities of my mother and father's psychological history. Alcoholism was a dominant feature in my mother's history. Her natural father and her stepfather both died at an early age of heart disease. My mother also was very sickly as a child with rheumatic fever and was overprotected by her own family. My father was surrounded and catered to by his mother and four sisters. His own father was a timid and withdrawn figure in the household, while his mother was the dominant figure. She died when my father was in his thirties.

Given this history, then, further examination of this picture (fig.2) might elucidate the challenges that I, as a baby was facing. It would appear that I could have introjected the results of my mother and father's problematic childhoods. Holmes (1997), in his interpretation, suggested that my mother is the figure standing, faceless in the corner, helpless, sickly, and contained in her rage (the fire). Her ground, the top of the hedge, he said, is the same color as the monster's leg in the right hand corner. There appears to be some connection between my mother's ground and the monster's leg from which another phallus has arisen to sodomize the babies that are rising from father's back.
This interpretation was of some interest to me. In fact, my mother took on all the female roles that her father had experienced in his family of origin, by pampering and idolizing him. His own pathology continued in his marriage, tied to his mothers and sisters, and then somewhere wedded to the responsibility of having a career to support a woman and family. He chose a career in business as opposed to an interest and ability in the creative side of his nature, art. He had gone to art school and had been a tie designer prior to marrying my mother.

According to Holmes, in the picture the father has no testicles; the leg which represents mother, has testicles. One would wonder who had the testicles in the family, his sisters, mother, or wife? His history would suggest that perhaps he was emasculated as a child, and his creativity as symbolized by the phallus was somehow "overcome" by excessive mothering. On another level, if he was caught in mother which is the basis for an artistic career or personality, he was just left "hanging" with a penis that wasn't creative and he didn't use, so he had to "play" with it all the time. His abuse of me, was a lame attempt to liberate himself from the trap that he was in with his mother and sisters, and subsequently with his wife. Furthermore, there is in the picture a sense of the abuser and victim being tied together with this long rope. In reporting my feelings about this I said quite simply: "I can't breathe when I look at that, and if that figure in the corner signifies my mother, and her rage, where am I....who am I?" At that point, I was unsure as to Holme's interpretation, because I had always felt that I was the one who was consumed by fire.

With those questions in mind, figure 3 looms large as I entered into my own chaos from my unfathomable traumatic beginnings. I related this picture to the thematic context of my whole life history, even though this drawing was done because of my frustration with the insurance company when I was hospitalized:
....the picture — rape from anyone...[I'm] thinking of the insurance company...everyone raping me — helpless, not able to put it together, all these penises...I can't even draw what I feel — dirty, bloody, bewildered, dead, tied up — I want to draw this over and over again.

My whole life had been one of feeling victimized, castrated, and strangled by outward circumstances that I could not understand nor control. Society itself was a danger for me, for I was still the baby whose innocence had been compromised. My inner life became a constant battleground, chaotic, and filled with crises that no one else could solve, including anyone who might befriend me. Again, however, in this picture, there is the eye and the sun, both symbols of consciousness that would lead me further into my process of exploration and healing.

**Dismemberment--The Ritual of Dismemberment and Rememberment**

After the realization of the abuse, my impulse was to begin to examine this experience in a more profound way. My art became a ritual that was enabling me to witness through my images, the rite of disintegration, or coming apart and the rite of re-association or coming together, which is similar to a shamanic initiation. According to Holmes, pictures #4 and #5 reflect my process of this ritual as once again the eye becomes one of the components of each picture. A shamanic quality, this eye of consciousness or God (Edinger, 1973, pp. 282, 285) seems to be always there in some form in my pictures. The eye is a symbol of insight. It is, according to von Franz (1980), the inner eye of self-recognition, the eye of wisdom. This is the divine eye who sees itself as the source of self-knowledge. It has been described, she says, as an inner "non-corporeal eye, surrounded by light, which itself is also light". Many Christian mystics have called it the eye of the soul, and others have referred to it as the eye of knowledge, faith, or intuition (pp. 165-169). It knows how to put everything back together.
It was at this time that I also began to work with clay. Sculpting helped me to remember: that I was never outside the realm of hope and salvation. The claywork contextualized my thoughts. It gave them form and texture, what I would consider to be creating a new life. I remember an incident that prompted me to sculpt my inner "scream": "I was in the kitchen, and feeling very poorly. I had called my therapist, but I had this terrible compulsion to cut myself. The knife seemed to appear out of nowhere and I went for my wrist. Simultaneously the phone rang, and I threw the knife in the sink. It was my therapist. She started talking me through this process, and in the middle of it, I felt this strange voice inside wanting to scream. My whole body wanted to let this out."

The next morning I took some clay and sculpted this being who was emerging from a rib cage, screaming in abject terror. A wild "she-animal" had finally surfaced and wanted to be heard. This unconscious being was brought to life for me to see, to touch, and to feel with all my senses. I was flabbergasted that something like that emerged from me! In my journal, I referred to her as a caged wild animal who lived inside of as depicted in figure 4. This was the part of me who had been unacknowledged and who now needed to be heard and to be released from her cage. She wanted to open up a dialogue in my journal and to be given a proper name:

D: ...I feel her rising up inside and I don't really want to speak with her and am trying to deliberately hang on to this pen so she won't appear...

She: ...Good luck, fucker, here I am...you can't stop me now. I won't be stopped until you give me my due, my name, you hear, you slut, cut, cut, cut — there's blood in your gut!

That night I had a dream, and a name appeared. It was Hecate. Hecate, I later discovered, was the Guardian of the Harpies, the night goddess known to be the most
powerful witch, guardian of the underworld and closely associated with Persephone. Her symbols were the key, whip, dagger and torch, and she was hermaphroditic, both male and female (Graves, 1955, 1960). She came out screaming at me and would not be still. Hecate gave birth to the theme of dismemberment as she was released, compensating for the good girl or quiet, repressed, silent woman whom I had adopted.

Hecate was very clear about what she wanted from me; she wanted to "cut" through her vocal chords, and open my mouth. She was the wild animal, the shrew who needed me to scream her name. She clearly is associated with the mouth imagery in figure 4, and with primal sexual energy as is noted again by the phallus. The knife is a further introduction to the dismemberment process, which is more clearly delineated in figure 5 with the display of four knives. According to Holmes (1997), four is a number of wholeness, so perhaps there was an unconscious message to me: "this is a matter of your wholeness, a matter of wholeness to allow yourself to be dismembered." Hecate's energy arose to begin opening up my heart to release this outspoken, unsophisticated cat-woman with the knives (fig.5). The eye here, in the solar plexus which Holmes says is the center of personality, the "gut vision" might say to me: "I've got to take it all apart and look at it". I had no control, for Hecate would mercilessly interrupt me with crudities:

...Fucker, you can't...here I am...you can't control me...now I am up to your throat...you saw those knives...

The way was now being paved for me to embrace my trauma and to allow the Universe to perform the psychic surgery that was necessary for healing.

**Dissociation -- Symbolic Formation/Healing Level**

As I began the process of dismemberment, a taking apart of my psyche, many facets of my personality appeared, parts of whom who had split off when the original trauma/abuse occurred. These other aspects of my person had emerged to help me
survive my childhood. I was virtually unaware of them, or how effective they had been. I had been very adept at "fooling" people because I lived in my mind which was a protection from social intimacy. I would take on many different roles without knowing it, and without feeling the feelings associated with social intercourse. Other human beings were simply not to be trusted. I remember an example: When I was about ten, I changed my name to "Jackie" when I went to camp because I felt like a boy. I always wanted to be one, probably because no one usually picked on boys, and they could go anywhere without fear. In short, I dissociated or split off from my main personality so I could be a person no one would abuse. I, then, would not have to associate or attach myself to anyone else. I was in a role of protector.

This dissociation took on many forms as is illustrated by my drawing (fig. 6) of some of the parts of myself whom I had to acknowledge:

[ref: fig. 6 in my diary]...you are elusive—wear many faces, have many parts, voices that crop up when I least expect them...you are my ghosts, my grief, my anger...deep down inside—terror—I see you, see you, watching me or I watch you, keep you contained...

...[feelings]...I feel haunted, ghost-like, I feel like my whole identity has been and still is wrapped in a death wish, and that you won't release this, let this out or let me act out on it...

As my journey deepened, internal "ghosts" quite literally rose from the dead in my journal and in therapy. I felt that these aspects or parts of myself had to be given names in order for me to embrace them and to understand their function in my own ego
development, for I had somewhat of a language processing problem. This was possibly related to the original trauma.

It seemed as though the parts of me who wanted to come out needed to either talk or to scream. The mouth and throat seemed to be a theme not only in my visual art but also in my writing and in dance when I took some coursework in dance and movement. The earlier "personalities" who came out were Joe who functioned as the sadist who spoke to Sweet Jesus, the Baby; Matilda, a pauper baby who was hidden in a drawer and subsequently died in the fire—she surfaced later as an older Matilda who was the core depressive personality, the waif; Angel, a four-year old; Jackie an eight-year old; Carla, a tight-fisted woman heavily endowed with a large buxom, and she was able to set everyone straight; and Emily, the poet, a very strong figure in her own right, but a recluse. There was one personality who seemed to be the overseer, and that was a magical, wise-person called Mahael. I likened her to a spirit-guide.

Later on in the therapy, more definitive personalities surfaced and had to be dealt with, one by one, and embraced to become part of the whole. The four most prominent ones were named Hecate, George, Matilda, and the Baby. Hecate, as noted previously, was the wild-cat who had to be freed; she was my supportive vital energy. George arose out of a dance class that I was taking when I did a sculpture of my feelings. He was the predator, the demon, and had language that was worse than Joe. The rage usually took over my entire journal page, and manifested itself in strange handwriting. His language was vile and he was clear in his intent to harm me:

**D:** You are George

**George:** FUCKIN ASSHOLE, FUCKIN ASSHOLE...I SPIT ON YOU...

**D:** You're the devil in disguise that wants my demise

**G:** CUT THE POETRY, CUT IT, YOU ASSHOLE...YOU LIVE IN A FANTASY YOU THINK YOU WANT GOD.WELL I'M HERE TO TELL
YOU HE DOESN'T EXIST YOU REMAIN WITH ME YOU ALWAYS THOUGHT THAT ANYWAY — THIS BLACKNESS SO WHY SHOULDN'T I TAKE YOU?

D: I want my soul back

G: YOU'LL HAVE TO CONTROL ME FIRST, FUCKIN, SQUEEZY ASSHOLE... KEEP CRYING AND ROCKING THAT SUITS ME I CAN KEEP ON RAPING YOU...

George was finally embraced and used as my strong male energy. Matilda, the Waif was more difficult. She was the depressive core of my personality. She simply had no will to live or to be part of the universe. Matilda kept calling on me to hold her and to call her by her name but I was consistently denying her, expressing a feeling of loathing for her "whimpiness". Even George had trouble with Matilda as she called on both of them to embrace her: "call me by name, let me have life, let this poor soul have life". Finally, through therapeutic trance, I was able to allow George to become the protector of Matilda, so Matilda was able to begin to find her voice, and with that I was becoming more awake to the pain of the early trauma as I began to speak to all of those split off parts of myself including Matilda.

The next two drawings (fig. 7, fig. 8) depict the dissociation that arises when the personality starts to disintegrate. This process usually happens sometime after the trauma. In fig. 8 there is a picture of the labia with the split heart "falling out" of the body. I remember expressing a feeling of emptiness at the time I spoke about this picture. Figure 7 reveals a picture of a scattered mind that contains a coming-apart process without decompensating as it is projected onto a boundaried space. There appears to be autonomous phallic symbols "floating" in space denoting this scattered energy, but there is the positive grounding color, green, covered by a more morbid-colored phallic image. Over to the left, still within the paper boundaries, are reddish
Figure 12
phallic symbols, that felt like rage, as I stated in my journal: "All this energy inside, everybody fucking everybody else, all these voices, here, there, and everywhere. I feel like I am exploding."

Splitting is represented in figure 9 with the hands being cut off and bound, unattached to the body. With the hands bound, the child couldn't handle "this whole mess" as I had felt many times. The hands, it would seem, then, represent the helplessness of the child. The child has no way of understanding or coping with a powerful sexual experience. It is also interesting to note that the color, veridian, is connected to the monster who is depicted in earlier drawings.

Final Remembering — Reintegration/Healing/Birth

Returning, for a moment to figure 7, I am reminded of the vagina that housed the broken heart, and what that "two-ness" evolves into—what was the coming apart becomes the two-ness that is not broken. This process is shown in figures 10 and 11, in the dynamic movement of the heart coming together. In figure 12, the heart now has a container, a spiritual reality as there is no longer a physical demolition of the personality. I am being raised to a higher level, sanctified in relation to the cross, symbolizing this connection to the Self which allows me to be reconnected to my psyche or soul.

My wise-person, Mahael, gave this healing image (fig. 12) to me:

...the image of love, the image of the cross, the image of redemption and fulfillment—the cross represents the crossroads, the peace that surpasses all understanding, and you need to place a heart on the cross signifying the love that embraces the suffering and all of this is surrounded by the Light, the unspeakable light that takes it back into itself—so you draw that tonight or in the wee hours of the morning and release Joe into the light so he can be once again welcomed back Home—then you let go and let God take over—your ritual is simply your offering of your two selves to God so there are no more Star Wars, and your children can grow up and be witnesses to each other.

I used this image to re-connect the rest of my internal "children" subsequent to the first embracing of Joe. I followed Mahael's advice as she told me who the children were:
"The children are the undeveloped, or underdeveloped parts of your self, and you need to take them individually and nurture them and bring them into you to form your new identity."

In my dialogue with Mahael, I wondered if the children would grow into adults. Mahael replied: "Absolutely, they will grow, all except Baby because Baby is your reminder of the innocent child, the purity, the challenge, the wonder, the littlest angel in love with God, the trust..."

Remembrance, reintegration, the recombining of the two — this is the positive side of the splitting that suggests the potential of combining the two to create a third, the birth dynamic. I had to have two for the birth, and this symbology is represented by figures 13 and 14. Holmes (1997) suggested that this symbology is representational. The fish (fig. 14), he said, represent the friendly contents of the unconscious, and the boats are vehicles to travel in the unconscious. My abused babies didn't have that; they floated in the unconscious. Then, (in fig. 13) two figures are coming out of a coffin which might indicate that life may be rising out of a death, the death of the whole abuse complex. The crucifix allows for meaning: in death there's resurrection, rebirth. Finally, in the background of figure 13, the breasts move me to a higher level, one that is nourishing, and heavenly — the divine embrace in the rebirthing process.

This process then moves from the representational to the symbolic when, in figure 15, there appears a symbol of this doubling related to the chromosomal separation at birth, supported by a background of positive and fluid color. There seems to be a positive feeling context here in which psychic rebirth can take place. The positive feeling background could be the therapeutic container (the therapy), and there is this repetition of doubling (Holmes, 1997).

By placing the heart on the cross (fig. 12) and accepting Joe, I was able to begin to unite the opposites within myself. I "remembered" that I had the capacity to transform my abusive past and instead of repeating it, it could be embraced. I could now begin the
task of making that necessary connection towards the restoration of the broken heart (figs. 10, 11). My act of remembering the heart with compassion was my link to the other two hearts (10,11); my own dismemberment becomes remembered and the apartness comes together.

Finally, conception arrives in figure 16 when all the disparate parts of my person are melded together to be readied for a new birth arising from a single vessel, the Self, whole and entire. The picture conveys movement and resurrection, a delightful explosion from the confines of what I had experienced as a heart surrounded and bound by a soldered shield. I am awake. I can feel the pain. I can feel other emotions such as joy, love, lightness and relief. There is a certain knowing that this work has not been done in vain.

Concluding Remarks

Through the use of metaphor as experienced through art-making one healing process has been outlined in this chapter. This process is specific to my way of making sense out of certain early traumata in my life that caused certain dissociative reactions and lack of a stable ego identity. My own narrative was predicated on creating a thematic representation of the shamanistic practices as noted in many of Carl Jung’s works, the birth/rebirth theme. This was demonstrated through artistic representations of early trauma, its after-affects resulting in abuse and internal psychic turmoil, which, in turn, caused certain personality fragmentation or dissociation. Finally, as these dissociated parts were embraced, a rebirthing or reassociating to the original Self prompted a sense of personal identity to form.

I refer once again to Daniel Stern’s suggestion that the subjective world of the infant needs to be recognized (p. 1). As the clinical infant in my narrative, I chose to give a certain structure to my healing based on my own cognitive history: family environment, spiritual involvements and educational experiences, and reading. This structure was formulated through my writing and my art. The art recreated what Stern referred to as the
observed infant. I had to create a visual map to literally find the salvific threads to weave a personal tapestry that could be proudly worn. This was required because I had no voice or adequate language skills to express the internal anguish I was feeling.

Early spiritual training had given me a certain perspective about healing: the story of Christ and His suffering and the themes of birth/rebirth, redemption and grace, all very much a part of the quest for wholeness and self-identification. Later I experienced Jung’s typology of the process of individuation being very much attuned to the shamanic practices of underworld descent and upward ascent of the person in order to facilitate total transformation of the psyche. For me, the inner journey was a salvific process rooted in an existential desire to be a whole person not merely a functional one. It was a process that was inherently creative and spiritual at the same time and integration became an ongoing ontology of movement prompting expression and expression rendering its ultimate reward: the passion of a living identity, being a whole persona, not a composite of parts who could not embrace each other.

Though this process continues as my work matures, questions remain as to a more global significance of the healing process in dissociation. This dissertation study, as noted previously, has arisen out of this personal experience of identity formation. The purpose of my narrative, placed here is a prelude for further examination of how others who have been traumatized before full language production have managed their own healing. My questions raise the possibility that common threads among subjects might be indicators that a more philosophical and artistic approach to the healing process in dissociation could be more helpful than more traditional medical models. To this end, then, cross analysis of the experiences of the four study participants follows.
Participant Choice

As mentioned previously, this is a study which requires the use of more diverse methodology in order to comprehend the broad spectrum of lived experience of study participants who represent what I have called a dissociative culture. The research was designed to flow from an autoethnographic study of my own healing from a dissociative disorder. The purpose of using my own experience as a pilot study was simple: there has been very little academic exploration of the healing/recovery process for those persons who have experienced early trauma, who have been diagnosed with a dissociative disorder and who have recovered.

Criteria

It was therefore necessary for the participants to have met the following criteria:
1) Having had a clinical diagnosis of a dissociative disorder (DID or DDNOS); 2) having experienced psychological trauma before full language production (infancy through age three); 3) having gone through the recovery/healing process and willing to share their recovery experience.

The Interview Guide As Basis For Thematic Exploration

As mentioned earlier, the participants participated in three 1-1/2 hours of in-depth interviewing. These were based on open-ended questions designed to be a guide for personal reflection on the meaning(s) of their lived experience of the impact of early traumata on their subsequent dissociative disturbance and recovery. Three sets of questions were included in the Interview Guide, one for each interview session. These were intended to provide a structure for the kinds of items that I wanted to explore as a
result of my pilot study and focused mostly on the recovery process rather than on past traumatic events and behaviors.

The first interview included basic demographic material and a reflection on relevant trauma-related experiences in their lives up to the present. They were also asked about what indications they had about the etiology and memories of the trauma and what indications they had then or now that they had experienced dissociative states. Concomitant with these queries, they were asked to consider the meanings these experiences have held for them.

The second interview centered on the healing and recovery process. In this interview, they were asked to share the details of their present experience as a recovered(ing) person and to elaborate on what was particularly helpful in their healing. Included were questions about the creative arts and spirituality to determine whether these were variables that played a role in their recovery. To conclude their reflections, they were also asked if there have been any significant changes in their social and professional relationships related to the recovery process and to describe their present daily living patterns.

In the third interview, participants reflected upon what they had shared in the previous interviews and considered some of the main landmarks or breakthroughs in their healing process. They were also asked about how trauma occurring before effective language production has impacted on their development and their subsequent recovery: i.e. what was the meaning of pre-verbal trauma for them? As a final reflection/synthesis, they were invited to think about what the future might hold for them.
As with many an open-ended interview method, the use of the questioned responses varied among participants. In the process of deconstructing their narratives, it became clear that many of these questions were overlapping and will be discussed further in the findings section.

Procedure

The process of choosing participants began with a query letter sent to therapists who treated clients with dissociative disorders. I also networked with colleagues and other acquaintances. I had about five to ten responses and queries from two clinicians. Finally I received a reply from five persons, one man and four women whose ages ranged from the mid to late thirties towards the mid to late forties. The male withdrew, citing lack of time in his schedule. Contact was made through phone and email. Consent forms and the interview guides were sent to the respondents, who subsequently returned them and we made phone contact. Due to the very delicate and private nature of this study, I felt it was important to spend some preliminary time speaking with each of the participants before scheduling interview times.

Interview times were then set. I traveled to the first person’s home and finished all three interviews during my weekend stay nearby. Since the other three persons lived in different states, I interviewed them by phone using a speakerphone and tape-recording them within the privacy of my home. To ensure their feeling of safety, I reiterated the fact of our privacy and told them that I was the only person in the home, and I spent some preliminary time on the phone with each person at the beginning of each interview session. This appeared to be very important for all of them, and each person wanted to
make sure that I was capable of understanding how emotionally charged this process was for her.

Participants

Ann is a twice-divorced single woman who lives alone in a small rural community. She was 48 years old at the time of the interview and was a violin teacher. She had endured multiple experiences of childhood emotional neglect and abuse beginning in early infancy which continued in various forms throughout her life. Born with hip dysplasia, she wore a brace early on and was tended mostly by her grandmother who lived with them and then by her father because of her mother’s depression. She stated that she had memories of herself in a crib, and spent most of her infancy screaming, and no one would pick her up. She was told always to lie still, and there was no nurturing from her mother. It was painful, she said, to move from the age of 5 months to 1 1/2 and she suspects that her grandmother abused her by giving her enemas a lot and by being an extremely toxic person. She has no memories of this period except tactile ones that surfaced years later. Other traumas followed in middle childhood when she was sexually assaulted and drugged by a neighbor. She explained that she became the family scapegoat (she was one of four siblings), was always being sent to her room and began to burn and cut herself early on. She received a psychiatric evaluation at age eight and her problems intensified in adolescence as she engaged in drug and alcohol abuse, and sexual and other behavioral acting out. She attended college, receiving a B. A. degree with a visual arts focus and finally a M. Ed. in middle school education. At the time of the interview, she had been in recovery from substance abuse for thirteen years. She had
been hospitalized three times, and it was during her second hospitalization that she was diagnosed with DID. At the time of the interview she had been integrated for four years.

Clara is a 48 year old (at the time of the interview) woman married for 27 years with two young adult children. She usually works as a library assistant; however, at the time of interview, she was taking a sabbatical and was unemployed. Clara suffered from severe and prolonged sexual and emotional abuse and neglect as an infant through adolescence. She related that her mother rejected her at birth because of a physical deformity (club foot) and her father took over her physical therapy. In addition, he had incested her from infancy through adolescence. She has two brothers, the eldest of whom had been physically beaten by her father and who also sexually abused her. Clara reported that she self-mutilated with razor blades, had electric shock treatments, and was hospitalized four times. It was after the last hospitalization that she was referred to a trauma therapist who diagnosed her with MPD, now known as DID. She has had twelve years of intensive therapy for this disorder and is now feeling well and stable.

Susan is 45-year-old twice-married woman (at the time of the interview). Her first husband was physically abusive, and they were divorced after six and a half years of marriage. In her present, second marriage, she has one young daughter. She works from home in computer programming and also is a part-time minister, and attends graduate school for the study of clinical psychology. She describes herself as a “white, Anglo-Saxon Protestant” and belongs to a Pentecostal church. She has a brother three years her senior and a younger half-sister by her father and stepmother. Susan states she was sexually abused by her father beginning in infancy. She has few memories before age nine, but she believes she was because she had infant alter personalities, a clear crib
memory, body memories, and physical evidence of scarring in her rectum that was found in her twenties. Later in therapy, other memories surfaced which included satanic ritual abuse between the ages of 6 months and 2 1/2, oral sex, pornography, child prostitution, and at six months old there were occult symbols written on her with blood. Her father stopped abusing her after he and her mother were divorced, when she was in middle childhood. Her mother, she said, had been diagnosed with paranoid schizophrenia, and her father, she suspects, was a multiple. He had drinking problems and problems with memory. Her brother also had psychiatric problems as well as her younger half-sister, and Susan herself remembered seeing a psychiatrist between the ages of five and nine. She also reports that her step-mother had a drinking problem. She was diagnosed with DID during her therapy with a Christian psychologist. At the time of the interview, Susan had been integrated for about four years after four and one half years of intensive therapy.

Beth, age 40 at time of the interview, is a married woman of 18 years with no children. She has one older sister. Beth is an artist and college-educated with a Bachelor of Fine Arts degree. She presents a history of sexual abuse by her father starting at age two. The worst abuse happened, she says, was between the ages of two and six and included rape — oral, anal, and vaginal. This gradually diminished as she got older, her last memory being when she was about thirteen. She said she was not abused as a teenager. At seven, she was placed in a day psychiatric hospital for a year with symptoms of enuresis and social problems at school. This is where she had active dissociative symptoms, blacking out on many occasions, shaking all over for no reason, and, according to the teachers, seemingly spacey and unable to concentrate. Beth reported that the hospital stay was in general a positive experience and she felt some measure of
safety. She was also identified as a gifted child there and felt understood. At age eight she was raped by an eleven year old older brother of a friend. Her father died in 1997 and her mother is still living. She was diagnosed with MPD (DID) by her second therapist and has spontaneously integrated and now is doing more cognitive work with another therapist. She is presently not working but is preparing to go to school for a graduate degree in art therapy.

**Identification of Emergent Themes**

The purpose of the first interview was to gain access to a reference point for the subsequent reflections on the healing process. Thus, in the last section, I briefly described the participants and summarized their initial experience of early trauma to offer the reader context. The interview transcriptions were analyzed individually and across cases for themes that evolved from the issues on the interview guide. I also looked for other themes that were beyond the scope of the guide.

This was a laborious process due to the disparate and complex nature of the data engendered by the deeply personal and subjective narratives of these trauma survivors. The transcripts were read several times, and major points were highlighted in the text, subsequently followed by another reading and narrowing down repetitive themes throughout each of the cases and placing them in the margins of the text. I also took into account any corrections or additions made by the participants in their own transcript review. I then made a list of what I called “buzz” words, words that were used in each interview that seemed to hold prominence in the narrative. I cross-referenced those in the other narratives, thereby engaging in a process of constant deconstructing until I was able to determine what appeared to be the major categories across the cases. I made a
summary table for each of these categories and listed how each participant described the experience and what she felt about the experience. I then looked for common themes for each of the categories across cases to determine if there were core similarities that described the lived experience.

FINDINGS

My cross-case analysis of the participants’ narratives yielded eight clusters or categories and three sub-categories related to the healing process in dissociation: 1) the meaning that pre-verbal held for them; 2) the experience of dissociation and its impact on their lives; 3) their experience before recovery: behaviors and feelings; 4) how they defined healing/integration/recovery; 5) the major breakthroughs/landmarks in the recovery process; 6) their experience post-recovery; 7) the experience of what was helpful to them in the healing process and the three sub-categories which included a more in-depth explication as to the role of witnessing, the arts, and spirituality; 8) future projections. The participants all spoke about these issues in some way throughout their narratives. What follows are the summary expressions and descriptions that have emerged within the context of the above categories. I identify the emergent themes in each category supported by participant interview statements and group them across cases.

Categories and Participant Expressions and Emergent Themes

Pre-Verbal Experience

In terms of the acknowledgement of pre-verbal or early experiences, all the participants mentioned or referred to infant memories and flashbacks with two stating that they had early crib memories and one inferring that maternal rejection started right
from the cradle, and one who spoke about how the body remembers early trauma and the debilitating the fear is for a two-year old:

**Ann:** I have always had a memory of being preverbal. A couple of memories. I remember my little sister's baptism and I would have been one month shy of two. And I remember before I could talk being in my crib and having my parents walk through the bedroom to get to their bedroom and I was crying intensely. And, and, and, my Dad told my Mom "don't pick her up, she'll cry herself to sleep". Which made me furious because I couldn't talk back. That's how I know for sure it's preverbal. I couldn't say anything. But I could understand what they were saying... and I've always taken for granted that these memories are real because they are part of a stream of remembrance...all the way through childhood.

**Susan:** ...I did get one pretty, for that age, pretty clear memory from being in a crib and not really be able to [move], maybe I was at a crawling age, but I know I wasn't at a walking age, when that particular memory happened. Then there was, the alternate personality [who was] enough like an infant that I had a girlfriend who asked me if I had any infant personalities, because apparently I switched to an infant personality and started speaking baby gibberish.

**Clara:** ...I was born with a club foot, and my mother told me later in life, she was ashamed and embarrassed to take me home from the hospital. Her best friend had a baby at the same time. That baby died, it was stillborn. And my mother said I wondered, why couldn't it have been you? That baby looked perfect. There wasn't a flaw on that baby, and that one died. And I couldn't figure out why I had to take you home with this foot that I couldn't even put a booty on.
Beth: ...I was raped when I was two years old. That was just so overwhelming for me. I think our organism is just kind of designed that when something bad happens like that, and we survive it, I think the organism is designed to really remember that, so that doesn’t happen again...[the internalization of the trauma in the body at age two caused]...this disabling fear...and so then I was left with this residual fear that some terrible awful life-shattering catastrophe could happen to me at any moment, precipitated by just about anything.

All reported that there were body sensations, memories, and bodily physical manifestations that appeared to have their origins in infancy. Ann alluded to having an “anal” fixation a number of times. She attributed this to her early experience with her grandmother who apparently consistently gave her enemas. When she started to have flashbacks while experiencing an orgasm during a sexual encounter, she said that she had body sensations which told her that “…that felt like I’d had one before, but I didn’t remember ever having one before. But it felt so familiar”. Clara, also, had clear pictures of body sensations which evoked memories of early infant abuse by her father: “I’ve been given very clear pictures and it’s like, I get the taste, I get the sensation, I can, it’s like I’m above my body watching what he did”. Susan also reports having body memories that arose outside her therapy session along with imagery that suggested sexual abuse: “…and then outside of therapy I started getting body memories, and...stuff started to surface”. Finally, Beth, had physical manifestations which were corroborated by her psychiatric records during her first hospitalization: “…I didn’t want to touch anybody…I didn’t want to do that [have to hold other people’s hands]...I am pretty sure that I did not have a hymen”.
The experience of being traumatized in infancy impacted on the participants in similar ways and had mostly to do with not having the words to express the pain.

**Ann** said:

*My childhood experience of being pre-verbal was a state of rage in not being able to express myself... For pre-verbal trauma to have happened on any kind of regular basis implies that your emotional reality has not been taken in. And it's not like babies are so subtle, or so hard to read. But that's how it felt to me, that nobody could read me, no one could know me. I felt like I was invisible and that it didn't matter how much I screamed or yelled, nothing was gonna work, and nothing would, I would have no impact, no power, on anything that happened.*

**Clara**, in speaking about the reason for self-inflicted violence, refers to the paucity of words to express her feelings:

*I can remember thinking and maybe even saying, it's the only way to bring it out. It's the only way that somebody can see how bad it hurts on the inside. And that's, I think, because it was preverbal. I did these things as a young adult and even an older adult, and I wasn’t, I did have words, but I couldn’t find the words, because it started before I had words. The only words that would come were to try to describe why. What are you doing this? I don’t know. Because you hurt so much on the inside I have to bring it out. And it was all real vague. But I would say, this is nothing compared to the pain that I feel on the inside.*

**Susan** spoke about her pre-verbal personalities who worked together with the adult in order to find the words:

*I found that when preverbal personalities were working in the therapy, that we would have the helpers that were kind of motherly They would actually come out together with*
the pre-verbal personalities in order to talk to the therapist. They would, and what would result would be very childlike mannerisms with an adult vocabulary. This was very helpful to be able to do it that way, because they could tell my therapist what we were remembering and what they were feeling, and so on.

Finally, Beth, in reflecting about her therapy, reported that she needed help to translate her early experiences into words: She said the therapist would ask her questions and she finds “it very difficult to put into words what exactly the answer to the question is”, but “once I find the words, that’s a helpful thing for me”. She continued by saying that she went through the process of trying to take that “pre-verbal thing and really find words for it”.

Both Susan and Beth expressed feelings that the issues of trust and fear of abandonment were pre-verbal issues and, for, Beth, in particular, the meaning of pre-verbal trauma was clear. In addition to the lack of basic trust, she had chronic a feeling of helplessness, residual fear and lack of safety: “I think that being so young when I was abused, it just totally overwhelmed my resources, and it left me with a chronic feeling of helplessness”.

Summary

The major components of pre-verbal experience for these participants have been reviewed and appear to be centered around the following themes: 1. memories which include crib and body memories; 2. lack of adequate language skills; and 3. pre-verbal issues/feelings. Three out of the four participants spoke of having crib memories and body memories and one spoke about physical manifestations of early trauma. Three spoke about the lack of adequate language skills to express their pain, while one spoke of
having “pre-verbal” personalities who had to somehow notify the adult to find words to express the pain. Two labeled their issues of trust, abandonment, fear and need for safety as pre-verbal issues, while one referred to her anger as “infantile rage” and called this the “feelings of a baby”.

**Experience of Dissociation**

Dissociative experience appeared to be consistent across all four cases involving memory problems, a sense of detachment, and feelings of inner separation and fragmentation of the self – lack of a sense of a stable ego identity.

Memory problems were mainly described in terms of time loss: Ann described this by saying, “...time would just evaporate”. **Clara**, when she was diagnosed with DID, said it fit in with her pattern of consistent memory loss: “It fit with the contradictory behavior patterns I had and loss of memory...not being able to be accountable for things I had done”. Susan had memory problems when living with her mother and father for the first nine years of her life and they became less after she started living alone with her mother: “It was at that point when I started living alone with my mother that my memory was clear...which makes me suspect that the host personality, a host personality anyway, took over at that point and was continuously in executive control from that point forward...because I didn’t have a lot of time loss after that”. Beth reported that as a child when the abuse was at its worst, that she had memories of “having blackout-type memory blackout things and sometimes just being confused as to how time went” and memories of going to bed at night and “awakening” somewhere else:” I would go to bed at night, but when I would wake up, I wouldn’t be in my bedroom. I would be at school”.
A sense of detachment manifested itself in a variety of ways which included daydreaming, hallucinations, and depersonalization. These are all included in Ann's reference to dissociative episodes in school:

I had them [dissociative episodes]. I was considered a space shot...I remember having teachers stand next to me say, 'is Miss A. present in the room?'...I used reading compulsively as a kid to keep out of my body...so I was spaced out all the time...By the time I was a senior, when I would be spaced out, I would be having kind of visual hallucinations and things too. I would picture people down long tubes. When people talked to me they seemed to be talking to me down a long tube.

Clara said she spent her whole childhood dissociated, and in school, she was usually the class clown and the life of the party, and "yet", she said, "I had all this stuff going on at home". Later as a young woman, during her first hospitalization, she was treated for hearing voices in her head: "...what they were treating me for was hearing voices inside my head...and they were trying to get rid of the voices". Susan felt that her "core personality went to sleep at around 2 1/2 and didn't wake up until therapy", and sometimes felt like her life was on automatic pilot: "...I felt like I was running on automatic pilot where someone else was going through doing things and I was just standing back and watching...I never knew who I was". She also heard voices: "I've been hearing voices all my life and didn't know what that was". Finally, Beth reported that she was probably actively dissociating in school. School reports indicated, she said, "that I seemed kind of spacey, and sometimes I wouldn't be paying attention. I seemed to be off in a world of my own".
A fundamental sense of separation and fragmentation of the self seemed to be a central theme for all four participants. They all used the word “switching” to describe a process in which they would appear to change their observed personalities and become another person. Ann asserted that “I have always been somewhat of a chameleon” when she was describing her experience with her second hospitalization at which time she was diagnosed with a dissociative disorder. She referred to the switching process as beginning with going into a “spacey” state prior to entering into a different personality:

That’s where I would go before I would enter into other personalities. I would be in this space place. And you could tell when I was in different states of mind because I would look in different directions. There are photographs of me at the time, and I was definitely transformed. It was definitely a pretty spooky experience for my friends, to watch me going through this.

Clara reported that she switched as a child after she saw herself in the mirror and thought she looked pregnant: “And just like that, I switched, and it’s like, oh, but I know where babies come from, so I couldn’t be [pregnant]. It wasn’t even a month later my brother got sent to Boy’s Town, Nebraska”. Later her diagnosis of DID made sense regarding the apparent separations and amnesias she had: “It just fit…with the separating from everything that had happened so I could continue to function on a daily basis”. When I first had email contact with Clara, well before her recovery, I would, on occasion, receive emails from other parts of her. She had no knowledge of writing those notes.

Susan said she switched into different personality states early on without knowing it, but when she reached junior high school she used to switch on purpose: “I would, when the kids would tease me, I would switch to another personality that the kids ended up nicknaming S. because she was so emotionless. And that’s how I coped with
the teasing”. She continued the discussion on switching by saying “....when I was in therapy...I’m doing inner child work when suddenly I had three inner children and they were talking to each other”.

Fragmentation was Beth’s main theme as she viewed the switching process:

...I was feeling that maybe I was kind of fragmented on the inside. Part of it was that I found it difficult to be consistent about anything, and sometimes it just felt like, I almost felt like I was a different person when I was experiencing different states...

She continued to explore this with another therapist:

What ended up happening was that, kind of people, or alters, or parts, or whatever, emerged spontaneously during therapy sessions. Suddenly I would be just talking in the voice of somebody else who identified herself with a different name. I would be conscious when it was happening. I would not experience amnesia. But I did not feel like I was controlling what was happening. It felt like kind of this other part of me had just taken control, and I was just the observer of it.

Reflecting on this later, she said that multiplicity became the model for this deep sense of fragmentation she felt.

Summary

Participant narratives about dissociation has yielded three main themes that best describes their experience: 1. memory problems; 2.a sense of detachment; and 3. a sense of separation and fragmentation of the self. As stated previously, all four participants regarded these themes as descriptors of their experience. All reported some kind of memory problem that concerned itself with loss of time. All reported that there was a sense of detachment manifested in daydreaming, a feeling of watching and not
connected to self or others, and other certain distortions and visual and auditory hallucinations. Everyone seemed to have felt a deep sense of inner separation from the self and often engaged in a ‘switching” process whereby they entered different personality states. Of all of the participants, one (Beth) placed more emphasis on the word, fragmentation, to sum up her experience.

Experience Before Recovery

The participants’ felt experience before recovery was not, in general, a topic of sustained focus. Two reported feelings of sadness and grief; three reported that they had anger issues; three focused on variations of fear, ranging from feeling totally disabled by it, to feelings of terror and being scared. Almost all, in some form throughout the interviews expressed that a feeling of a lack of safety and trust and pervasive feelings of chronic helplessness played dominant roles prior to recovery. Also two reported that they felt a lot of guilt and shame throughout the pre-recovery period. There were, however, clear behavioral manifestations of their disturbances prior to recovery: all four reported having had sexual difficulties, acting out behaviors, suicidal ideation, poor social skills, and “switching” (as noted in the last section). Three had, at times, work problems, two had engaged in self-mutilation and two had experiences of cognitive distortions. One had a long history of drug and alcohol abuse.

Ann

Ann experienced a wide range of feelings which included anger, grief (crying was a theme throughout her childhood), helplessness, and fear, and her behaviors included many years of substance and alcohol abuse, sexual acting out and suicidal gestures:

I was angry. Nobody was gonna control me. My family was not gonna control me. Nobody was gonna control me. I wanted to be out of control.
I was going to cry myself to sleep and I wasn't going to get what I needed...and the intensity of my grief at that time. It felt like it could kill me. I felt like I could die from my pain...at that time...it felt life threatening.

So, my history was that when I hit puberty, I became obsessed with being sexually defective. I was terrified I didn't have a vagina...I couldn't talk to anybody about it...[later]...I was part of the hippie generation. So it was the free love thing...I became sexually active when I was fourteen...I got very little sexual pleasure, but it was an important thing for me to do...within a year of becoming sexually active, I started to become promiscuous...

She became involved with an older man:...it all started with him giving me a joint to smoke, which I had been smoking pot since I was 13. That was all it took...this sort of laid the tracks for how things continued to go. I used more and more, I drank more and more.

After that, a new boyfriend:...I stuck with just him in my senior year of school. When that broke up, I started to lose the ability to cry, and I began burning and cutting myself...I would feel like I was gonna explode, from the feelings that were inside me, and there was no outlet...

**Clara**

Clara's sadness and grief was oftentimes expressed through self-inflicted violence:

*I can remember saying about the self-inflicted violence that there's more than one reason*
for it. Yes, it takes my mind off the inside pain, so it serves as a distraction. I can remember thinking...it's the only way to bring it out. It’s the only way that somebody can see how bad it hurts on the inside. And that’s, I think, because it was pre-verbal...One time I burned my leg...I think there were eight or nine, oh about 4” long and an inch wide burns all the way up my leg and then they got infected...not only would I burn myself, but then I would rip the skin off when the blister formed...I did show a teacher because I was concerned. She couldn't even hardly stand to look at it. There was this cry inside of me. If you can't look at this, you'd never be able to look at what I've been through.

Susan

One of Susan’s biggest fears was fear of abandonment and that fear, she said, would result in clinging behavior:

Basically it would express itself in terms of being very insecure with someone, and checking with them, you know, if they hadn’t called in awhile, being afraid that they decided they didn’t like me anymore.

She also spoke of chronic suicidal feelings and her time was spent more in very socially isolated activities:

I’d see a train and get an urge to jump in front of it and I thought that was one of...the temptations in life...I had a lot of this stuff going on with me without any explanations, you know, my symptoms were all over the map...

My time was spent in very socially isolated activities... It used to be I’d eat by myself quite a bit at work.

Beth

Beth’s residual fear resulted in interpersonal problems, a fragmented work history and an all-encompassing focus on trauma as being a “core thing” in her life:
“... my work history has been pretty spotty, and I have experiences of having problems at a job and then getting scared and quitting, and having interpersonal problems with people and then kind of avoiding people because of it”.

**Summary**

A review of participant pre-recovery experiences has yielded themes relating to early pre-verbal developmental issues of basic trust and lack of safety. The lack of trust and safety, in turn, appear to have created a profound fear of abandonment which impacted on their understanding and discharge of grief and anger and embedded them with a continuous underlying sense of helplessness. This fear was manifested in self-destructive behaviors which included: substance and alcohol abuse, sexual difficulties, self-inflicted violence and interpersonal problems.

**Participants’ Definition of Healing/Integration/Recovery**

Healing, integration, and recovery were oftentimes used interchangeably in participants’ narratives, so they were grouped together here to ascertain what meaning these words held for them.

All four spoke about healing as a process. As Ann was telling me the story of her third hospitalization, she shared a dream which was reflective of her belief that healing is a mysterious process, a battle to the death with the false self:

*To me, healing is a very mysterious process. Before I went into this hospital,...I had a dream three times in a row. In this dream, I was in caverns under the earth, and ...this OLD crone was there, and she was girding me up for the battle, and she was giving me this dagger, and she said you must battle to the death with the false self...I’m all glib in my dream, I’m like, this is like a metaphor, right? She says, no, this is not a metaphor. If*
you do not kill the false self, the false self will kill you...go out there and fight, and I did.

And in the dream...it was like real hand-to-hand messy blood gore.

In a later interview, she asserted that healing is a process which involves both verbal expression and working with “the energy systems” of the body “which is again, non-verbal”.

Clara

For Clara, recovery and healing were synonymous as she explains that recovery is an exhausting and time consuming process: “recovery is like peeling an onion. You do it in layers, and you weep with each layer”. Healing, she said, takes place from the inside-out, and the meaning of wellness for her is to have peace and to be able to move through to the core of what makes her panic:

...to be able to have peace, no matter what the circumstances are. Even if I’m going through a triggering time or an abreaction, to not go to panic, but to just be able to remember that this, I can work this through, I can get to the core of why this is happening. I don’t have to stay stuck in this triggered place...

Susan

Susan says that healing comes from the inside in the sense that she’s indwelt by the Holy Spirit and it is both a psychological and a spiritual process: “…recovery has to do with engaging in [a] process of healing for psychological issues…spirituality plays an important part in it, but I don’t believe that recovery for things like DID can happen apart from a therapeutic relationship”. Spirituality works in tandem with psychological healing as she continues by saying: “…I believe that they are very much intertwined. The both impact on each other...if a person has psychological issues, that’s gonna sap their
spiritual strength; whereas if they have spiritual issues, that’s going to sap their psychological strength”.

**Beth**

Beth regarded healing as a process also involving a cumulative progression through therapies. In referring to her earlier therapy which concerned itself with integrative work with different aspects or parts of herself she said: “...maybe I needed to work with those parts, and maybe just what happened was that I ended up achieving a certain amount of integration, and once I was more whole, then the whole of me needed to do more work”.

All participants emphasized that spirituality was an important part of the healing process for them. Ann spoke of the healing nature of God within the context of the creative healing forces in nature: “I think the healing force in general is a constant. And I believe in healing...you can see it happening. You can see your wounds on the outside heal up. You can see that healing can be rapid or slow given different kinds of circumstances, so I like to believe that you can become at one with the healing nature of God”. She continued later by saying: “Being able to find your spiritual center in the midst of the hardest things is a form of healing, too”.

For Clara, the healing process involved the awareness of her connection to her real self who is a part of God: “My real self is a fragment of God’s perfect being. I mean the multiple in this whole scenario is God. And we are all fragments of God. We, together, form God. And that connect, once it’s realized, is all that matters”. Susan’s whole sense of the healing process, as stated previously, was its inseparability from
from the spiritual process: “I cannot picture my healing process without it”. Finally, Beth considered that healing and spirituality dovetail one another: “I feel like that what I consider to be God is really kind of a force, and it’s a force for healing, it’s kind of the life force inside of us. The part of us that wants to grow and to thrive, and that through my spirituality I kind of tap into that”.

Integration was thought to be an act of surrender and an act of the will for Ann, while Clara’s sense of integration was described in terms of establishing a connection to her core being which is “a spirit being”. For Susan, integration meant “feeling like a whole new person and at the same time all the other people together, not so hard to conceptualize, but hard to express it in English”. Prayer for her was the process of integration by which she asked God to provide her with the images that were necessary for her healing. Beth exclaimed that integration, the process of becoming whole equaled the healing process. She said that people who have wholeness “have it because inside of themselves they’re so healthy. They heal so much inside themselves, and they developed themselves so much. They don’t have holes inside of themselves that they’re trying to fill. They’ve figured out to fill those holes from within”.

**Summary**

Findings across cases seemed to be consistent concerning participants’ feelings that for them healing was both a psychological and spiritual process, and that the concepts of recovery and integration were used interchangeably to describe what the healing process meant for them. The review, therefore, of these shared meanings, has yielded three major themes: healing as process, healing as a spiritual process, healing as a process resulting in psychological and spiritual wholeness which has been called by
mostly all the participants, integration — the coming together of the fragmented parts of their personality to form a more stable ego identity. A more detailed description will be given in a later section that discusses what was helpful to these participants in the recovery process.

**Breakthroughs/Landmarks in Recovery**

Major landmarks or breakthroughs that occurred varied to some degree for each of the participants. One, Ann, did not speak directly about this in her story. She would emphasize a few things that were important and helpful and these will be discussed in a later section. The other three participants were more specific about transitions and breakthroughs that stood out in their process.

**Clara**

The first landmark for Clara happened when she was settled down after having been out of the hospital for ten years. She said she probably felt safe enough to start recovery and the flashbacks began and she went into what she called “a horrible abreaction” and didn’t know why: “…it did show me something is terribly wrong here and I have to address it or I won’t be able to raise my children”. This, she said, was the biggest clue that she had a history that needed healing. The next key point for her was her diagnosis of a Dissociative Identity Disorder. This seemed to bring relief, for it seemed to fit in with her experiences of feeling separated from things that happened to her, the hearing of voices, the loss of memory, etc. After the diagnosis, the next landmark, she said, “was allowing the child parts to develop a sense of trust in my therapist, to gradually allow nurturing to come in, to be receptive to that. It was very healing, and it also brought forth a flood of incidences that they…my child parts, had experienced with
complete, vivid detail”. The next two key experiences/landmarks started when integration began with the acceptance of her memories without judgment and finally reaching a place of acceptance in which she began trusting in her own intuition:

Integration started by accepting the memories while they came, without making any judgments, without going into denial. And that was a real gradual process, because my recovery, just from the incest, was spread out over the course of 12-14 years. But now I do accept it all as true, and that’s probably the last landmark, is just reaching a place of acceptance. Accepting myself, accepting what has been, what my story is. When things come now, I just take them and believe them. I trust my own intuition.

So, for Clara, her landmarks became her own stages of recovery: flashbacks, diagnosis, developing trust and acceptance.

Susan

Susan listed her breakthroughs:

I think the major breakthrough in my recovery would have started when I first recognized that I was from some sort of dysfunctional family and started going to 12 step meetings for that. The next major breakthrough came when I recognized that I needed to get into therapy, and I tried working with non-Christian therapists and it didn’t work out, and then I started going to Christian therapists. A major breakthrough in association with that, he also had more training. Because the first person was master’s, the person before my psychologist was a masters level. And so his additional training made him a better diagnostician. But being told that I had PTSD and that these weird things about myself had logical explanations, I think was also a breakthrough for me. And recognizing that I was multiple was a big breakthrough. The first integration that I did was a breakthrough. The incident I described to you with the guided protector was a big
breakthrough. The last integration was a big breakthrough for me. I would say that the first time I dealt with the ritual memory was a very important breakthrough for me. And in the case of my first integration and all of the memory work that I did in the last integration, all of those were very much integrated with spirituality. I would say those were the major landmarks and breakthroughs in my recovery.

Susan’s breakthroughs, focused on her process, then, could be outlined as follows:

1. recognition of family dysfunction; 2. therapy (a Christian therapist); 3. diagnosis of Post Traumatic Stress Disorder; 4. Diagnosis as a Multiple (DID); 5. first integration; 6. last integration; 7. ritual memory integrated with spirituality.

**Beth**

Beth, also, listed her breakthroughs:

*The first breakthrough was when I first entered therapy. The first breakthrough was when I actually came to the conclusion that I needed to be in therapy, and I made an actual commitment to that...I really needed to do something about these problems. Then probably the next breakthrough right after that, was when the memories started to come back, and I realized I was an abuse survivor, and that was a big thing. But the good thing about that was that it really kind of put me in a direction, it allowed me to make sense of things in my life, allowed me to make a certain amount of sense of my problems, and I began to see that, okay, this is who I am, this is what I need to deal with, and there’s a certain amount of relief in that because it’s no longer a mystery. do you see what I’m saying?...*

*...I’m trying to think of what some of the other breakthroughs were. Okay, one thing that, it was kind of a small thing, very early in therapy, but it was very important, and it’s something that I’ve always remembered that was kind of a turning point for me. It was very early in therapy. I was having a really bad crisis, and I was talking on the phone to*
P. She said to me that no matter how I feel, I have a choice as to how I was going to behave... To just hear that little bit of wisdom helped me to feel less afraid. It reminded me that I do have control... Then, let's see, actually reading The Courage To Heal was important for me... Particularly I got a lot from the idea that the healing process [was] mine. That I can decide how it's going to be, and that the important thing is to focus on what helps and what works, and keep doing that, and to kind of eliminate things that aren't working for you... I had an important landmark when ... I was seeing the other therapist... and that was that I became aware of precisely what this kind of mechanism was that caused these attacks of panic... I realized that there was this vicious circle in anxiety where you start to feel a little bit afraid, and then it's like you totally get into that fear and you start avoiding things, and that makes you feel even more afraid, and then you avoid things even more, and that makes you even more afraid, and it becomes this kind of vicious cycle, which eventually leads to panic. Once I was actually able to see that cycle, that had a big effect on me because then I was able to see when I fell into it during its very early stages and I could stop it before it turned into full blown panic... So that was a real turning point for me...

...Since I've been in therapy with this therapist, I've had several turning points within a short period of time. Recently I've discovered, this happened very early in our therapy together, is that I erect barriers in front of people, and I kind of push people away, and that's why I have trouble functioning socially... Now that I'm aware of that, I'm working on not doing that... So that's one breakthrough. Another one is that we've worked on shame, and I've been able to really identify how shame functions for me, and that for so much of my life I've been just so totally shaming myself, and that I'm vulnerable to be overwhelmed by shame...

...Also an important breakthrough has been becoming increasingly more aware that I have control over myself and who I'm going to be. And also that I have control as far as
my emotional reactions go because I have control over what I think about and what I focus on...[and]... Just very recently I've had a breakthrough about the concept of boundaries... I had this vision of when I was a child... that in my family... everything was all mushed together, and that feelings didn't even belong to certain people... there were no boundaries there. That taught me to figure out what this whole thing about boundaries is...

Consequently, Beth’s breakthroughs, could be categorized as follows: 1. an awareness of need and subsequent commitment to therapy; 2. flashbacks, a realization that she was an abuse survivor; 3. a realization that she had choices; 4. reading the book, *Courage to Heal*; 5. triggers—becoming aware of mechanisms that caused her panic attacks; 6. an awareness of erecting social barriers; 7. an awareness of the role that shame played in her life; 8. cognitive awareness—being able to identify feelings, to focus, to change her thinking, and a cognitive awareness of the importance of having boundaries.

**Summary**

A review of some of the major breakthroughs or landmarks in participants’ recovery process appeared to have yielded the following themes: 1. recognition of the need for therapeutic intervention in all but one (Ann, as noted, did not really say this specifically); 2. the diagnosis of a dissociative disorder in two; 3. the importance of the process of integration, stated in two participants, implied in the third (Beth) when she spoke of identifying triggers.

**Experience After Recovery**

Participants’ lived experience after recovery was mostly consistent across cases with all four emphasizing growth: in taking responsibility for their lives, in self care; in
their social and professional lives. Two of the four made direct comments on the importance of cognitive restructuring as applied to their daily living tasks.

**Ann**

Ann has taken responsibility for her emotional life by learning how to identify feelings before they overwhelm her:

...my process has involved learning to walk into emotions and out without going too deep. That's how I've discovered safety. Another way not be overwhelmed besides dissociating. So I've learned how to cross the bridge over into a feeling, and stick my toe in, identify what it is, and before I go deep at all, be able to pull back, walk away, so that I can always know that I have a handle on how I go at any time... that's been a critical tool. I have a lot to talk bout with that, and I won't be able to do, I feel guilty that I'm going over time...Taking responsibility for my emotional life is difficult, it's exhausting, it's the hardest work I've ever had to do. But I have a life.

She has also learned to care for her self as an integrated person by learning to self-soothe and to make more intimate social connections:

...as an integrated person, I experience...that I have a lot of resistance to doing the things that I have to do. And it makes it much harder for me to do those things. How do I take care of this? I don't ask more of myself than I need to. I'm willing to let things pass that are not so important... holding myself is important, noticing when my body starts to do repetitive motions, and if I notice that, then if I can get myself to do some large muscle activity then I kind of feel better ...Now I get interested in learning how to do more body movement. And I'm finding ways to supply the things that I have missed. I didn't learn how to move freely when I was a baby...
...I know how to take care of myself, and when I don't, I can't take care of myself while I know what to do to get help and support. I no longer am isolated and unable to have emotional contact with people...

One of the big changes I made, I learned to stand in one place longer when I said hello to somebody... it made a big change in my life, because I would hit and run when it came to hello...I am joining the human race, and I am not wedded to being special anymore. I don't have to be special. I don't have to be smarter. I don't have to be more creative. I don't have to be intelligent, ambitious. I want to be enjoying simple pleasures of life as much as possible while I have the emotional, physical and mental health to do so.

Ann's professional life has also improved:

...It's definitely improved. I don't take so much time off. I'm able to follow through and organizing appropriate places to do what I do. I have a more successful program than I used to. I have a permanent office space... for the arts. I'm reliable, and so people are happy to have me.

Clara

Clara has learned to take responsibility for herself, by learning to enjoy being by herself and learning to identify what triggers overwhelming feelings and learning to accept the lack of primary nurturing in her life:

I'd see myself as very easily stepping back out of public things...I enjoy being by myself...

I continue to have things that will trigger me, but I don't see that happening quite as frequently as it used to. When it does happen, it's easier to work through it, it isn't as devastating... Identify what your trigger is, put a name on it, release it as part of the past and not the present, and then just find that release and move forward. And it's worked time and time again, no matter what the trigger is...
... Another area that... I think is more resolved that it's ever been. My whole life I have been obsessed with this drive to find a mother figure. I have never experienced nurturing. Even in high school, my attachment with friends would end up being more wanting a relationship with their mother, a need to be mothered than it was the friendship... it followed me even through my married life. I'd befriend older women, wanting that mother figure. I finally have reached the place of accepting it as part of who I am... I watch the pattern, and I'm also realizing that it's begun to diminish. Once I accepted it and not fought it. I just looked at it and said, oh yep, I can see why you do that. It's no longer a big deal in my life.

When asked if there had been any changes in her social and professional life, Clara replied:

*Oh definitely. When I didn't have a handle on things, when I didn't know who or how I was, I had such extreme alternating parts to my being. I would be just the life of the party, the clown. I would be totally withdrawn in some instances. I would be very promiscuous. I would be like a spinster. I had such extreme differences in who and how I presented myself, that it would confuse people. Because of that I had quite a wide variety of friends that they didn't mix. There was no consistency. The one that I would be with would be completely different from somebody else that I was a friend to. Such contradictions in my own being and how I presented myself, in what I was attracted to, what I drew to me. And that has stabilized. Because I think I have integrated so much, so I feel more balanced...*

She concluded her post-recovery descriptions by remarking that there are some issues that will probably be never resolved, but she is aware of this:
... I have some peculiar daily living habits, which I do feel are a part of the abuse. I can't function without taking laxatives every day of my life, and I don't know if that will ever get resolved. I've been aware of it all along, but I don't know how to change it... I journal just about every day. It seems to be what I need to move things through. I need time to myself. It's so important that I get time alone, to myself. For the most part, though, my day is on a real even keel. I do need, before I can be sexual with my husband, I need a certain amount of time to mentally prepare. It isn't a natural thing for me... My daily routine isn't a whole lot different than other people's I don't think, except for just needing space and needing time to myself. But a lot of people need that.

Susan

Susan has also learned to access the skills necessary to take responsibility for her life:

Post-integration, I would say that I am probably more aware than the average person when something would push my hot buttons. I don't over-react, I'm just aware of it and deal with it when I have some time to be by myself... As I apply the techniques that I've learned for dealing with things to integrate my spirituality it's pretty easy to get rid of them. So I've got a real short list of those things now, and I don't think anybody attains perfect mental health in their lifetime. I think every human being has their areas they need to work on. I think I'm kind of on par with most singulars in that regard.

She has used these skills to change the way in which she relates socially:

So because of working through my own stuff and dealing with, uh, persecutor alters and things like that I've learned to have more tolerance with other people's issues... [and] one of the things that has been most helpful to me is the recognition of God's unconditional love for me...because Christ died on the cross while we were all still sinners, that's a huge expression of love. Why should I then love myself any less than that, and why should I then love my neighbor any less than that...
...Another big change for me was that I used to hate children, I didn’t want anything to do with them. What I didn’t realize was that it was that it triggered me. Now I love children, I have one of my own now, and I don’t mind them at all.

... now I seek company at work as much as I can. I just don’t feel like eating alone anymore. I used to eat my lunch at my desk and keep working, and now I just do that when I’m really pressed for time. I make a priority of spending time with people, even though I am in graduate school and working, which is not at all what I would have been like before recovery.

Beth

Beth has become more independent and less helpless as a result of taking charge of her life:

Well, I feel like that I’ve made a lot of progress, and that I still have a little ways to go. I feel like I’m functioning better than I used to. Emotionally I’m doing a whole lot better. I’m a whole lot less anxious than I used to be... So I’m feeling a lot different about myself on the inside. And I’m also feeling less dependent on what other people think... [I am] learning about boundaries and about basically developing my own individual self. And learning to like that self and take good care of that self, and realizing that that actually puts me in a better position to relate to others.

...I’ve been working on improving my appearance in personal hygiene... and I’m working on trying to be a little bit neater about my house and stuff. And, you know, I haven’t ever really worked at a job for a long length of time, so part of what I’m planning on doing before I go to graduate school is to really have a job and really work at it...

And also I don’t drive a car, and one of the things that I have planned for later on is go to driving school, learn how to drive, get my license...
She has also been learning to broaden her social contacts by meeting other people:

... My social skills need a little bit more improvement. I really don’t have very many social contacts. There’s my husband. I’m on good terms with my sister, and I know a few people on the internet but I really don’t know anybody else locally. But I’ve been working on that. I’ve been getting more out into the community, taking some art classes, mainly in order to meet other people, so I can get more friends, that kind of thing.

Summary

It appears that the following themes have emerged as a result of the participants’ experience after recovery: increased self-functioning exhibited in increased responsibility for self-care and improvement in social functioning and work-related activities. All of the participants reported that they now were more aware of emotional triggers that had diminished their emotional stability before recovery. Now they were better able to move through impasses that could hamper their functioning. All of them were increasingly aware of the need for social contact and were actively working on engaging in less isolated activities and doing more networking: Ann is interested in “behaving and connecting” – she calls this “social creativity”; Clara’s social life has stabilized and more balanced and she is more open to people; Susan’s priority is spending time with people; and Beth has expressed a need for more social contacts and is taking art classes and establishing more friendships.

Experience of What Was Helpful in the Healing Process

Again, due to its subjective nature, the healing process for each of the participants was disparate and simultaneously complex. It was disparate in the sense that an individual’s inner journey to health cannot be compared to another. It is a solo
process, and, as Clara had remarked earlier, a process akin to peeling an onion, “you do it in layers, and you weep with each layer”. It was complex in that there were interrelated parts of the healing that were both individual and corporate at the same time.

For this reason, I describe what was meaningful to each of the participants individually in terms of more generalized techniques and then speak about three major themes that appear to be common underlying ones across cases. These themes revolved around the importance of the therapeutic relationship and witnessing, the use of the arts in various forms as a technique, and finally, the experience of spirituality.

**Generalized Techniques**

There were combinations of processes that the participants have undergone in order to find healing:

**Ann**

For Ann it was the 12-Step Programs and support networks, bodywork and energy work, acupuncture, the creative arts, and cognitive work, and medication. Other helpful techniques included Gestalt Therapy, exercise, guided meditation, and group therapy, all of which helped her to work spiritually and practically with her anger. Underlying all of this was a deep sense of the journey being a spiritual process.

Her third hospitalization was vital to her recovery, she said. It was there that she learned how not to dissociate and learned practical aspects of recovery and self-advocacy. Some techniques used there were Gestalt Therapy and Psychodrama also. She disengaged from her previous label of multiplicity in order to function and received behavioral and cognitive restructuring types of therapy:

* I was not able to have a life...They gave me real solid practice help at [the hospital]...

* It's not the only kind of therapy that I would recommend for someone, and I'm not
mocking the other experiences. The fact of the matter is that I have an adult life now as a result of the help they gave me, and just busting through my denial about the seriousness of what I was doing to my life by not taking responsibility... it was [there] that I learned some basic practical things about what my history and life habits were doing to my present life. How I was driving people away. They were not going to engage with working with dissociative disorders. They were the absolute opposite of everyplace else I had been....Labels have a big tendency to become self-fulfilling prophecies. So although I understand they're necessary for insurance reasons, I don't think therapy is well enhanced by [being given] a particular diagnosis and working in a particular way. I think it has to be very individual, and that you need to take into account the person’s living situation and everything else...That's one of my favorite things about [the hospital] was that they didn't[dismiss] other forms of therapy, but they said, here's the situation. The situation is that people are being sent to us for insufficient amount of days, unable to function, and insurance won't cover anything else. And many of these people are in situations where they're not getting any support from anywhere else to speak of. So what they worked at was to bring people back into the highest functioning possible in the shortest amount of time. They were very successful... They were very successful at getting other patients to say the truth to each other. Their therapy sessions were, it didn’t feel brutal but it felt like you did not get by with any illusions around this place. There was no cobbling, that's for sure. It was not an easy place to be, but there was respect...

The 12-Step Program played a very important part of her recovery, especially Co-Dependents Anonymous (CODA):

CODA especially is good for anyone with trauma history because there's no crosstalk which means that people do not advise, comment on or in any way stick their fingers in
your emotional pie. So you're able to express yourself safely without judgment, without anything invasive...

Other helpful techniques included psychology of mind, shiatsu, and acupuncture:

That is, among other things, I've done a little psychology of mind, too... they teach you to access your calm center and to wait for the truth. No matter what your background, the premise is that you learn habits, emotional, mental, thought patterns...

I started doing shiatsu at a time when I couldn't wear shirts that had collars. I couldn't be touched unless somebody came at me from face on and had my permission...[with shiatsu], I didn't have to revisit it [the pain] to let it out. It lived in my body. It lived in places in my psyche that could be accessed indirectly. This has been extremely valuable. Indirect access and working with balancing the healing energies inside you... It always brought the grief up without having to go into the psychodrama, into the re-experiencing of trauma...

...To me, rather than thinking about it as moving things out of my cells, I think of it more as tying into my energetic system. My energy system. Thus directly into psyche. Auras are electrical, too. So I mean it's really mysterious. Now I do acupuncture, and one of my points to be punctured is particularly right for it. I feel that needle connected to that energy before it touches my skin. It's very interesting, very mysterious and very different. But there are spiritual points, I mean there are points that really work directly with your spiritual and with your instinctive self. There are points that work with your emotions.

And the shiatsu was a good preparation for the deeper work of acupuncture...

Clara

As noted in previous sections, what was helpful for Clara was actually the diagnosis of DID and finding a therapist who was knowledgeable in that area:
Probably the most helpful thing was finding out, being diagnosed with a dissociative disorder. I have up on taking any kind of medication, and I have never needed anything since I found that out. It's just like when I was told that, it clicked, it said who I am and what I've experienced. It's like I didn't need a hospital, I didn't need, I didn't need a psych ward, anything that had been tried previously and didn't work. Once I was diagnosed and I didn't try to shut out the voices in my head, I just came to understand why they are there, and began to listen to them in a cooperative way.

Techniques, she said, really didn't matter; it's the love: “You can’t teach people compassion... That comes from the inside. It isn’t something you get from a book.” For her, the therapeutic relationship became the building block for learning to be in relationship. So techniques were used to help her move to the place of learning to trust in her own feelings and instincts. These mainly consisted of using the creative arts—music, art, writing, poetry, etc. in helping her to work with difficult imagery within her memories. The underlying and most pervasive theme in her story was her strong sense of the spiritual. The themes of the the arts, therapeutic relationship, and spirituality will be elaborated on in the next section.

Susan

Planned integrations for each of her alternate personalities was important for Susan. The main technique that she used with her therapist was prayer with imagery that was different than the kind of imagery one has when memories are uncovered:

My integration I did, I did what imagery worked for me for the integration, and a lot of them had to do with picturing the personalities laying down on top of each other or sitting down inside each other. So, for me it was important to do explicit, planned
integrations. I'm sure that it works the other way, spontaneously too, and that's fine, but for me it was important to say goodbye to each other, but not really (laugh). So you sort of goodbye to each other because you no longer will be able to talk to each other as separate personalities anymore.

... I'd ask my therapist to pray, and he would pray and, generally speaking it would tend to happen, while he would be praying for me about integration with the imagery that I had asked him to use.

... it's a different kind of imagery than when you get memories. Yeah, that was something that I, yeah, it was in the inside world. I was using my inside world as a place to have my images develop.

She used this technique to “restructure” her images. This involved a tripartite process that included prayer and journaling whereby she would, 1) have a memory, 2) go back to the memory and ask the Lord to speak to the memory and 3) receive healing images (restructure the happening):

...It would seem to me that Jesus would speak to me when I was journaling, and so what would happen sometimes is that I would be stuck, Jesus would talk with the personalities and I would listen and type my journal, because I type 60 words a minute. Keeping up with all my personalities, it's much easier just to type it. There would be a lot of time where I would have interactions with Jesus in my journals. After I would have a trauma memory, I would then pray and ask the Lord to show me something about the memory. The first time it happened my therapist did it. I had a memory and he prayed, I want you to try to visualize Jesus in the memory. And, this was an incest memory with Dad in my bedroom, and I saw him sitting at the foot of my bed crying. I had a picture of Jesus sitting at the foot of my bed crying. That did two things for me. To me it was not my fault. And it also helps to relieve the grieving. So I got in the habit, after I had a
memory, I would go back to the memory and ask the Lord to speak to me in the memory. So I would have things like, various and sundry images that would be very healing and actually would be doing kind of a restructuring. One time I was feeling defiled, although I hadn’t put those words to it yet, but that was my emotional experience, and the image that I got was of Jesus having me stand under a waterfall made out of light.

Other experiences that were helpful to Susan, besides having a Christian therapist, involved attendance at 12-Step meetings. She led a Christian one, went to another Christian one for her own recovery, and also went to a secular SLA (Sex and Love Anonymous) meeting. Techniques her therapist used involved deep breathing and relaxation exercises, some inner child work and religious imagery.

Beth

Congruent with her primary stated landmark in her recovery process, Beth said that her first hospitalization as a child was very helpful in that it was there that she was told she was intellectually and artistically gifted. The use of the visual arts and writing would become a vital part of her recovery over subsequent years. In her narrative, she also focused on therapy groups and support groups including an internet support group, art therapy, and body work as being helpful in her recovery:

One thing is that I’ve done a lot of work with groups. I’ve been in therapy groups, and I’ve been in support groups. When I was in K., I was in three different therapy groups, and they were led by different therapists than my individual therapist...The therapy group I was in when I was in K, the first group that I was in, I was in for about six months. It was led by a couple, a husband and wife team of therapists. It was interesting because these therapists were very humanistic and they were like, they did like Reichian stuff and body work, stuff like that... One interesting thing that we did, was that once a month
we would do a body work thing where they would have a kind of re-experience a traumatic event, where we would like talk about it, and it was like a gestalt thing where we would pretend like we were actually in the event, and say in the moment what we were feeling and what was happening. And they would sometimes do these things where they would touch parts of our bodies to help us release certain physical stuff... it was actually pretty helpful

...I've also done support groups. When I was in K, I was in a very large support group...that was for women who were survivors of child sexual abuse...And that was a peer-run group that was all run by survivors...And then I found the internet support forum that I'm on now, it's called “Sanctuary Mud”... You can either talk in real-time with people, kind of chats, or you can post on bulletin boards, and there's a bunch of different bulletin boards on different subjects...

...I've found peer support groups to be somewhat more helpful than therapy groups. And there's a reason for that... in a peer support group, the individual members of the group take a little bit more responsibility for making the group work, at least that's been my experience... in therapy groups, all too often, a lot of the group members just kind of let the therapist kind of run things, they're even kind of resistant to themselves in participating, where they might participate a little more if it was more on their shoulders to have to do it. The exception to this was the art therapy group. The art therapy group I thought was really good. It was probably because of the art process...

She also found a technique for doing memory work very helpful:

I felt that that memory work has really been very helpful to me... it's been a very important key element... it's really kind of a pretty simple uncomplicated process. The way it works is that, I tell her[therapist] about the memories. I go into detail talking about memories, telling her exactly what happened, exactly how I felt about it...I try
mainly just to stay present and not dissociate while I do it... But I kind of know how to do that. It involves me sitting in a balanced position with both my feet on the floor. It involves me continuing to breathe, to keep my eyes open so that I'm in the present. And I found that while I'm doing that, there usually comes a point where the feelings connected with that memory just suddenly come up and I experience them.

Beth expressed a feeling of gratitude in the support system that involves her husband, her survivor community, and her therapist. Though she spoke a great deal about the importance of group experience as important factors in her healing, the individual therapeutic relationship, the arts and spirituality were prominent themes throughout her narratives. A discussion of these themes follows.

**Major Themes: Witnessing/Therapeutic Relationship; The Creative Arts; Spirituality**

All of the participants placed emphasis on the role of witnessing and spirituality as major components in their healing process. Three (Clara, Susan, Beth) were very specific about the therapeutic relationship as being vital in the recovery process. Ann did not speak directly about the individual therapeutic relationship, but included it as a type of witnessing that was important to her. The creative arts were used as initial expressive tools for Ann, Clara, and Beth. Susan said that the arts to her were not particularly helpful, that writing was her medium. However, it would appear that Susan’s perception of the use of the word or words, “creative arts” may have meant the visual arts to her. The creative arts, as defined in this study, carries a broad definition that includes writing, journaling, poetry, etc., all of which Susan did.
Witnessing/Therapeutic Relationship

Ann

Ann honored the importance of witnessing and its transformative value. She described the different types of witnessing that was helpful to her as consisting of group, individual counseling, friends, CODA, and her boyfriend. Initially she spoke about Re-Evaluation Counseling as introducing her to the value of witnessing:

"It's called Re-evaluation counseling. It's based on the premise that it's important to vent your feelings in a safe way, and be witnessed venting. That if you vent without witnessing that it doesn't have the same sort of transformative value... my favorite thing about re-evaluation counseling was honoring the importance of a witness, especially considering that in my story isolation was one of the major forms of abuse. Isolation and neglect. So crying alone is far from being helpful. It's really re-entering a place of feeling helpless and hopeless.

She had been witnessed in assorted ways:

I've been witnessed in a variety of ways, not just with the RE. Why I brought RE up was because of how pleased I was to discover that far from having to abuse my vocal cords in order to vent old baggage, and acupuncture and shiatsu were ways that I could access and work with emotional transformation without abusing myself by re-experiencing trauma.

...there's been a lot of different types of witnessing in my life. I said before that the importance of the 12 step recovery. So witnessed, I'd get witnessed in a group setting very frequently. I'd go to between 3 and 5 meetings a week, and I've done that for the last nearly 13 years. I've learned to share in safe ways in those settings where I'm able to share about the emotions without entering into a lot of specifics. Yet it's still very
powerful, sense of it's a place where I can come and be real. I've had just about 10 years in therapy with J, and she remembers things very well. She's vitally important as a witness. And I have one friend who's been just wonderful in this area as well. He's like a soul mate friend. A gay man who I've known for the last 5 years, and he's done a lot of work on his emotion issues, too, and he has a lot of them. He really understands. He's one of the best witnesses who doesn't try to change anything. Here. My ideal witness does not try to change or alter the course of things unless there's any aspect of safety that would need to come in... Co-dependent recovery was good for that, too, with the cross-talk boundaries where you don't... I've learned to trust verbal pretty well, but one of my favorite things about the boyfriend I have right now is that he gets the non-verbal messages very well, including when I, the when I talk, how I talk, to deal with panic. He's very, he notices the subtle stuff. And I love when people notice the subtle stuff. I love any time somebody perceives what I'm experiencing without my having to say something. That feeds a really deep need in me. For pre-verbal trauma to have happened on any kind of regular basis implies that your emotional reality has not been taken in. And it's not like babies are so subtle, are so hard to read. But that's how it felt me, that nobody could read me, no one could know me. I felt like I was invisible and that it didn't matter how much I screamed or yelled, nothing was gonna work, and nothing would, I would have no impact, no power, on anything that happened.

Clara

An overarching theme for Clara in terms of witnessing has been the therapeutic relationship, which, in a sense, to her, became the prototype of learning to be in a real relationship. The unconditional love and validation which she experienced within this relationship was more important than therapeutic technique. In this relationship, she said,
she learned to trust; the therapist has been a link for safety and nurturing. Developing a sense of trust was the key to recovery for her.

... She brought me into who my divided self was... It's like she nurtured in a non-threatening, safe environment and as that happened, more and more trust was developed. She never turned on me. She never closed the door, and she received me. The more she received, the more I dared to share... trust developed, and it just, it just changed everything for me.

...beginning to nurture and develop a sense of trust was THE KEY to my recovery... She would be very validating to every part of me, even the ones who seemed self-destructive. She would explain to them how they just need to change their job description inside. She would build a trust relationship with each fragment of my personality, which of course would bleed through in a real subtle way, even to me. I didn’t know exactly what was happening because I wasn’t coconscious at the time, but I would leave there in better shape than I was when I came, every time.

The unconditional love of the therapist and her letting this in were vital to her recovery:

... I can’t say that I was never treated in a loving way by other people, but I never let it in. And it’s like she broke walls that were built by protectors, and she broke them with love... it saved my life. It was like I was experiencing God’s manifest through a person, directly. Because I’m sure there were times when, just on her own she couldn’t continue to love, but she was open to God’s influence, too. She was just, she wanted to be used by God. And it just was so apparent. I felt God’s love first hand. It’s like she just stepped back and let God love me. It’s probably not something that would work in a textbook for a therapist, but it sure worked for me.
Finally, Clara has suggested that it has taken a profound measure of love and acceptance to effect her healing and this, she implied, was the direct result of her therapeutic relationship:

... When you look at the measure of brokenness and the severity of the abuse, it only makes sense that it would take the same measure of love and acceptance and non-judgment and listening and caring and compassion, to heal. I don't think you have to be a rocket scientist to see that there's a pattern there.

**Susan**

Susan said that recovery from DID cannot happen apart from a therapeutic relationship with a person skilled in treating dissociative disorders. She stressed that a therapeutic relationship was needed. The faith of the therapist and the acceptance of her spiritual inclinations was vital. She, therefore, chose a therapist who was a Christian like herself, held the same values, and with whom there were shared religious or spiritual experiences. A previous therapist had discounted her religious experience. The Christian therapist worked with her using religious imagery and prayer as an important part of her therapy. In her recovery she also noted that the advocacy of the therapist was very important to her and she defined this as the willingness of the therapist to express emotion, to be a witness and to partake in the journey:

An incident just came to my mind in the therapy, that might illustrate the...I had a personality, the one who cuts my body, she never did, but she wanted to. And she was what people would call a persecutor personality... I had emergency session and she came out to talk to him, and I had decided, because I do believe that demons are real, and they can inflict people, I had decided that, to ask that my therapist would pray with every personality before they would go back inside. And it was something I initiated, and he
was amenable to it, and so she was out and talking to him, and she was sick of talking to him and wanted to go back inside. So she said, okay pray so I can go back inside. I mean, she was really just like a hostile, disgusted, angry, hateful person at that point in time. And he started to pray for her and she was just sitting there being grumpy, and she noticed he had started weeping. And at that moment, she came to the realization that she was not a demon. Up to that point, she had the (cognition) that she was herself a demon. Because he started weeping, that was like a major blow on...I can’t be a demon. People don’t cry over demons. That was how she responded to it. She went back inside, and I, the host was processing this with my therapist, and he was almost apologizing for crying. But he said, I couldn’t help it. The Holy Spirit fell on me and I could not not cry.

**Beth**

Safety and trust were substantial issues for Beth as well and were factors in her individual therapeutic relationships that promoted healing. She reported that the most important component of her recovery process was her individual therapy. Beth had three therapists, each providing her with a strong measure of safety. Qualities of a good therapist for her included safety, respect, caring, professionalism and modeling and a sense of a professional discipline in terms of a theoretical orientation. Beth felt it was very important that a therapist see her as competent and had faith in her ability to heal herself. This has been especially true with her present therapist who is doing more cognitive work with her.

Beth has said that her therapy was progressive and she reflected on some of the changes in the therapeutic relationships she had experienced:

The first therapist: *...She always treated me as if she had a great deal of respect for me, as if she respected my competence, and that was great because a lot of times I really*
didn’t feel like I was very competent... she showed through her actions and the way that she treated me that she really believed in my competence... she had faith in me. And that’s really important.

The second therapist: ...this therapist was eclectic... She was a good group leader. I kind of want to say that she may have been better at being a group leader than she was at being an individual therapist... She was a safe person. She was very supportive, and we talked about that, and I need a little more than support...I felt like, though, for some reason, this might have been just a thing about our personalities that the therapist-client relationship was not quite there... There seemed to be something missing.

The third therapist: ... She an Adlerian therapist, that’s her theoretical orientation.

She’s real challenging... She kind of helps me to see that I have these underlying beliefs that I didn’t even know that I had... I really feel like she accepts me wherever I am in my process... so I think that that helps me to be able to look at things... her role in that is basically just to listen. And she’s really good at listening. She’s... just so present while I’m doing this, that she’s... really listening.

The Creative Arts

Ann

Art and music were always used by Ann to process powerful emotions:

...Always. Always. I’ve always done art and music, and I’ve always used them to process powerful emotions, even when I was at my most out there, as a speed freak.

Druggie drunk. I was still doing water color paintings, pretty horrifying ones. I’ve always, always done those thing... in the heyday of my healing process, I did need to do a lot.
Art was and still is very much of her authentic voice, although she uses it in a different way now. Her creativity has been cyclic, varying among the visual arts, poetry, song writing, gardening and what she calls social creativity, and using her art to connect with people:

... Creative. It’s all becoming one to me. My creativity now is very much a function of my relationships with people. As I learn to have these, in a deeper sense, I’ve put that as a higher priority so that right now, for example, the most recent painting I did was a portrait of someone. So it’s coming into my art work now to connect with people. I’m applying a lot of my creativity to just studying how people behave. I’ve never known how to behave. I’ve never had an interest in behaving.

... I’ve always in my creative life found that I cycled from one area to another. I do visual art. I do poetry. I do songwriting, which is not the same as poetry. Gardening. I consider also a creative pursuit. I get very involved in one area, and another area less so has been my history. But now I have to add to that list social creativity. And this has become most important now. I can isolate with art.

Before integration Ann’s art was translation; now, she says, she needs no translation — she has a native language.

... the arts are good for non-verbal, but there’s still a translation. Words are a translation. Music is a translation. Visual art is a translation. All different forms of translation. And I think I’m getting a little closer to the native language. I don’t need to translate. And that’s why I just love it when someone can see the look on my face and say, “are you okay?” Or when I’m talking a whole lot, and I look at my boyfriend, and I can see that he knows that I’m doing that because I’m nervous about something.

Clara

The arts played a very big place in the healing process for Clara:
Very big place. Very important. And I think that started even before I started recovering. I think the creative arts helped keep me able to survive...now, the arts are a way for me to express. And in recovery, it's always been a way to express. Before recovery, it was a way to escape. Now it's more a matter of expressing deep feelings...I feel comfort in music. It can be really calming and soothing when I'm uptight...It really seemed to keep me progressing. In the recovery process. It's like I would allow myself to feel the pain. I would weep or I would just sleep. Whatever I needed to do, I just would allow it...I would listen to a lot of instrumental, like piano music.

...The journaling, the writing, I think helped me to get in touch with, like what would be a trigger. ...When you write, it's like you just keep peeling away the layers until you find out what needs to surface... through the course of the writing, something comes forward. So then I can do the name, identify and release whatever it is.

The visual arts have been a self-teaching tool for Clara:

...Another thing I've done a lot of is drawing. A lot of art work. And usually it's symbolism in the art work. I can ask inside, after the drawing is all done, what different parts of the picture are to symbolize, and the teaching will come from the picture... So I think those kind of drawing from my higher self, it's leading me into a better place where I have more understanding...At the time that the picture presents, it doesn't make any sense at all. The words will come, but even the words are, it's like they're in a language that doesn't, it isn't quite clear to me. But after I have learned what I'm supposed to learn, I can go back, I can read the teaching. I can look at the picture and it's like, oh that's what it meant.

The pictures she had drawn led her to another interior level which she has labeled as wisdom:
...Yeah, only they're on a level of wisdom. It's like how I told you how the pieces of my life fit together, well this will talk about the purpose in them. That it all has a higher purpose and if we get caught up in the scenario of what we've been through and we don't look ahead to the higher purpose, we can stay stuck. But if we just are thankful for it and keep moving, it's obvious. It's like part of a global evolving. It's like, learning deeper spiritual truth by going down in the trenches and fighting.

Susan

Susan declared the arts were not particularly helpful to her; writing was her medium, although she did do some coloring, journaling and poetry: “More of the writing. I did do some coloring, a little bit of coloring, but for me the writing was the big thing... I wrote some poetry, not a lot.”

Beth

For Beth, art really was important in her healing as was the showing of her creative work:

*Art has been really important for my healing... when I was going to school, I ended up one semester studying with a visiting artist...I found out that what I needed at that time was to really produce artwork that was about my abuse... this visiting artist that I was working with was open to that, and she let me do that. And that was a big turning point for me creatively... she was really good at helping me to be safe about that... At the end of that semester, our class ended up having a show at a gallery, and I showed a lot of that work...It was scary, but it was gratifying because I ended up having a lot of the other students coming up and say that the work was powerful, that some of them talked to me about their traumatic experiences, and that they felt that I really had kind of spoken something they could hear...*
The use of metaphor was important in Beth’s healing process for it helped her to find resolution. She would write “therapeutic stories”, fairy tales, to work through some of her issues. She was able to translate her pre-verbal memories more into her adult part, so that they could be seen, and words were her vehicle:

...One of the things that I do is write these little therapeutic stories, stories that are kind of like fairy tales. What I do is I take some issue that I’m working with in my healing, and I make up a metaphor about it, and then I write a sort of fairy tale story about that metaphor. Like the most recent one I’ve written was one called “The Little Girl Who Never Grew Up”. It’s about a little girl who just doesn’t grow. She gets older but she never grows up... I wrote that story specifically about that issue and about learning to see myself as an adult who has power over myself, and that I have power over my life, and I’m not just a hopeless little girl anymore...

...Sometimes when I’m struggling with...some particular issue and feel like I’m at an impasse with it, so then I’ll try to think of a metaphor for it. I’ll think, well what does this remind me of, what kind of metaphor does this remind me of. And I’ll work very hard for my creative self to try to find a metaphor that really feels right, that really seems to be accurate that reflects that. Then once I have the metaphor, often the metaphor will then lead me to a resolution of it...

...To be able to create something gives me something that I can look at... Sometimes I write[therapeutic stories]... based upon an insight that I’ve had. But sometimes the metaphor comes first and the insight comes afterward. It’s like sometimes if I could find the right metaphor for something that I’m really struggling with, that leads to a breakthrough in understanding.
Spirituality

Spirituality, in some form, appeared to be an underlying, fundamental theme throughout all participant narratives. It has already been referred to in other sections that have dealt with what healing and recovery has meant to the participants and what was helpful to them. There may be some overlap here; however, a brief summary may broaden the reader’s perspective as to the importance that the participants attach to this theme in their process:

Ann

For Ann spiritual work was and remains vital in the healing process. It is akin to a battle to death with the false self. The 12-Step Programs were and continue to be a spiritual mentoring process for her.

...Well the 12 steps are a spiritual program. It’s based on that you have a Higher Power of your own understanding, which means, it can be God, but it’s not necessarily God according to anyone else’s model, or Goddess. Or it can be Buddhist sorts of non-theistic sense of truth.

Ann used the words, “Higher Power” as part of her description regarding her attachment to a sense of the spiritual while she acknowledged her own powerlessness over a final healing — that there must be something greater than she who would mentor her through the process:

... But I don’t feel like I have to have so much power for something to be healed. I have to do the work, but I don’t have to have so much power, The concept of a Higher Power is very helpful. Because, and it’s hard because where was my Higher Power when I was little? So a lot of my relationship with my Higher Power is in a relationship of being angry with my Higher Power... it’s okay if I’m angry... the first time I got in touch with
my Higher Power, I had to pray to be safe enough to be angry with my Higher Power. 

My Higher Power helped me to be angry at my Higher Power. So it's beyond okay. It's vitally important.

Her relationship with her Higher Power has changed during the recovery process as she speaks of spirituality and alignment being the same...

...it changes all the time. It doesn't remain static. It's, but I would say, it's almost like a Buddhist idea of Higher Power the way I work with Higher Power. It's not like I picture some personalized God or a God that's directing me. Although, if I need to be held, and there's not someone there to hold me, I will visualize that power holding me. But it has to do with alignment... almost, taoist idea, and it has to do with personal revelation, almost gnostic in that sense. I believe that my Higher Power supplies me with the images, the dreams, the tools, and the support that I need to do more than I could do for myself, by myself. And I believe that I don't always manage to access all that's available to me in this way unless I cultivate a relationship with Higher Power. This aligns me with the path of least resistance for healing... My spirituality maybe is a process of accessing, some people would say your Higher Self, or your wisdom voice inside, your true-ist nature. I believe that if I become centered in my truest nature, that I can access larger truths than my own individual truth.

Ann has suggested that our hearts are invested in faith and faith and the healing process is the same organic process in which things grow:

...That leaves you with faith. The whole concept of faith is that it's something that can't be known, and can't be seen. But we invest our heart in it anyway. We search for the places in our heart to thrive through having it. And if we find those places that thrive and center in them, then you have a tendency to grow. And so, see this is the healing
process is the same organic process in which things grow, and only it happens in the invisible places. I hope that I'm right, but I can't know. And as I find that I'm right here and I'm wrong there, then I have to adapt my belief as I'm learning along the way. But I believe that if I cultivate that spiritual growth, it will be with me as I either decay or become curtailed early, as I go through the latter phase of my life. I've seen serene elders, and my grandmother, I've seen bitter, hateful. I used to really hope that I would not become old.

She also attributed the concept of serenity versus the hatred or bitterness to spiritual development:

...I think that's where the spiritual development comes in. You see it in monks and nuns and all sorts of practitioners of all sorts of spiritual paths. Not to say that you won't find bitter nuns, too. But overall when you see people who have dedicated their lives to spiritual development, you find people who are finding a measure of peace in their elder years.

Clara

Clara's experience of spirituality in the healing process was that it was her survival. As noted in previous sections, her alignment to the concept of Spirit has been all-encompassing throughout her whole process. She has not separated it from the process.

... I could not have ever survived without a connect spirit. And even if I wasn't aware of it, that is how I survived and how I continue to thrive now... what really matters is... spirit connect. All of this scenario, it's (so immaterial) compared to my connect spirit...
Her suffering, she said, has been a blessing; it has brought her closer to what she has defined as wholeness, communion with spirit or God and is a matter of transcendence:

... I'm at a place now where I see what I've been through as a real blessing... I see it as part of my shaping for, it gives purpose and meaning to life... I want something with depth and meaning. On a spiritual plane. Not just for today. Something that is evolving all of God's creations. The scenario, the circumstances are kind of insignificant if you get the meaning of it and you move forward out of that. If I stayed stuck in the fact that I'm an incest survivor, or I stay stuck in the ritualism and the abuse that took place, I have hopelessness, I have nothing. But if I go beyond that, I see that as part of separation from spirit, that needs to be mended and this is a way that I am drawn to God, and that communion with spirit is all that really matters in this life. That is my richest blessing because it has put me in God's hands, completely.

Spirituality, for Clara, has and continues to be everything in her recovery process. It is the "call-back" from the small voice that has always been inside of her:

...It is everything. I realize now that I have always had a still small voice inside of me, and I have had a call, which we all have, and that call is, we are spirit beings, and spirit is simply calling back fragmented parts that have been allowed to be through creation, calling these fragmented parts back to themselves. Our whole purpose is just to realize that we are spirit beings. We're having a physical earthly experience, but we really are spirit beings. If I look at everything from that perspective, that is why I survived. Maybe that's why it was even allowed to happen, for a deeper spiritual attachment to my true, my Higher Self. And it's really the only thing that matters, in this whole life, to me, is how and where and when I can experience the awakening of spirit inside of me, and the rest is just trivial.
Her struggles have helped her to reach that conclusion:

...I think the struggles have helped lead me to this conclusion. And I think working through the struggles, looking back at what I endured and wondering how I did, why I did, everything has pointed me back to the same thing. That I am a spirit being, that there was a voice inside of me that kept me going through all of it, that encouraged me. It's like there was always somebody I could rely on to get me through the day... who I still have contact with. I had friends, there was always somebody, and it was like an implant from spirit... that's the way it's been my whole life. I've had something click to keep me going, how can there not be a spiritual intervention there?... I did have to do the hard stuff... But I feel like I've evolved through that and become more of who I'm intended to be. Clear off some of the crust of the ego-self and getting more in touch with my spirit self.

Clara’s reply to the question as to whether her spirit self and her real self were the same for her was:

...Yes. And the rest of me is just doing this earthly experience. That's part of my spirit being is doing this earthly experience. But the true being that will continue to go on and on and on is my spirit being.

When asked whether she believed that union with spirit or union with what some people might call God is the objective and will make her a whole and undivided being, she said:

...That's been my experience, yeah. Everybody has their own scenario. Some don't reach that same conclusion. Some maybe never find purpose in their pain, but that is what my belief is.
So the purpose for her pain was the impetus towards self-realization, and self-realization was the acknowledgement that she really is the spirit self. God did not cause the initial abuse, but the suffering was a transformative experience. It led to her to a strong belief that healing comes from the inside-out and it is a spiritual process, a reassociation and a remembering of her spirit, which is God. Part of the transcript describing this experience follows:

C: ...What I am not saying, though, is that God caused all of this to happen. That I don't believe. That God caused my father to abuse me. But what He did is He turned a very seemingly unspiritual scenario into one of pure good.

D: So you’re suffering transformed, was a transformative experience for you.

C: Yes, absolutely. And sometimes I still forget that, but I always go back to that and then I'm always back in a place of peace. When I forget it, my peace is in an upheaval. But as soon as I remember it again, there’s just a flood of peace very time.

D: As soon as you remember...

C: That I am a spirit being just having a physical experience, and that all that I've been through, if it drives me closer to my spirit self, then only good can come from it. Because ultimately the only thing that matters is that I connect with my spirit, which is God. Doesn't matter if it's this scenario of mine or anybody else's. Ultimately, that's what matters. That we connect with our spirit self, which is God... That comes from the inside. It isn’t something you get from a book.

Clara consistently maintained that for her wholeness cannot exist apart from God or spirit; all else is illusion. What corrects the illusion is to see things in a more “proper perspective” which she calls connection and connection is her core being, spirit:
...Yeah, it’s to be consciously aware of that connection that exists. And that connection never does not exist. When we are in turmoil, the illusion is that we aren’t connected to our spirit self or to God, so we gotta get back out of the illusion that we aren’t connection, because we can’t be not connected to our core being, which is a spirit being...anything that takes away from that connection is illusion, and yet the outside world too is other fragments, all living things are a fragment of God’s being. But the illusion is not seeing them as that. The illusion is seeing them as something else like our enemy or something that we don’t work with cooperatively...If we would see them as all part of the same being, which we are too, I feel like that’s a more proper perspective...sometimes...I see the conflict instead of the connection....so I retreat and I get it back in perspective, and then I go and try again, and concentrate on the connection instead of the illusion which is conflict.

Clara was asked, in the context of her experience, about her healing process. Was it what other people would call a mystical process? Healing, she suggested, is the call-back and the inner nagging voice she sees as an implant from God:

...Yeah, oh yeah. I don’t see it any different, there are different people, Neil Welsh has written, conversations with God. Or Shirley MacLane who was on a spirit mission. There are evidences of it everywhere in the world. It may look like a different path, but I think...there’s only one destination, there are many paths, but there is only one destination, and that is to connect to our spirit self...There’s just so many different paths to that same place, and some end up being real alternate routes that are gonna get them lost for a while, but they’ll be drawn back. Because it’s in us, we’re called back. This voice that won’t leave us alone, and will just keep calling in a real gentle tone, but it just resonates inside of us and we don’t have peace until we find the source of that voice. It’s an implant. I see it as an implant from God.
Susan

Susan’s healing, as mentioned previously, was notably rooted in spiritual experience. She was a part-time minister and very much involved in her spiritual process and church attendance as a member of a recovery-oriented Christian Pentecostal church. As it has enveloped her healing, so has it done so here in its involvement within this category of what helps in the recovery process. She had maintained throughout all the interviews the fact of not being able to imagine her healing process without a reliance on prayer and on Christ as her therapist, and His place in the therapy room with a Christian therapist. Her final realization of God’s unconditional love for her was prominent in her integrative experience as well.

She also related how this therapy work deepened her relationship with God:

...Before I did this, my therapy work, I was basically relating to God primarily on an intellectual level. Occasionally, as a Pentecostal, services can be emotional at times, and I would have some emotions in worship, but it’s only been since I started doing the therapy work that I have had what I consider to be a really emotional relationship with the Lord, that I was connected to him emotionally and not just in life form.

For Susan, very little work was done without an underlying spiritual theme, so the psychological and spiritual were very much intertwined:

...But because I was working with a Christian therapist, and because I preferred to work integrating spirituality into my work when I would work alone, in my journaling, there was hardly, you know, very little work was done without spirituality being drawn into it... because I worked with somebody who shared my faith, it was like Jesus was co-therapist or chief therapist in the session, and my therapist was really co-therapist. So it’d be very
hard to piece apart the purely psychological for the purely spiritual in my healing journey.

Each of her therapy sessions were opened with prayer to make the environment feel safer for her:

...Basically, it was actually that he would open the sessions with prayer. For me, safety and trust were a gigantic issue... I just had huge issues of trust, so having a therapist who shared my spiritual values made it, made the environment feel safer. And I had asked him to open the sessions with prayer, and to pray for God's protection around the session. And I found that this made my personalities feel much safer, especially the child personalities. I believe that I did have encounters in my childhood with demonic beings, and so the idea of surrounding the office with angels, for example, asking God to do that, made them feel safe to come out and talk about what happened, it added to their ability to be able to feel safe.

Beth

Beth developed her own set of personal beliefs that have evolved through her healing, and she referred to this as spiritual development throughout the interviews. God, wants us to be whole, she said. For her, as mentioned previously, God is a force to be tapped into; one taps into that source through prayer, by being in nature, and with the practice of Yoga. She has developed spirituality now as she has healed and has experience with this life force inside. She has also been able to come to terms with the problem of suffering and God.

... I found that my spirituality has kind of grown as a result of my recovery process, 'cause before I entered healing I really didn't have much spirituality... throughout most of my early adulthood I was kind of an agnostic... what was interesting was that once my healing kind of process kind of started, and I heard about spirituality and about how
others had used that in their healing, I began to develop my own sort of personal set of beliefs, and that’s been kind of evolving gradually over time since I’ve been healing. And now...I believe in a God that wants us to be healthy, and that wants us to be whole. And that that God is a kind of a force that we can tap into. I tap into that source through prayer, I pray a lot for my healing, and I find it actually helps... Mostly I feel like I get a lot of spiritual feelings from nature... Sometimes I practice yoga and that’s also kind of part of my spirituality, too.

Beth described the life force inside of her as her Higher Power and she spoke about its relationship to the problem of suffering:

...That would be my Higher Power. This force is a lot stronger than any of us individual beings are, but I don’t consider it to be infinitely powerful. This is kind of how I’ve resolved the problem, the spiritual problem that most survivors have of, how could a God who loves us let this horrible thing happen to us. The way I’ve resolved that is, I’ve decided that the God that I believe in is not all powerful, and that God doesn’t always win. And that we have free will, and that God will guide us, but does not compel us to do things. We have to make the right choices. And my perpetrator made the wrong choices. That was a situation where God didn’t win. I feel like that God feels very badly about that, but she doesn’t have that kind of control over everybody. Part of the whole thing is that we’re supposed to become independent beings ourselves. We’re supposed to have free will. And part of that, kind of the downside of having free will is that some people will do bad things. So that’s kind of how I’ve resolved that for myself, that the God that I believe in is not all powerful, but she is much more powerful than any of us.
Beth referred to God as "she", she said, "because that makes me feel closer to her, because I'm a 'she'". When asked what that meant for her within the context of being whole and being integrated and what it felt like for her spirituality, she replied:

... It feels real good. It feels like being spiritual is much more possible, because I'm able to have access to all parts of me. I'm able to be calmer and more centered, which is important to be able to experience a Higher Power. It's important to be able to calm yourself and become centered. I'm much more able to do that than I had been in the past.

Healing has been a big part of the spiritual growth process for Beth, and the spiritual growth process is the bigger, broader process. She needed to ground this in the every day practicalities of living:

... the spiritual growth process is the bigger process, the bigger broader process, and healing is kind of part of that. It's an important part. It's not something that's divorced from it. It's not something that's separate from it, it's very much in it...It's important for me to feel very grounded with my spirituality. Though some of my spiritual beliefs encompass some things that maybe some other people might consider to be maybe magical or psychic or something like that, I tend not to try to think of it in those terms. I try very hard to keep my spirituality kind of grounded in kind of practicalities.

...It's the real physical world that we must live in, and there are practical things that need to be done. The way we ground ourselves spiritually is by competently dealing with those practicalities. If we are confidently enough grounded, and if we work hard on healing ourselves, and dealing with those practical down-to-earth things, then that can leave us open to some real interesting spiritual things to happen. On the other hand, if we kind of focus on all these kind of mystical things and we don't get grounded, we can also have some devout experiences but they won't really be spiritual, and we won't really
be prepared to understand them, and it can actually kind of lead to some really bad problems. It can make us vulnerable to, say, being manipulated by a cult leader, or it can lead us to psychotic functioning where we’re believing in dysfunctional things that really aren’t there. So it’s important, I sort of, I sort of believe there’s a hierarchy in spiritual experience, and that we have to kind of get the fundamentals down first before we get to the stuff that’s a little bit more unusual and not part of everyday reality. I also feel that the ultimate point of this is our own growth spiritually, and although some of those more unusual experiences are part of that, they’re not the point of it. They’re just kind of a part of a greater process.

She was clear about the meaning of spiritual development for her, that the ideal is for a person to have inner compassion, an inner sort of singular focus and lack of ego:

...It means becoming a healthier, better person basically. It’s like, I’ve identified certain people who have existed on the earth that I consider to be very, very highly spiritually developed. People like Ghandi, Mother Theresa, or Peace Pilgrim, these are people who, and if you look at them you notice that there’s very much a lack of ego. The people who are so strong within themselves that they can devote their whole lives to helping others. They have so little fear that they can do things like, Ghandi would encourage the people to stand in front of the guns, without guns of their own, and even risk their own lives to make things better. That’s what I consider to be a model of what spiritual development is all about.

Summary

A review of what was helpful to participants in the healing process has yielded summary evidence pointing to the importance participants attached to 1) witnessing, in particular the therapeutic relationship; 2) the creative arts as a major technique for self-
expression; 3) spirituality as an underlying component. Cognitive-restructuring work also emerged as another thematic component in three out of the four. Other techniques that were helpful varied in their intensity with each participant.

Witnessing and the therapeutic relationship was important to all four participants. For Ann, the therapeutic relationship appeared to be as important as other types of witnessing. This included her social support networks and attendance at various 12-Step meetings, particularly Codependents Anonymous and her initial experience with Reevaluation Counseling. Clara insisted that the therapeutic relationship was of paramount importance in her healing, far more important than technique. Susan felt that the therapeutic relationship was vital and necessary for her recovery, and, in her case, her healing was contingent on her therapist being a Christian witness, having similar spiritual values. Susan also sought witness in various 12-Step Programs. Beth, too, placed great emphasis on individual therapy and its value in learning to be in relationship. The therapeutic relationship was primary; ancillary work in terms of witnessing occurred regularly with her art therapy group and other support groups.

All but Susan said that the creative arts were of strategic importance in their healing. Susan stated that the arts were hardly used. However, writing, journaling, and working with religious metaphor and imagery were her media which do fit the study’s stated definition of the creative arts. Ann used a variety of the creative arts to help her process: visual arts, sculpture, music, poetry, and song writing. Clara felt that the visual arts and music were extremely helpful and she also journaled. Beth used the visual arts and placed emphasis on working with metaphor in writing what she has called “therapeutic stories” to help her to conceptualize her feelings and to seek resolution.
Spirituality was a vital part of everyone’s process across cases. Two, Clara and Susan defined it as the whole process, that their process was inseparable from their interior value system. Ann felt that her process, too, was the engagement, the struggle, “to the death” with the false self and that spiritual mentoring was vital in her recovery. For Beth her whole journey was a progression leading to increased spiritual evolution and development. Words that participants used to describe their spirituality included connection to spirit (Clara); Higher Power, and having an authentic voice (Ann); indwelling of the holy spirit (Susan); and God is a life force inside, living in nature (Beth). All felt that healing was both psychological and spiritual and the two were intertwined. Clara, in particular, said that her goal was not to be merely functional, but to be whole. For her, the spirit-self is the real self; healing is a spiritual process and connection with spirit which is God is the only thing that matters. Both Susan and Clara spoke about the importance of the realization of God’s unconditional love for them, gained through the therapeutic relationship.

Other aspects of the healing that were especially important for Ann, Susan and Beth was cognitive restructuring — grounding their healing by focusing on the practical aspects of taking care of themselves in their social and professional lives, setting goals, improving their living skills, etc. Three used other more specific techniques that were helpful to them individually: Ann used bodywork and energy work that included shiatsu and acupuncture, and used Gestalt therapy and psychodrama; Beth, at times, used bioenergetic energy therapy and Susan used guided meditation a great deal.
Future Projections

Participants’ feelings about the future appeared to be centered around social, spiritual and professional goals:

Ann

Ann did not speak much about the future; her basic goals appear to centered on the here and now and the importance of being an authentic person: “I’ve got to be real…truth is vitally important.” Development and consolidation of her social skills and spirituality is part of learning to be in the here and now and being authentic. She has been learning the art of making conversation to establish social connections:

... it’s the basic stuff that I never got, and I never learned, and I always thought was bullshit when other people did it. I had contempt for people who made small talk.

Anyway, so I studied, I became my own behavioral experimentalist. I learned to hang around where there were people and watch them and observe them and try out acting like them. I tried out all kinds of things... social creativity... this has become most important now. I can isolate with art. I would do a lot more visual art right now if I was in a class situation that I was enjoying. Right now, I am mostly interested in things that bring me into the fold.

Clara

Clara’s main goal is to cultivate her intimate connection to Spirit and to write more in connection with her real voice:

I desire to culture within me my very intimate connection to Spirit, my Spirit and the Spirit of God. I want to be able to see that everywhere I look. I want to be able to watch for purpose and manifest of Spirit wherever I look, even when I come in to conflicts with people, not look just at the conflicts, or just at the person, but try to find that spark of
spirit that is in them and find what am I supposed to learn through this... If I can apply that to whatever happens to me, I don’t feel that there’s anything that can defeat me anymore. One of the things I wish to do is to write more. I journal just about every day, but I want to do it more deliberately. I’ve learned that if I quiet myself, and if I ask a question and direct it inside, the Spirit will just speak to me. It’s an audible voice, I can hear it. And then I write down what I hear. And usually the answer is quite universal.

At the same time that it’s personal... I want to concentrate on more of more of my energy on that specific connect that I have inside of me. Because that’s what matters. The way that I’m learning to do that is just to be quiet, to be reflective, to listen more, to be more observant. It’s there, it’s wherever we look, whenever we listen. That presence is with us, and it’s just a matter of fine-tuning into it. I want to remember that I am a spirit being and that I’m just having an earthly experience. So that I can stay in a place of peace. Anything that’s threatening to that peace, I have to put it aside until it’s no longer threatening, like my job... peace isn’t dependent upon my outside circumstances, because it does come from inside of me. And that is what I have attained through recovery. It’s like I have this gift which we all have, and it was never unwrapped. And it had to get unwrapped through a painful recovery process. But now it’s here. And I can just reap the benefits of it. I just can’t see that anything will change that, it will just grow and get better. And that’s kind of how I see my future. Each day is a little better.

Susan

Susan’s future goal is to finish her degree and to do therapy and also to do research in incorporating spirituality into clinical treatment. She is especially interested in Theophostic training, a specialized healing technique that appears to parallel her own healing experience:
... I see myself finishing my degree, going through the internship...getting licensed...
down the road I would like to be working in a Christian counseling center, and I would
like to be speaking in churches in terms of helping to improve awareness of these kinds of
issues in people’s lives and how they can help. I have personally trained in an inner
healing technique call Theophostic which I believe is very effective. I’m considering
using that in my research paper.

Beth

Beth’s plans include continuing to work on becoming more independent, training
as an art therapist, and improving her social functioning:

I have some good plans for the future. I’m at a point now where my big goal is to pull my
functioning up, to become more adult, more independent, and a big part of that is
developing a career and actually being able to work for a living... I’m planning to go to
graduate school and getting training in the art therapist, and there’s a whole lot that
goes with that. It’s a whole general pulling my functioning up. It’s learning how to take
better care of myself, learning how to take better care of my home. Eventually I’ll learn
how to drive a car. Learning how to be with people and not be so scared of people
anymore. To be able to make friends... improving my social functioning. It’s all about
right now pulling my functioning up... That’s kind of my goal right now... The future
looks pretty good to me...

Summary

Participants future projections yielded individual goals that were mainly related to
career building in two (Susan and Beth), improving social functioning in one (Beth), a
focus on the present in one (Ann), and a deepening of her spiritual life through more
reflection and introspection in one (Clara).
Synthesis

A cross-case analysis of the four study participants has yielded eight categories relevant to the participants’ healing process from a dissociative disorder. These included pre-recovery issues involving their pre-verbal and dissociative experience, their own definition(s) of healing, recovery, and integration, the major landmarks in their recovery process, post-recovery and what was helpful to them in the recovery process, and finally how they perceive their future.

Pre-recovery emergent themes concerned pre-verbal memories and memory problems associated with the dissociative experience, lack of adequate language to express what happened early on, pre-verbal issues of abandonment, trust, and safety and a deeply felt sense of internal separation and ego fragmentation. Behavioral manifestations of these issues presented in significant social and professional impairments resulting from alcohol and substance abuse in two of the participants, sexual difficulties for all, self-inflicted violence in two and suicidal ideation for all, and social isolation and interpersonal problems for all.

All of the participants regarded their self-engagement in attempting to make sense of their early trauma as a gradual unfoldment or a process. Not only was healing a process, but it was also a spiritual process. They were unanimous in this regard. Finally, healing for them was a process resulting in psychological and spiritual wholeness which they described as integration of their fragmented selves.

Landmarks or breakthroughs in their recovery process generally varied from person to person, but one theme here stood out, and that was their first awareness of the need for some kind of therapeutic intervention. Three out of the four stated this and the
other implied this by virtue of her entering therapy. Other prominent landmarks included the diagnosis of DID in two and the importance of the process of integration in two and implied in another.

The general post-recovery overarching theme was one of increased self-functioning for each of the participants. For all of them, this meant taking on increased responsibility for their self-care and improvement in their social and professional life. They were clear about what was helpful and what was not helpful in their recovery. The first was witnessing, especially the witnessing that occurred in the therapeutic relationship. For all of them it was necessary to experience unconditional acceptance and love without any judgments made as to the veracity of their memories or their spiritual proclivities. The second was the use of some form of the creative arts as a tool to express their pain. All used writing in different forms. All but one engaged in the visual arts. Two out of the four found music to be helpful. The third, and the most talked-about was the importance of spirituality—a sense of the indwelling of the holy, the Spirit, Higher Power, God, Lord. These were words or phrases or feelings that were expressed throughout the interviews from each of the participants. They considered their healing process of its very nature, spiritual. Fourth, three spoke about the importance of doing some kind of cognitive restructuring during the last phases of their therapy—e.g. learning practical living and social skills and basic problem-solving skills to apply to their daily living situations. Finally, there were individual ancillary tools that were used like body and energy work, psychodrama, Gestalt therapy, guided imagery, and meditation.
Their projection for the future mainly centered on continuing to improve their social and professional functioning with one expressing, more intensely than the others, a need to deepen her spiritual life through more reflective and contemplative practices.

The reader may refer to a table on the subsequent page describing participant themes. Discussion and dialogue concerning these emergent themes will follow in the next section, Part IV, Conclusions. In the first part, there will be a dialogue of these themes in relationship to the pilot study (researcher process) and to my original presuppositions. This will be followed by a dialogue with the literature review and the methodology used in the study. The final part of this section will be reserved for a discussion of the implications this study has for clinical and teacher education and issues for further study.
<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>ANN</th>
<th>CLARA</th>
<th>SUSAN</th>
<th>BETH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRE-VERBAL</strong></td>
<td>memories; pre-verbal issues/feelings; language deficits</td>
<td>memories; language deficits</td>
<td>memories; pre-verbal issues/feelings; language—preverbal personalities</td>
<td>memories; pre-verbal issues/feelings; language deficits</td>
</tr>
<tr>
<td><strong>DISSOCIATION</strong></td>
<td>memory problems; detachment; separation/fragmentation; switching</td>
<td>memory problems; detachment; separation/fragmentation; switching</td>
<td>memory problems; detachment; separation/fragmentation; switching</td>
<td>memory problems; detachment; separation/fragmentation; switching</td>
</tr>
<tr>
<td><strong>PRE-RECOVERY</strong></td>
<td>Developmental Issues: lack of basic trust, safety; Feelings: sadness, grief, anger, fear, guilt, helplessness; Behaviors: substance abuse, sexual problems, self-inflicted violence, switching, interpersonal problems</td>
<td>Developmental Issues: trust and safety; Feelings: anger, fear, terror, sense of self as spirit; Behaviors: alcohol abuse, sexual problems, self-inflicted violence, switching, suicide attempts, interpersonal problems</td>
<td>Developmental Issues: trust and safety; Feelings: anger, helpless, chronic suicidal ideation, out of control; Behaviors: cognitive distortions, sexual problems, switching, interpersonal problems</td>
<td>Developmental Issues: trust and safety; Feelings: disabling fear, chronic feeling of helplessness, guilt, shame, fragmentation; Behaviors: interpersonal problems, work problems, lack of self-care skills, switching</td>
</tr>
<tr>
<td><strong>MEANING OF HEALING/INTEGRATION/RECOVERY</strong></td>
<td>Healing as both a psychological and spiritual process; becoming one with the healing nature of God; Integration: an act of surrender and act of will; Involves verbal and non-verbal</td>
<td>Healing as both a psychological and spiritual process; no separation; also social; Recovery used interchangeably; Integration: oneness with God; Involves plan for identifying triggers and release.</td>
<td>Healing as both a psychological and spiritual process; no separation; also social; Recovery: engaging in healing process; Integration: feeling like a whole new person; Involves plan using prayer as technique, imagery.</td>
<td>Healing as both a psychological and spiritual process; no separation; also social; Recovery: finding the &quot;keys&quot; to &quot;get out of prison&quot;; Integration: wholeness; Involves working with metaphor</td>
</tr>
<tr>
<td><strong>BREAKTHROUGHS/LANDMARKS</strong></td>
<td>Did not speak directly about this; placed emphasis on Reevaluation Counseling as important tool for recognizing value of witnessing</td>
<td>Awareness of need for therapy; diagnosis of DID; Importance of process of integration</td>
<td>Awareness of dysfunctional family and need for therapy; diagnosis of PTSD and DID; first and last integration; ritual memory integrated with spirituality</td>
<td>Awareness of need for therapy; flashbacks; awareness of choices; reading &quot;Courage to Heal&quot; identifying triggers; cognitive awareness of social problems, shame</td>
</tr>
<tr>
<td><strong>POST-RECOVERY</strong></td>
<td>Increased responsibility for self-care; improvement in social functioning and work-related activities</td>
<td>Increased responsibility for self-care; improvement in social functioning and work-related activities</td>
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<td>Increased responsibility for self-care; improvement in social functioning and work-related activities</td>
</tr>
<tr>
<td><strong>WHAT WAS HELPFUL</strong></td>
<td>Witnessing: 12-Step Programs, social networks, therapeutic relationship; Creative Arts: visual, sculpture, music, poetry, songwriting; Spirituality: spiritual work is vital; 12-Step Program: alignment and spirituality; Cognitive Restructuring: Bodywork, Energy work; Other: Gestalt therapy, psychodrama.</td>
<td>Witnessing: therapeutic relationship paramount; mirrors God's unconditional love; Creative Arts: visual arts, music and journaling; Spirituality: the whole process of her healing, impossible from inner value system; her survival</td>
<td>Witnessing: therapeutic relationship vital; importance of Christian therapist; mirrors God's unconditional love; 12-Step Programs Creative Arts: used mainly writing, journaling, working with religious metaphor and imagery; Spirituality: vital, prayer as the process for integration; indwelling of the Holy Spirit; guided meditation Cognitive Restructuring</td>
<td>Witnessing: therapeutic relationship vital and primary, therapist validation: — therapy and support groups; Creative Arts: visual arts, working with metaphor in writing &quot;therapeutic stories&quot;; art therapy Spirituality: healing as a progression leading to increased spiritual evolution and development; Cognitive Restructuring: Other: bioenergetic therapy</td>
</tr>
<tr>
<td><strong>WHAT WAS NOT HELPFUL</strong></td>
<td>2nd hospitalization, labels, memories questioned by professionals, medication techniques</td>
<td>Shock treatments and medications, memories questioned, techniques</td>
<td>Visual arts not helpful; disrespect for spiritual proclivities</td>
<td>Therapists who do not have a discipline and who cannot see behind the &quot;mask&quot; and who support colleagues guilty of malpractice.</td>
</tr>
<tr>
<td><strong>FUTURE PROJECTIONS</strong></td>
<td>Focus on the present, development and consolidation</td>
<td>Deepering of spiritual life through more reflection and introspection</td>
<td>Career-building and further training in Christian counseling; research</td>
<td>Pull functioning up — emotional and social; training as an art therapist</td>
</tr>
</tbody>
</table>
PART FOUR: CONCLUSIONS

Introduction

The healing process as it has evolved in the pilot study and for four other persons who were traumatized before full language production and before age three has been discussed in Part Three. Part Four, as has been noted, will conclude the study by engaging the findings in dialogue with the presuppositions and pilot study, the professional literature and the research methodology and will discuss ways in which these findings impact on clinical and teacher education.

Dialogue With Presuppositions and Pilot Study

As noted earlier, the presuppositions emerged as a result of my process as participant-researcher. This, section, therefore, will discuss each of them in relationship to my process in the pilot study and in relationship to the study findings. To review, the presuppositions for this study were basically four in number and were concerned with the healing process in dissociation: 1) Psychological and spiritual development are synonymous; 2) Healing involves environmental connection, social connection, and an interior connection to the Self; 3) Healing also involves using metaphor to explore the inexplicable psychic pain engendered by pre-verbal trauma; 4) Healing also involves surrender to the divine as the source of the whole self or authentic identity, i.e. the integration of all the dissociated aspects of the self.

Psychological and Spiritual Development are Synonymous

The first presupposition stated that psychological and spiritual development is a synonymous process. As the participant in the pilot study, as noted previously, I could not separate psychological and spiritual experience in my own recovery; I could not
experience one without the other. My spiritual path was the underpinning of all my psychological query into early traumatic experiences and the early pre-verbal issues of trust and abandonment. Thematic content and context of this process revolved around the “evolution” of my psyche and I compared it to a shamanistic process or cycle of “soul” growth. This involved cycles that included experiences of 1) birth/rebirth; 2) abuse/chaos; 3) splitting/dissociation; 4) remembering/reintegration/healing/rebirth. Healing, therefore, involved transendency, a need to go beyond my ordinary waking consciousness: “There appeared to be a need for transcendent healing, for it seemed that that level of abuse and disconnectedness was connected to the self and not to the ego”. I simply could not understand the depth of the inner angst or separation that I felt inside of myself. My journey, therefore, became a quest for a wholeness beyond being a more functional person. My goal was union with the Self or with God, using this term for the divine or my “essential” self.

Study findings have shown similarities in participant experience. As noted, all participants have said that healing was both a spiritual and psychological process, and, all except for Beth, felt the two to be inseparable. Beth implied that there was a cumulative progression: doing the psychological work was the basis for increased spiritual evolvement, but that also the spiritual and psychological was very much intertwined; that really one could not have one without the other. Ann felt that both were inseparable and she described her own journey as a “battle to the death” with the false self —very much akin to a shamanistic process of soul-growth. Clara, also, referred to this “soul-like” struggle as she viewed her own process as strictly a spiritual one; there was no separation between the psychological and spiritual. The goal for her was union with Spirit. For
Susan, too, the healing process was both spiritual and psychological, both irretrievably bound together. The importance she attached to spiritual evolvement was vital to her recovery.

The word synonymous means the same or almost the same. The findings in this study, I believe, partially affirm my initial assumption as to the validity of this statement. For me the two processes of psychological growth and spiritual growth were the same. The participants confirmed the idea of the inseparability of these two processes within the context of their healing and recovery process. As it was for the researcher/participant difficult to separate these two processes, so it was for the participants within the context of their own narratives. They were not however, as explicit in their description of synchronicity of these two terms. They used words like “inseparable”, or “intertwined” to describe what I have called a synonymous process. This may be a matter of semantics on my part, as researcher, and a matter of my basic philosophical view or bias that is reflective of a proclivity towards Eastern thinking as described in the literature review. What is needed here is further field testing to determine if there is a fundamental difference in these processes for these participants.

*Healing Involves Environmental, Social, Interior Connection*

The major theme here is *connection* rather than separation or dissociation. This presupposition supported the notion that healing is a tripartite process involving making simultaneous connections with one’s physical, social and interior life — that is, as one becomes aware of one’s physical environment and surroundings (i.e. stepping out of the dissociative process), one begins to make social, interpersonal connections which also increases the capacity to have a sustained affective internal appreciation of self as whole
and dynamic. As researcher-participant, my initial identity problem manifested itself in a fragmented and separated self-image. I was dissociated from the fact that I was a physical being, had physical needs and that I was living in a world that required me to take care of myself. I not only was lacking in self-care and basic living skills, but also in interpersonal skills, and to find something inside myself that was stable and trustworthy. My healing process, as noted, appeared to be an on-going process for me in all three areas. The more I was able to express my pain, the more I was able to make social connections (friendships, social networking, community relationships) and interior connections to myself (increase in spiritual awareness and growth), and to discover how to navigate my basic physical environment in very practical ways: i.e. home-living skills (house-keeping, finances, etc.), basic problem solving and career decisions, etc. All three overlapped and were intimately connected and seemed to be synchronic and evolutionary. At the same time it was a very dynamic and creative process consisting of cognitive awareness ("I am here". "Now, what do I do?" and "How do I do it?"), social connection, and spiritual connection.

Participant findings seem to substantiate the second presupposition. All assumed more responsibility for self-care which began with cognitive awareness of the need for self-care. They all began to acquire more personal home-living skills which included learning how to problem-solve in relationship to their physical surroundings. All stated that there was improvement in their social and work-related activities and were more interested in increasing their social networking. All made reference to a certain sense of "connection" that they felt to themselves and to others and that underlying connection seemed to be spiritual in nature as their recovery process moved forward.
The only differences appeared to center on to the degree of importance each participant placed on these connections. Ann was concentrating on taking care of her physical space and gardening, making more social and professional connections and interested in deepening her relationship with her Higher Power. Clara’s emphasis was similar in terms of making social and professional connections, but her main focus was increasing her connection and relationship with Spirit. Susan attached more importance towards ending her social isolation and developing a strong relationship with God. Beth’s professional, social and spiritual life remained an integral part of her healing, but, for now she was placing more emphasis on taking care of her physical environment. It is my opinion that these differences exhibit a normal human growth process wherein needs are met as they surface. The basic recovery themes are similar.

Healing Involves the Use of Metaphor

The use of metaphor as a means of recovery from dissociative identity disturbances arising from pre-verbal trauma was a major theme throughout the pilot study. Metaphor was used as a way of accessing the imaginal realm. Because my trauma occurred before full language production, my language processing skills were sparse, and I had an undeveloped imagination. I needed to learn how to access the angst I was feeling. To do that, I had to literally uncover the imaginal realm inside of me. Drawing was a beginning. Drawing helped me to form images which, in turn, became metaphors for discovery. Metaphors were used or considered to represent something that had been unconscious. As the images arose, my capacity for using the imaginal realm expanded. For me, metaphors were visual cues that allowed me to access the inexplicable grief that previously had no outward expression. In turn, the arts in various forms became dynamic
expressions of a metaphor before a witness. At first I used visual images and then sculpture, music and movement to express what could not be verbalized. Words came later.

The witness, as exemplified in the person of a therapist, was vital in the recovery process. A corrective trusting relationship developed as the witness unconditionally accepted the metaphors I gave her in the context of my own lived experience. I learned to trust another human being who was without judgment of the material I brought into our sessions. Working with the metaphors within the therapeutic relationship and within my own internal process, I was able to begin to “translate” what I was seeing and hearing into words. I began to contextualize my hitherto inexpressible pain, give it form and apply it to the living and behavioral issues that had led to my initial identity problems. This process also led to a heightened awareness of the transcendental nature of the metaphors and how they related to my concept of self as the total Self, the one who is inseparable from the divine. So I was able to discover a deeper meaning and purpose to my life: the memories did not matter, but my internal separation and existential angst did.

All of the participants used metaphor as a means of expressing their pain. They did this mainly through the use of some form of the creative arts: Ann used the visual arts, sculpture, music and song-writing; Clara used the visual arts, music and journaling; Susan used mainly writing, journaling and working most specifically with religious metaphor and imagery; Beth used the visual arts and art therapy and stated that working with metaphor in writing therapeutic stories was very important for her.

While all the participants agreed that witnessing was vital in the healing, only two (Clara and Susan) directly made reference to their bringing in their metaphoric content
into the therapeutic sessions and how this became a transcendental process for them. For the other two, Ann and Beth, working with their art as metaphor appeared to be a process in itself. Ann, for example, would reflect on her art as a process for accessing the feelings associated with her early trauma, and Beth said that her therapeutic stories became the process for acknowledging and correcting these feelings. So, here, the direct linkage between the use of the metaphor and the deepening of transcendental awareness was not established by these two participants, but only implied.

Healing Involves Surrender to the Divine

This presupposition identified the concept of surrender to the Divine as the source of being as vital towards establishing a sense of an integrated self. This was and has been an important part of my own recovery as noted in the pilot study. The meaning I had attached to surrender was similar to the old adage “let go and let God”. In other words, my final healing appeared to rest on the fact that I really wasn’t in control of anything, that there was a force greater than myself, and somehow this force lived inside of me and was an inseparable part of me and, in fact, was I, my real identity. It was the essential part of my being. To be whole, for me, meant to literally “surrender” to that fact, and to let go of any pre-conceived notions or behaviors of how I ought to be in the world. To surrender included turning over my life to what I eventually would call the divine love inside of me, or simply put, God. Therefore, when I really was in concert with my true self, I was at one with God, and things generally went very smoothly even amidst problematic events.

The word, surrender, was present but not a strong theme in the study findings. It was used by two participants and not discussed at length. Ann and Susan mentioned it
specifically. Ann implied that surrender was a part of the integration process when she said that integration is an act of surrender and an act of will. She allowed that she was no longer pushing herself nor pressuring herself to impress anyone else. She implied that she was simply striving to be in the moment and the Higher Power was/remains a very integral part of the moment. Surrender has been a part of Susan’s experience of healing. She spoke about surrender in the context of the indwelling of the Holy Spirit when a person acknowledges s/he is a sinner and is in need of God’s forgiveness and asks for it. This is a kind of surrender, she said. The concept of surrender and letting go was implied for Clara in that her whole focus was union with Spirit, and she defined Spirit as her real self. So her implied goal appeared to be a total letting go of all her suffering and turning it over to Spirit. Beth did not speak of surrender in such concrete terms either. The findings for this presupposition seem to indicate that this particular concept was not an overarching theme—it seemed to be the end result of the process for some and implied for others.

It should be noted here that, though the processes seemed to be consistent, there was inconsistency within participants’ narrative content. All participants have experienced certain processes in internal movement from dissociation to a more integrated state. There appeared to be a consistency in that process, but the content is not consistent because the movement or growth is individually experienced.

In sum, the first two presuppositions resulting from the pilot study seem to be upheld by the participant narratives of their own lived experience of the healing process. Presuppositions three and four were less clear. In the third presupposition, it was clear that all the participants used metaphor in some way to express their pain. However, there
could be further clarification on the relationship between metaphor and transcendental experience for this particular group of participants. The question I would have, as researcher, would be: Is the creative process and spiritual process one and the same? That was not a question that was clearly directed to the participants. The fourth presupposition, the concept of surrender needed more study. Again, this was not a question that was directly asked of the participants, yet this is a concept that is valued in the 12-Step Programs that both Ann and Susan attended and a concept implied in the other two participant narratives.

The next dialogue will present a reflection on the professional literature as it pertains to the study findings.

**Dialogue With The Literature Review**

Some, but not all, of the segments of the literature review appeared to be relevant to the findings of the study. These were seen most notably in the areas of socio-emotional development and trauma theory, the dissociative experience, some of the current treatment modalities that include the arts, and the healing process in the context of spiritual experience.

*Socio-emotional Development, Trauma Theory, and Dissociative Experience*

Participants did not speak much about having language difficulties per se. They spoke mainly about finding words to express feelings that they felt had been held in their physical body. Language theorists, also, in general, did not specifically link language and trauma, although Braunwald (1983) proffered that there are processing problems and psychological deficits that happen as a result of trauma. Penny Lewis (1983, 1984) and other expressive arts theorists (Adler, 1992; Chodorow, 1997; Marcow-Speiser, 1995;
Serlin, 1993, etc.) have suggested that trauma is often repressed in the body cells of the infant who has no immediate language to express distressing feelings. One participant, in particular, Ann, said that she used energy and body therapies to access these early feelings and to express them physically. Another participant (Beth) mentioned the use of bioenergetic therapy as a helpful access tool.

As noted, most of the participants did refer to certain pre-verbal developmental issues that had been consequences of their early traumatization. These included issues of basic trust, abandonment, fear and a need for safety, and as one (Ann) described previously, “infantile rage”. The developmental literature as cited appears to support the participants’ lived experience of loss and abandonment. Theorists, most notably Erikson (in Crain, 1992, 2000) and Mahler (1968, 1975; Blank & Blank, 1974), both emphasized the importance of the establishment of a loving and trusting relationship with the primary caregivers to give the infant stability and a sense of safety and nurturing, so that the infant could experience and maintain a sense of object constancy and object relations — i.e. form an ego identity and be able to make social connections. Stern (1985, 2000) also maintained that infants have some sense of self existing prior to self-awareness and language. It is therefore quite possible for the infant who has been the object of neglect and abuse, to internalize this experience but not be ready to organize it. Thus, this lack of a basic coherent sensed experience may be maintained throughout subsequent years and is unexpressible because there were no words. There was only an inner basic subjective perspective.

Participants, at times, referred to their “child” parts and allowed expression of the inner subjective experience of the infant. Stern’s reference to the “clinical” infant in the
therapy session is important in this regard and is reflective of the way in which patients have access to these early feelings.

Most notably again, all the participants consistently mentioned their anguish over their experience of early neglect and emphasized how alone and abandoned they felt, and how trust was a critical issue in almost every subsequent relationship they encountered.

In addition, trauma theory clearly applies to the participants' dissociative ways of handling the stress engendered by their early experience. Writers in the field (Terr, 1991; Van der Kolk, 1987; Vankoneu, 1993; McDougal, 1978; Herman, 1992; Share, 1994; Khan, 1964 [in Share, 1994]) have noted that trauma exerts extraordinary blows to persons' psyche and oftentimes renders them helpless and unable to cope with daily life situations. Trauma is cumulative, they say, as the personality is prematurely developed, leaving an inadequate repository of self-differentiation instead of a unified personality structure. Trauma can create disconnection that may manifest in dissociative disturbances and behavioral patterns. McDougal (1978) also maintained that infantile trauma can cause developmental deficiencies that carry over to adulthood wherein behavior manifests itself in constant projection/introjection, splitting and hallucinations. Dissociation, therefore, can become a central defense against the early traumatic memories. These are all symptoms of dissociative processes according to Krippner (1997b) and others—the focus on splits in conscious awareness which manifests in rapid behavioral change (switching) and a fragmented self-image or lack of a coherent identity.

The findings seem to corroborate this initial research on the relationship between trauma and dissociation. All of the participants reported memories, whether body or cognitive memories, of early traumatic events. All had some degree of personality
disturbances of a dissociative nature that manifested in behaviors associated with personality “switching” (as they termed splitting off into different aspects of themselves), poor social connections, and expressing feelings of fragmentation, amnesia, losing track of time, day-dreaming or trance-like states, and hallucinations. All reported that these behaviors seemed to be cumulative and followed them throughout their lives until they began to become more self-aware usually through the above-mentioned memory recall via flashbacks or bodily sensations.

*Current Treatment Modalities*

The literature has cited several types of treatment for dissociative disorders that have evolved over the past twenty years. Among those have been Hypnotherapy, Psychodynamic Therapy, Ego-state Therapy, Family Systems Approach, Cognitive Restructuring, EMDR, and Expressive Arts Therapy. These therapeutic theories in the literature have served to inform clinicians who work with dissociative clients. In terms of the findings in this study, these treatment techniques or models seemed to have a modicum of influence upon the basic healing experience of the participants.

There are a few things that stand out, and those arise in the areas of therapeutic relationship and the use of the participants’ metaphoric content within the context of their healing. The approaches that were used within the therapy appeared to be mostly eclectic utilizing psychodynamic techniques, trance and ego-state and family systems approach at different levels of work. During the last stages of their work, a certain amount of cognitive work was done to help participants learn to problem-solve. Fine’s (1996,1999) work is germane in this way to participant experience.
Participants, in general stated that their healing seemed to evolve in stages, which supports the SARI model of Phillips and Fredericks (1995). The major phenomenon that they found helpful was witnessing through the therapeutic alliance and adjunctive peer groups like the various 12-Step Programs or art therapy groups (Beth). The therapeutic alliance or witnessing was not really addressed with any regularity in the traditional professional clinical literature concerned with the treatment of dissociative disorders from the patient/client’s perspective. The psychodynamic literature speaks about how to manage transference issues, but the participants in this study were clear that therapist investment in them as real persons capable of being loved and loving in return was more important than an analysis of the transference. Listening, witnessing, and personal, authentic connection was primary. The expressive therapies literature, notably the dance and movement therapies, do speak about somatic transference and the importance of the therapist being able to literally “feel” the patient/client’s feelings (Lewis, 1993; Adler, 1992).

In sum, it seems as though the treatment techniques as explicated by professional clinical theorists were really made to offer support to those who were treating these disorders in order to help them understand patient/client processes. As has been noted for the participants, however, this was not a major factor in their healing. One major factor in their healing was learning to be in a primary relationship so they could learn to trust and to grow in such a way as to get in touch with themselves as unitary individuals. They did not want to use dissociative defenses to survive. The tools used to do this seemed to evolve out of learning to use their imagination, using its metaphorical content to learn
how to solve their own issues. Consequently, they had to learn how to heal using their own inner resources.

*Metaphor and the Creative Arts*

For the participants, learning to use their own inner resources meant using the arts in some form to express traumatic experiences in a language that was largely non-verbal in the beginning for most. It was here that the word, *metaphor*, seemed to emerge quite spontaneously within the context of their narratives.

It is within this domain of metaphor that the expressive therapies literature seems to offer some insight into the healing process of the participants. As has been noted, Jung (1959, 1965, 1968) was perhaps the precursor of the expressive therapies movement. He proposed the idea of using the *active imagination* in the healing process whereby there is various interactions with the complexes and archetypes of the personality. He encouraged the use of fantasy and voice dialog in an attempt to find resolution to intra-psychic problems. Kane (1989), Bowers (1994), Politsky (1995), Barclay (1997, von Franz (1997), Ward (1997), and Beeman (1996) all spoke about the role of imagination, metaphor and symbols as playing an important role in healing. Dance and movement theorists, Lewis (1993), Adler ((1992), Marcow-Speiser (1995), Serlin (1993), Ambria(1995), and Chodorow (1977,1991) stressed the importance of movement in giving expression to the imaginal realm. McNiff (1988, 1992, 1995), Levine (1995), Murphy (1994), Cohen (1996), and Cohen and Cox (1995) maintained the importance of the visual arts. Levine (1992) spoke about prosody and poetry as being part of the recursive creative healing and Gerrity (1999) suggested puppetry was also helpful. Music theorists, Moreno (1988, 1995) and Volkman (1993) added to these professional
voices, and Knill & Barba (1995) called for an integration of all of these creative processes. This, they called Intermodal Therapy. The list appears to be an inexhaustible array of creative alternatives to fit a person's proclivity and interest.

The findings in this study did not reveal any paucity of creative expression. Quite the contrary: participants were clearly very involved in determining what metaphors were to be helpful to them for their own healing and used tools that were natively comfortable for them to safely express their pain: e.g. visual arts, sculpture, journal writing, song-writing, "therapeutic" stories, poetry, religious imagery and metaphor, etc. In fact, the study participants' creative process was correlative to Somer and Nave’s (2001) research on the healing/recovery process of five persons diagnosed with a similar dissociative disorder. The patients, in their study, all stressed the importance of the arts in some way in their healing process.

*The Healing Process in the Context of Spiritual Experience*

It has been clearly stated by all the participants that the healing/recovery process for them was both spiritual and psychological, and that the two were inseparable. All the participants either stated directly or implied that the underlying unifying part of their recovery was spiritual in nature.

The literature seems to be similarly connected to their lived experience. Both Western and Eastern practitioners/thinkers as reviewed considered healing as a soul-centered activity (Becvar, 1997; Boadella, 1998; Fauteux, 1994; Elkins, 1995; Hall, et al.; 1998; Kelman, 1960; Moore, 1992; Jung, 1933, 1957; Boorstein, 1997; Borysenko, 1993; Walsh, 1989; Washburn, 1994; Vaughan, 1986; Roshi, 1983; Khan, H., 1982; Khan, Pir V., 1982; Odanjk, 1998; Singh, 1990; Ramaswami & Sheikh, 1989a; etc.).
There appeared to be discrepancies, however, within the context of process in participant experience. This seemed to involve the use of intuition and creative thought. The literature speaks of the disparities between Western and Eastern thinking: Western thinking tends towards the linear, rational, scientific and conceptual mode of knowing; Eastern thinking is a non-linear and non-cognitive process focusing on a multidimensional way of being-in-the-world and true reality lies within a person (Walsh, 1989; Kelman, 1960; Ramaswami and Sheikh, 1989a).

In my observation of the participants, there appeared to be a sense of recursiveness in their healing process. One participant, Clara, described her process as one akin to peeling an onion, taking off a layer at a time, and implied that each time this happened another level of transformation was reached. The others spoke about how their imagery and metaphors helped them to conceptualize and then to concretize their previously unexpressible issues. This led to deeper understanding, more resolution to troublesome issues and a gradual inner transformation. It also seems to me that their healing process seemed to evolve using different types of thinking and that there was an underlying process akin to a sixth sense or intuition that seemed to help them along. This thinking appeared to involve both a linear and a non-linear process. For example, some participants described a process whereby body feelings were accessed through various energy therapies such as bioenergetics and shiatsu. Certain types of mental imagery would arise and then they would use a some kind of creative tool to give it form: e.g., either through the visual arts, sculpture, dance, poetry, etc. Once this feeling had form, visual or tactile, words usually followed. The words gave them a vehicle through which they could now share their experience with another (usually their therapist or close
friend). They, thus, used both a non-verbal, tactile process and used their cognitive faculties to organize their learning and to express it outwardly. Through this process, certain inner changes took place and they were able to acknowledge and embrace their suffering and let themselves go to a deeper level of healing.

Participants, once again, were clear that their healing was an interior process which occurred from inside of themselves. Once this inner, intuitive and creative process began, it seemed to be self-perpetuating. As a result there were interior structural changes, and participants moved on to use their cognitive skills in tandem with this process to make behavioral changes. Cognitive skills were necessary to apply what they learned to real life situations. Thus, the literature of cognitive restructuring also is germane to their healing, making, I think, healing both a linear and non-linear process.

In the final analysis, participants implied that the cognitive and the more intuitive, spiritual aspects of the healing were inseparable. Wholeness and the impetus for further change and growth comes from within. Accordingly, it would appear that healing is more of a teleological activity which, by its very nature, is a spiritual process, the undergirding of the awakened personality.

In terms of the literature, it would appear that the participants’ multivariate thinking processes are a segue into transpersonal theory. As has been noted, practitioners of transpersonal psychology (Boorstein, 1997; Walsh, 1989; Wilbur, 1996; Washburn, 1994) call for a synthesis of both Western and Eastern thought and practice. They seem to suggest that both the linear and non-linear perspectives are necessary in the healing process.
Eastern thought, however, removes this dual perspective when some researchers assert that thinking is a detour. Spirituality is the core dynamism that moves throughout both West and East and it is this dynamism or energy that does not have thought or conceptual attributes, because it is one’s essence, or essential being (Singh, 1990; Kakar, 1982; Roshi, 1983; Ramaswami & Sheik, 1989a; Odajnk, 1998).

Healing is an illusion because the real self has always been there, according to some Hindu thought (Singh, 1990; Kakar, 1982). No words, no thoughts can contain the container which is the core essence of the individual, who is at once unitary and a part of the larger whole. For two participants (Susan and Clara), finding and being at one with their essence or real self whom Susan called Lord, God, or Jesus, and whom Clara called Spirit was their only concern. One was a self-avowed Pentecostal Christian and the other’s philosophy was perhaps more eclectic, but both implied that their internal engagement with the divine was a mystical process. For them this meant union with the divine other who was not only the object of their inner integrity and but also their true identity.

So, it would seem that the literature review concerned with spirituality bore relevance to the participants’ recovery process, and, in fact, they were dependent on that as the undergirding of their healing. These findings also suggest that a review of the theological literature that includes the domain of mysticism would be in order: for two of the participants this was clearly a focus. Their spiritual proclivities and practices stood out as the most significant part of their healing, for being whole to them meant being at one with God (Mysticism has been defined as being at one with the Divine; see, Underhill, 1999). In addition, though this was not stated directly by the other two
participants, this on-going journey to a spiritual wholeness was an overarching theme that appeared to be incremental and progressive in their thoughts.

*Summary*

In summation, most of the professional literature reviewed here, I believe, was the result of research done to help clinicians understand the concepts surrounding dissociation and its treatment, but little was said about patients’ lived experience from the their perspective. The main relevant article that stands out is Somer and Nave’s (2001) study in which former DID patients did speak of their healing experience. To my knowledge, theirs was the first academically-oriented qualitative research study that was a phenomenological systematic examination of the integration process for a small sample of patients who had recovered from Dissociative Identity Disorder. Previous literature consisted mainly of case studies or were autobiographical (Phillips; 1995; Sizemore, 1989) in nature or were written in tandem with patient and clinician (Bryant and Kessler, 1996; Casey and Wilson, 1991).

Somer and Nave’s focus appears to differ from this dissertation study in that a central topic of interest concerned the convergence of borderline and dissociative symptoms. Included in this was a discussion of the role of fantasy and spirituality and some therapeutic processes and patterns. This dissertation research has concerned itself with more specifically the healing/recovery process for those participants whose dissociation originated from early trauma and has sought to offer not only a phenomenological understanding of participants’ lived experience but also to offer a trauma-based teaching paradigm that will support a deeper level of awareness on the part of both clinical and educational professionals.
Dialogue With The Methodology

Methodologies tended to overlap and became intertwined as the study progressed. The initial use of autoethnographic (Patton, 2002) material in the pilot study, as noted, became the basis for the use of the subjective mode of heuristic inquiry (Moustakas, 1990, 1994), followed by the more objective forms of phenomenological (Patton, 2002; Moustakas, 1994; Willig, 2001) and grounded theory methodology (Strauss & Corbin, 1998; Seidman, 1993; Willig, 2001; Patton, 2002; Moustakas, 1994). Finally, all three appeared to merge as the findings seemed to support and stress the importance of using both objective and subjective narratives that both describe and explain the lived experience.

The use of my own autoethnographic material appeared to be critical in making initial connections with the participants. It appeared to be important to them that I had more than an empathetic understanding of what they had endured. Each of them asked questions about why I was doing this, did I have personal experience, and would they be safe with me, etc. Within this context, not only was I the researcher, but also another participant as a trauma survivor. Therefore my own experience and introspection became a primary source of data to be explored and to be used within the context of heuristic methodology. This seemed to fit in with Moustakas’ insistence of the researcher’s total involvement in the uncovering the nature and meaning of the participants’ lived experience. Simply put, participants in this study, may not have been as eager to engage in a deeper level of introspection had I not selectively disclosed some of my own history. This disclosure contained enough descriptive information that allowed participants to
feel safe and also allowed me, as researcher, to maintain clear boundaries for the
duration of the study.

These boundaries appeared to be a container for the participants. They allowed
that they needed to feel listened to, to tell their own stories. I, as researcher, within this
context had to set aside my presuppositions and to engage in more of a phenomenological
objective inquiry, thereby incorporating some of Moustakas’s later transcendental
phenomenological methods that combines researcher intuition and the more objective
experiential descriptions. So, the combination of heuristic and phenomenological
methods lent itself to not only maintain the integrity of subjective lived experience and
objective (descriptive) experience, but also enabled the participants to feel empowered as
cr-researchers and whole persons: for example, the transcripts were sent to them for
review, and they returned them with their comments. Each of them stated later how
important it was for them to see and to read their own stories. It appeared to be very
much of a reminder of their own healing process.

In terms of data analysis, the more subjective, heuristic methods were less precise
and demanded more attention paid to the reading and re-reading of transcripts in order to
understand more of the inner nuances, thoughts, etc. of participants. These needed to be
supplemented by the use of a combination of interpretive phenomenological analysis and
grounded theory by working with themes, forming natural clusters of concepts and
making summary tables (Willig, 2001; Patton, 2002). What appeared to be needed in
order to understand the essence of the whole experience was this immersion and
interaction with the whole presenting data, both subjectively and objectively. In other
words, a complete understanding of participant experience could not be had without
using all these methods. For the participants, the essence was the emergent theme expressed by all: to end their sense of fragmentation, to be whole persons.

Finally, the study findings and conclusions have been based on a synthesis of what was observed (participant stories) and what was inferred (subjective feelings of dissociation, etc.): this integration of the data in the form of emergent themes that have been presented across the cases. This appears to use all three of the above-mentioned methodologies with a presentation of emergent themes that both describe and explain participants’ lived experience. They tell their stories (objective, descriptive) and give their feelings (subjective) within the context of their environmental antecedents, etc. They also talk about an indescribable spiritual process (subjective) that has been the underpinning of their healing. Sometimes this has been described through the contextual forms of metaphor (the various art forms), but it is always there, moving them to change their interior perspective. The arts, in some way, helped them to transform the metaphors into expression. Whatever art forms were chosen, words came and thought processes were altered. As a result, participants became more aware of their issues and feelings about them, and could begin to restructure their lives in such a way as to include the assimilated changes. Hence, the last phase of healing began when they could apply these interior understandings to real life situations and begin to problem solve in very concrete ways. In this way a certain cognitive restructuring took place which manifested in behavioral changes and a more stable ego identity. These changes, they all reported, came from the “inside-out”. This process most certainly appears to be a synthesis of all three methodologies that incorporate both objective and subjective data.
Theory Gathered From the Data

Upon examination of the presenting data, certain understandings have emerged. In sum, the healing process for these persons who were traumatized prior to full language production and who have had dissociative disturbances is complex. Their healing process as evidenced by their narratives involved:

1. **stages and recursivity**—Healing was incremental and cumulative. It involved going through various stages that included establishing trust and working through early traumatic issues and making internal changes as a result.

2. **social change**—Healing involved learning to be in relationship with the unconditional loving acceptance of a witness as a primary support and model. Techniques were not as important. The result of this learning to be in relationship prompted behavioral changes and interior cooperation among the fragmented aspects of their person(s).

3. **metaphor**—Working with metaphor in attempting to access early traumatic material was a primary way by which participants were able to express their pain. This involved using a variety of creative arts which included the visual arts, writing and journaling as therapeutic tools.

4. **spirituality**—An underlying sense of the divine seemed to become more apparent as the healing process attenuated; participants could not separate the psychological from the spiritual.
5. **cognitive restructuring/change** — Participants were able to learn basic problem-solving skills and to apply these to their daily living and work situations. This provided them with increased functionality and structure.

The basis for any new theory is the grounding in the presenting data. Grounded Theory is a systematic and a creative form of generating and stimulating new thought or ideas. As I began to look at the data findings, these five themes seemed to figure so prominently that I began to wonder what broader implications they could have in terms of graduate education. From the findings in this study, I discovered that the concept of dissociation figures prominently in the teaching/learning process. Participant recovery from early traumata that caused the dissociation or sense of interior severe fragmentation appears to be a cumulative progression of bringing together the mind and the heart. This coming-together or integration of their cognitive and feeling states was crucial to their formation of a whole undifferentiated identity, free of felt self-fragmentation. For them, they had to learn ways by which they could reassociate or reach this core identity. They did this through witnessing and through the use of metaphor. This, in turn gave them the tools to learn how to problem-solve, how to use their cognitive faculties and literally restructure their thinking in a more functional way in the environment.

My experience both as a social work clinician and as a teacher/educator has informed me of these broader possibilities of the creation of a teaching method that is an outgrowth of examining dissociative processes. Dissociation is a fundamental split in cognitive and emotional awareness as has been noted. What I have observed in teaching graduate students is the inherent need for them to have hands-on instruction that helps them to not only to conceptualize what they want to learn but also to place the learning in
context within their environmental milieu. For them, this literally appears to be both an objective process (lecture, reading) and a subjective process (experiential) leading to an interior assimilation of what is to be known (introjection). The learning, then, once assimilated in this way, can become an intimate part of the students’ repertoire as they then decide how to apply that to their professional and personal lives. This type of learning calls for perhaps a more transpersonal thinking—the going beyond ordinary waking consciousness that standard pedagogy has missed, according to social work researcher Edward Canda (1991). He implies that one must go beyond the boundaries of the personal and enter into the world of creativity, for simple rational thinking does not make a whole person (p. 138).

What I have witnessed as a result of this study is the apparent discrepancies that arise in graduate education. There is professional literature which speaks about experiential learning (Dewey, 1997; Freire, 2000, 2001 and others). In my experience, however, in both graduate clinical professional education and in teacher-education literature there has been a dearth of integrative teaching strategies that can formatively help students internalize their learning so as to be able to become skilled in its practical applications. In other words, Western education appears to have become so objectified that it seems to have lost its inherent transformative value. To my knowledge, there has not been a cogent and coherent teaching strategy that is an integrative process that brings together the “heart and head” which may end the cycle of dissociation so deftly described by the study participants.
Singh (1976), in his essay, *Toward the New Education* wrote about dissociation in an interesting way. Although this was written some decades ago, I believe this continues to be true in modern education. He wrote:

The chief malady of current education is that it results in the dissociation of heart and head. It lays emphasis on the development of head, and does sharpen the intellect to some extent. But more essential is the liberation of the heart. That will be done when the reason is awakened in sympathy for the poor, the weak, and the needy. Sacrifice grows out of the heart, so the heart is required to be unfolded.

The young should: 1) strive after the ideal of sacrifice and not emotions; 2) be simple, for simplicity is strength; 3) learn to cooperate with all, and not let differences in creed or political opinions stand in the way of solidarity; 4) accept the creative ideal, which regards humanity as one and service as the end of all knowledge. Teachers should train students in the spirit of sympathy and love, blending information with inspiration and knowledge with love. A man may pass university examinations and yet remain ignorant of the realities of life. He may have read a thousand books, yet be no better than a boor. But true education will make him truly cultured; and the soul of culture is courtesy. Scholarship may be proud; culture is humble... (p. 221).

Today’s teachers are faced with many students who have experienced some psychological trauma, serious enough to impact on their learning processes. This study has offered us a summary understanding of the socio-emotional, cognitive, and spiritual
developmental delays that have accompanied these trauma survivors with dissociative disturbances. These participants are only exemplars of what teachers may experience within the classroom. By focusing on an integrative teaching paradigm that includes both subjective and objective learning strategies and allows for inner transformation of both teacher and student, I believe, we as a society can start to break the dissociative barriers to wholeness.

Based on my experience within the cultural milieu of dissociation and the process that both I and the participants engaged in our journey to wholeness, there is the germ of a teaching strategy that can certainly be applied to modern pedagogy. An education process which affords students the opportunity to heal the dissociative split of heart and head is a holistic process, interdisciplinary at its core.

Born out of the recovery process in dissociation as exemplified by this small sample of survivors, I have started to use in my graduate courses in Learning and Development a method that I call Sensate Teaching. This is an interdisciplinary method that makes all the intelligences as defined by Gardner (1993,2000) in his Theory of Multiple Intelligences, one. Basically this method involves using all the senses in a transformative, practical way to create new internalized understandings of what is to be learned. This requires the teacher to use one’s whole self in the teaching process and is reciprocal between student and teacher. This is done by using metaphor or the creative imagination and working through the evocative images that students and teachers have about the focus of their study. The student and teacher, then, are collaborative learners (ref: Adult Learning Theory, Androgogy, Knowles, 1970, Cross, 1981; Kluft, 1990; Merriam & Caffarells 1991; Freire, 2000, 2001). One uses all of the senses at first to
assimilate the learning (reading, lectures, video recordings, etc.) inside of oneself, and then one suspends the external senses and integrates the learning through intuition, the 6th sense. As the core self or the Knower absorbs the learning, it identifies with it, so the Knower becomes the Known. This type of learning is similar to the concept of connected knowing as noted in the research offered by Belenky et al. (1986) and discussed in relationship to developmental theory in a later work by Marion Nesbit (2000). Basically, connected knowing is learning internalized at its highest level so that it becomes totally a part of the knower. This, I would suggest, is both a creative and transpersonal process as the metaphors become introjected in a new form within the person. This type of learning is also inherent in the incorporation of the creative arts as a teaching tool as exemplified by the work of Arnheim (1986), and Knill & Barbar & Knill (1995), Barclay, (1997), and Ward, (1997), and others who stress the importance of the use of metaphor in its application to self-knowledge as a learning process.

**Sensate Teaching**

*Sensate Teaching*, as I am defining it here, is a holistic teaching method that incorporates both subjective and objective experience. The senses give access to what is to be learned. They are used to experience and create metaphors and then left behind as the knowledge is absorbed and redirected into something new.

The process itself involves five steps;

1. **Introduction**: introduce the topic/idea; definition of terms.
2. **Theory**: explication of theoretical base or underlying assumptions of the topic.
3. **Lecture**: give historical overview of topic with examples.
4. **Learning Experience**: offer a learning activity that provokes a lived experience of the topic, using sensate techniques, working with all the senses in an interdisciplinary way; the arts, etc. and practice; small group work.

5. **Grounding**: ground the process by integrating theory and practice and applying it to everyday social and work situations; large group. Journal writing is encouraged throughout each step of the process.

This teaching method is related to the study themes of recursivity, social change, metaphor, spirituality and cognitive restructuring in the following ways:

1. **Teaching and learning involves incremental change in cognitive, socio-emotional and spiritual growth.** As an educator, I teach a graduate level theory course in learning and development within a psycho-social perspective. Most of these students are mature adults who are making a mid-career change and they are entering graduate education after having been out of school for many years. Many have diverse life experiences and academic skills which need replenishing. Results of a pre-course survey sent to them prior to the first class meetings, have indicated that most of them learn best by having a combination of teaching techniques that include lecture and hands-on activities. Subsequent class evaluations have indicated that this approach has helped them assimilate and apply the readings and discussions to real life situations. Examples of this were abundant in their final presentations in which they were able to plan and execute classroom learning activities that reflected the assimilated theoretical understandings, resulting in teaching strategies that clearly moved students to engage in learning in a more dynamic and thoughtful way. Summaries of feedback indicate that, for many, this
type of learning has increased their capacity for self-exploration and introspection which has enhanced their self-esteem and increased confidence in their intellectual abilities. Correlative to this sense of increased ability to introspect, many students have reported feelings of a deepening of a sense of wholeness and, even, at times, a sense of spiritual and creative fulfillment. This reported sense of increased well-being on the part of these students as a result of this teaching method, I believe, should be the subject of further research exploration.

2. **Teaching and learning involves using metaphor as a way to access and redirect learning.** Throughout the classes, metaphor was used in some way, whether it be through role playing, the visual arts, music or poetry to help students assimilate the learning experience. In one instance, for example, students were asked to engage in an intermodal art experience. They each had a single red apple. The focus here was to think about creativity as the product of observation utilizing all the senses. They were asked to name all the sense and to describe them for review. They were then asked to close their eyes, and to take a deep breath, while I facilitated relaxation exercises. With increased relaxation and eyes closed, they were then told to hold the apple in their hands and feel it, its shape, nuances, etc. and asked to write down any words or images that they experienced while holding and feeling the apple. Students repeated this exercise until they had experienced the apple through all the five senses. Continuing in silence, they wrote a poem using their words as a framework. Group sharing of their work afterward reflected certain learnings about the individuality of their own perspective/observations of this singular substance (the red apple). Not everyone saw or experienced this apple quite in the same way. Each person had her/his own. metaphor and
this, in turn, led to another level of observational and interior understanding of this experience. Each person, in fact, constructed her/his own learning by working with the metaphoric content inherent in their sensate experiences.

3. Finally, new thoughts, feelings, behaviors are engendered through a creative process such as described which involve an inner knowing—assimilated knowledge. The ‘heart’ and ‘head’ come together as connected knowing, thereby breaking dissociative patterning of splitting. Students, in all classes, for the most part, began to voice this as a learning outcome as they, too, would emphasize that they felt more integrated, that they could see and experience more of the inner integrity of the task set before them. This type of experiential learning enabled them to experience their cognitive process as a creative and dynamic one which gave them the opportunity to generate more options and pathways for future learning. By being able to create other options, they were more able to cognitively restructure their own thinking and apply the interior changes to their social and professional lives.

In sum, I believe this study of the healing process involved in dissociation has given me pause to think of a more holistic approach to the teaching/learning process that involves a bringing-together of the seemingly disparate parts of the self in order to make the internal connection required for a more complete understanding of the material. This is similar to Piaget’s (1954) concept of assimilation and accommodation. However, this appears not to be purely a cognitive process. In this study, participants viewed the world through dissociative patterning which literally prevented them from integrating their emotions (heart) and thought (mind). Their subsequent healing appeared to require a
more “hands-on”, experiential approach on the part of the professional persons in their life.

There appeared to be steps in this process which required socialization (the establishment of basic trust, witnessing, and modeling) and a somatic remembering wherein the use of metaphor helped them to strengthen their capacity for self-soothing. This was done through more kinesthetic approaches utilizing the creative arts to concretize and give form to their experience from both a subjective and objective perspective. This eventually enabled them to make the internal connections necessary to use their thinking in a new, more integrated way, thus bringing together all their previously disengaged feelings and thoughts. They literally learned how to assimilate knowledge through using both sides of their brain and to apply this to every day life situations. So, learning for them, became a whole brain activity and a whole body activity as an integrative act—the bringing together the heart and mind. Thus the total learning becomes an integrative experience, once again breaking the cycle of dissociative learning.

**Issues for Further Study**

There are limitations to a study of this kind due to its diminutive sampling of the target population. However, in further reflection on the process involved in this study, I have come to the conclusion that, for me, the study of the healing process is really all about dissociative learning and how to make it associative: i.e. how to bring together all aspects of the self and to make both the internal and external connections that are necessary for socio-emotional, cognitive and spiritual growth, which Nesbit (2000) and
Belenky et. al. (1986) have called “connected knowing”. Therefore, I would underscore education as a central conclusion and a vital part of the healing process.

This has raised questions and issues for further inquiry and exploratory research that include the following:

1. **The concept of dissociation and its implications for education across disciplines and globally including multi-cultural considerations.** Studies need to be done which examine what the dissociative process is and how it affects learning outcomes throughout diverse cultures and various academic disciplines.

2. **Pre-verbal issues, dissociation and the attenuation of a culture of violence both in the schools and in society: ethical values.** I would like to see more attention paid to understanding the possible linkage between early psychological trauma and dissociative thinking patterning as possible precipitive factors in the attenuation of a culture of violence that seems to have evolved more specifically within the American society. Another question to be considered here would be based on the possible connection to a lost sense of ethical values and conduct. Could this, in some way, be related to early traumatic experience and even subsequent dissociative social behaviors?

3. **The need for an integrated curriculum that brings together the ‘heart and head’.** I would suggest that a research design be implemented that examines in more detail the process of learning through more associative means; that is, the inclusion of a more, what I might call, sensate [feeling], holistic approach to education including the use of metaphor in the form of the creative arts.

4. **The question of identity and transference for the teacher trainee — its importance in educational settings.** My experience as both a supervisor for teacher and
clinical trainees has informed me of the necessity of providing students with the necessary skills that promote self-understanding as a prerequisite for practice in educational settings. I would suggest that this assumption needs to be tested through further more in-depth studies.

Reflection

Finally, this research experience, in retrospect, appears to be the culminating "learning activity" that has always been a part of my own interior journey. As noted, heuristic methodology suggests that theories are born out of experience. This study has been no exception. The pilot study was an examination of my own lived experience of dissociation and early alienation. This was the basis of the primary question of how others with similar backgrounds negotiated their own healing process. Examination of the healing process became the teaching/learning tool within the context of the revealed narratives of the study participants. For this small sample of persons traumatized as infants and whose internal disengagement manifested dissociative behaviors, the study findings have demonstrated that, in the final analysis: 1) healing was not only a soul-centered activity, and 2) it was also a cognitive activity. Participants needed to engage in both activities to become integrated persons. The process appeared to be creative and dynamic and very much a collaborative researcher/participant experience. This, I believe, fostered mutual independent thinking and self-awareness beyond the bounds of conventional knowledge which appears to be analogous to Belenky’s et. al. (1986) and Nesbit’s (2000) notion of connected knowing.

Study findings, I believe, have indicated that connected knowing is a kind of knowing that transcends the boundaries of conventional knowledge. Connected knowing
appears to me to be an integration of both subjective and objective modes of inquiry. It also appears to be interdisciplinary in nature as the study has involved viewing healing from a variety of perspectives: language and socio-emotional development, trauma related theories, and overview of dissociation and other research theories which examine spiritual perspectives concerning the healing process.

In conclusion, from my perspective as researcher, I wanted to contribute to the literature a "formula" or cure for healing, for not only the ills of those persons who were traumatized early on, but also for the more universal resultant global ills of society at large, which has appeared to me to be largely disengaged in corporate and self-awareness. However, as a result of this study, I discovered that there is not a magic formula or cure. This could not be done because of the subjective and disparate nature of the healing process for even this small participant sample.

The only observation that I made that could be helpful, in my estimation, was the use of metaphor in the healing process. Metaphor appeared to be the linkage between participants' subjective and objective experience, and, as such, was a powerful tool that subsequently led them to self-engagement, change and subsequent personality integration. This substantially ended the cycle of dissociative behaviors in their lives. Underlying all of this was an expressed sense of their healing as being a spiritual process.

Metaphor as used by study participants appeared in the form of artistic expression in various forms as noted. This art or creative process appeared to take participants beyond the obvious (conventional knowledge) and helped them to internalize and create new ways of thinking about their lives and consequently apply these changes to their present living environments.
Upon further reflection, the use of metaphor has made sense to me, and in the role as both researcher and teacher, I could see the possibility of an application of the metaphor in the form of what I have called, an emergent theory, Sensate Teaching as noted. Its application as an instructional practice, I think, will be an effective tool in helping students to be introspective and to internalize their learning in such a way as to integrate the "heart and head". I believe that the resultant findings of this study have supported one of my initial personal assumptions about healing the cycle of dissociation: healing begins with the individual and is a holistic process that includes the use of arts and social contact. Interior change in perspective hinges on a connected inner knowing and applying this to the larger environment. This process of internalization can be incorporated on a larger scale through the educational process to wit an integrated curriculum which includes the arts is vital in its application.
APPENDIX A

Preliminary Query Letter
A Study of the Healing Process In Dissociation

I am looking for persons to interview who have been diagnosed with a dissociative disorder, and who have gone through their journey and have integrated. I am writing my dissertation and subsequently a book about the healing process and dissociation. I am most specifically interested in those persons who have experienced psychological trauma prior to language acquisition and who have been diagnosed with a dissociative disorder.

As a survivor myself, I have my story as well and I am interested in hearing about others who have negotiated this process and more specifically, what kinds of interventions or therapies, etc. have helped in the healing process. The questions will be open-ended and there will be three interviews of about 1-1 1/2 hours each at each participant’s convenience. Confidentiality will be protected, and I will give each participant his/her transcription to be edited as h/she wishes.

By analyzing the process presented within these interviews through contextual clues from the experience itself and by examining the existing professional literature, I hope to discover a way to develop a curriculum for training mental health clinicians and educators in the field of infant trauma and dissociation.

If interested, please contact me at the above number, and I will speak with you at length about the project.

Thank you for your interest.
APPENDIX B

Consent Form
CONSENT FORM

You have been selected to participate in this study because you are a person who has been diagnosed with a dissociative disorder and have gone through the final stages of recovery. I am a Licensed Clinical Social Worker as well as a Doctoral Candidate at Lesley College Graduate School of Education.

Your participation will take about 1-1 1/2 hours in the form of an interview at your convenience. There will be three interviews all together, the first one being an introduction, and two more follow-ups. You will be asked to reflect upon the process or processes that were involved in your healing. By discussing what kinds of interventions or therapies, etc. have contributed to your recovery, you will be helping this researcher investigate and further understand the nature of dissociation in persons who had been traumatized as infants and the process involved in recovery. As a result of this research, you will make it easier for others who have suffered dissociation and recovered to share their experience as well. It is possible that recommendations or proposals may be developed as a result of this information in order to improve clinical education programs and therapeutic treatment.

There are no hidden or experimental treatments and no risks or discomforts that the interviewer is aware of beyond the possibility that some of the questions may remind you of past unpleasant experiences. If at any time you require emotional support/therapy, with your permission, I will make appropriate referrals in order to meet your individual needs and circumstances. However, as the interviewer/researcher, I cannot assume the financial responsibility for outside therapeutic intervention. Your participation is entirely voluntary, and you are free to discontinue at any time. If you wish to have any or all material excluded, just inform the interviewer of such. If you have questions now or at any other time, please feel free to ask the interviewer.

This research is being done as part of the requirements for a Ph.D. in Educational Studies at Lesley College in Cambridge, MA. All information provided will be confidential. That is, no response you provide will be associated with your name (or in any way associated with your position in your organization or academic environment without your permission).

The interview will be tape recorded, but your confidentiality will be protected in the following ways: No identifying information will appear on the transcript of the tape; all names, places, etc. will be deleted during transcription. Access to this interview will be strictly limited to this researcher and the Lesley College faculty associated with this project. Short excerpts from this interview may be used in academic presentations or in a few cases published reports of this research, but these will be disguised to insure unrecognizability. If any direct quotation from this interview is to be used in an article, academic presentation or report, it, too, will be disguised.

I have read and/or listened to and understand the statements listed above and I agree to participate in this study.

Name ___________________________ Date ________________
(Participant)

Name ___________________________ Date ________________
(Researcher)
APPENDIX C

Interview Guide
Open-Ended Interview Guide
Topic: The Healing Process in Dissociation

Interview One: Focused Life History

1. Demographics — Sex, Age, Marital Status, Occupation
2. Can you share whatever you remember that is relevant about the trauma-related experiences in your life until now? And what other indications do you have that this trauma took place?
3. What indications do you or did you have that you experienced dissociative states?
4. What has this meant for you in your life?

Interview Two: Recovery

1. Can you share the details of your present experience as a recovered(ing) person?
2. What has been helpful to you in your recovery process? Any therapeutic technique in particular?
3. Did the creative arts have a place in your recovery?
4. Did spirituality play any role in your recovery?
5. Have there been any significant changes in your social and professional life and relationships related to the recovery process?
6. Can you describe your daily living patterns now?

Interview Three: Reflection

1. Given what you have said about your life in the previous interviews, what do you consider to be the main landmarks or breakthroughs in your recovery?
2. Do you think that being traumatized before you had attained language had any effect on your later behaviors/relationships, etc.? If so, what were some of the behaviors and how did they manifest themselves, and what is your understanding of the role they played in your life?
3. Given what you have reconstructed in these interviews, where do you see yourself going in the future?
BIBLIOGRAPHY


