IMAGE AND MIRAGE

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Art Therapy with Dissociative Clients

By

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This book is dedicated to my son, David,
whose spirit touched my soul and smiled on my life.

FOREWORD

Years after her last book, Dee Spring again invites us to enter the world of dissociation with her as our guide. *Image and Mirage* is a magnificent book that exposes the real life drama of working with clients diagnosed with Dissociative Identity Disorder (DID). It challenges us to be honest with ourselves as clinicians regarding the personal toll we endure when working with this clientele. At the same time, this book acknowledges the incredible life lessons that can only be learned when working along-side the dissociative client. Dr. Spring acknowledges all aspects of her clinical trials in great detail so that we can learn from her mistakes, as well as her successes. It is refreshing to witness the respect that Dr. Spring expresses for her clients and the honesty in which she deals with her personal reactions and reflections on the therapeutic process. One can only hope that this will encourage more authors and clinicians to risk a greater level of self-exposure in their writings.

Only an art therapist is able to see the complete magnitude of creativity that is part of the everyday life of the client with DID. Many clinicians stand in awe of the transformative quality of the creative process. Through the eyes and expertise of an art therapist, however, the creative process is totally unleashed. Dr. Spring walks us through a gallery of famous artworks seen through an art therapist's eyes. She weaves her psychological skills with her knowledge of art to allow us a glimpse of the world as she sees it. It is with these skills that she forms the foundation of her clinical work.

Ultimately, the client with DID is a creative genius. They have transformed the horrible atrocities of their lives into a system of survival. They have painted an inner landscape of people, places, and things that represent safety and compartmentalized memories of trauma. Only the most creative mind can imagine the everyday life of someone living with DID. Dr. Spring possesses such an intellect and shows us through metaphor and archetypes how we can begin to relate to this way of being in the world. She gives us visual charts that explain the dissociative process and ways for the clinician to approach therapeutic treatment. Visual language is the common ground set between the therapist and client. The therapist is privileged to enter the world

of the client with DID through knowledge of multilevel communication. Dr. Spring shares her clinical experience with the reader through graphic examples of verbal and visual means of treatment. As an art therapist, she explains the necessity of the unthreatening vocabulary of the creative process through art making, art therapy, and poetry. She respectfully acknowledges the privilege it is to work with this extremely creative clientele.

Many of us who work with dissociative clients understand the complexity of the case situation described between Dr. Spring, Dr. Strickland, and Melinda Morris. Many of us have similar situations that have, or could have escalated to the level as did this case example. The complications of working with severely and multiply abused individuals are immense–much more so, than any clinician can foresee at the beginning of treatment. We hope that our clients will reach a level of therapeutic health that will allow them to work towards a healthy, stable, and often, integrated life. This is not always the case. Sometimes, the intense power of the abuser wins. The best laid plans for a positive therapeutic outcome can be futile when the abuse has been multilevel, multigenerational, and intrusively indoctrinated into the client's core being. A gift is hidden within these disappointing failures, if the therapist is willing to critically review and learn from the experience. None of us knew all that we currently do about setting and maintaining therapeutic boundaries when we began working as therapists. We learn best from our failures and mistakes. That is the gift that comes from fully acknowledging them.

Image and Mirage, Art Therapy with Dissociative Clients is an extremely valuable addition to the current writings on the treatment of dissociative disorders. It is a seminal book focused on the creative process and visual language that is inherent in this population It uniquely combines advances in psychology and art therapy to meet the dissociative client on his or her own creative level. I commend Dr. Spring for bringing this book to print and allowing the rest of the world to benefit from her insight gained from years of experience.

DEBORAH A. GOOD, PH.D, ATR-BC, LPAT, LPCC
Past President, American Art Therapy Association

PREFACE

One day, it won't hurt to remember.

This is a different book. It is about both the believable and unbelievable. It is about what I learned, observed, and accepted about people who live in imaginary inner worlds of dissociative phenomena. It is about a system of personality parts created for survival, an arrangement of relationships within that system, symbolic habitats, dramas of protection, memories forgotten, stories untold, and a fractured identity. It is about living and reliving horrible experiences, dealing with injustice, and managing incredible pain, both physical and emotional. It is about relief and release, the process of putting the mind's photographs in an imaginary album; locking it in a special place and walking away, knowing the key is close by; knowing there is a choice; knowing the key can be used at any time to open the past that cannot be changed. It is about trust and honesty, divided loyalties, deceptions, trickery, and nefarious people. It is about betrayals, ambushes, masquerades, and fallacy of vision. It is about extraordinary human experience, and co-mingling of pain and pleasure. It is about incredible journeys of the mind, and the nature of the human spirit to survive, adapt, grieve, and move on to the next stage. It is about tragedy and triumph, war and peace, collapse and transformation. It is about portraits of trauma, the reality, not the wish for a magical rescue. It is about walking through shadows and dungeons that dampen the spirit and numb the psyche. But most of all, it is about courage and determination to distinguish image from mirage.

D.S.

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INTRODUCTION: THE DRAMA

In the shadows, they look for friends, but they find only bodiless ghosts as they wander in the mists and cower beneath the storms. Caldwell, 1943, p. 111

At times, the victim is like a mummy bound, gagged, and immobilized by rays of the past. Where once the innocent child's eyes sparkled with wonder about the universe, the vacant eyes of the adult reflect painful scenes of past injustice and unsolved mysteries. The eyes became the mirrors of the mind separated from a body once filled with effervescent energy, now stagnated by a childhood lost. The body is numb and fragile, held together by an outside fabric woven from "invisible wounds" (Watkins, 1971); the body that houses many minds is divided by broken trust and surreptitious acts (Spring, 1993b). The jaw is locked and no words escape the mouth that is bound not to reveal the secrets; secrets that intrude on a mind that no longer knows silence. Voices in the shadows ridicule, criticize, and warn; figures emerge and disappear in the mist as the search for a friend persists. Inner and outer realities contradict and collide while image and mirage chase each other on a surrealistic landscape. The storm approaches. . . .

The rain trickled down the window, reminding me of rainy nights that marked specific events in the case of two women, both suffering from Dissociative Identity Disorder (DID), who ran a collision course with each other. The rain drops were reminiscent of their tears and their sadness as they articulated their historic images which impacted on current events.

When I reflected on my experience with Dr. Violet Strickland, a psychiatrist, and Melinda Morris, her patient, I began to understand my entanglement in their masquerade, and how the shattered images of their past jeopardized their future. Each of their traumatic histories and reenactments of past inequities caught me in a cyclone of confusion, frustration, and ambivalence caused by one escapade after another. The maneuvers and tactics employed by both women intrigued me, disgusted and angered me; their pain and suffering haunted me. The ethical dilemmas that confronted me,

and the apprehension exacerbated by unavailability of colleagues to consult, or attorneys versed in this disorder who could advise me, created an isolation that bewildered me.

The drama was rich in deception, manipulation, secrecy, threats of suicide and homicide. There was unprecedented attention seeking, harassment by a verified Satanic cult, and an underlying threat of violence. The drama involved some 300 identities, one therapist, three children, and the psychiatrist's husband. The circumstances were so out of the ordinary that had I not lived it, I would doubt its reality. My own secondary post-traumatic stress was an added element to the bizarre drama. The drama consumed my energy, my cognitive abilities, my management skills, and my emotional response. The drama infringed upon my capacity to understand their on-going crisis-violence lifestyle (Spring, 1993a). At times, I seriously doubted my abilities as a therapist and became fearful about my future in the field. The case of Dr. Strickland and Melinda caused me to make monumental changes in both my personal and professional life.

I share the intricacies of this case with the intention of bringing to light the complexities of situations that can arise in the treatment of this population; the perplexities and ethical dilemmas that interrupt one's life; the confusion surrounding volatile situations; and the difficulty in making decisions due to extraordinary circumstances. It is also my intention to address how failure of cases, and following cases over long periods of time lead to a depth of knowledge and understanding that can only be learned through experience. I believe sharing such experiences is the major way that we learn new strategies for managing difficult cases, and relearn the basics that we often forget along the way.

The drama began late one evening in the fall with my last appointment when Dr. Violet Strickland walked into my office. She had requested a late appointment, when it was dark, so she would not be recognized by colleagues in the office complex. She was a well-known psychiatrist in the small Pacific Northwest community where we resided. The only information she gave me was that she was having difficulty with a problem in which I specialized; a mutual colleague had referred her. She reported she felt desperate after many years of treatment with little result.

During the week following her call, I felt tense and wondered about her choice. Consequently, when we met for the first time on that rainy evening, close to Halloween, I felt anxious, incompetent, and dumpy. Before me stood a woman of remarkable intelligence, exquisitely dressed, at one time beautiful, now distorted by obesity and poor hygiene; a woman who had acquired an excellent reputation and credentials from all the right schools. However, there was an incongruency. When she spoke, her voice was that of a frightened child; her eyes darted around the room as though she expected me to

attack her. There was a deep breath and a drastic shift. The *Competent Doctor* was present with a deep, resonating voice and steady eye contact.

The *Competent Doctor* advised me that she had seen a number of psychiatrists over the past 12 years, but continued to be depressed with severe headaches. Neither was relieved by recreational nor prescription drugs. She claimed to have been sexually abused by two male psychiatrists and this was the first time she had chosen to see a female clinician. She commented about often thinking about suicide but had no plans; that she thought of homicide but had no victim. She reported having no friends and became very anxious at social or professional gatherings, thus no longer attended such functions. Basically, she isolated; her only interest was work which usually consumed six, twelve-hour days.

Although her specialty was child psychiatry, she told me that she did not like kids. She admitted having difficulties with her own children, Betty nine and Luke seven, related to boundaries and discipline. She described herself as "overly indulgent." Her pattern was giving her children anything they wanted because she felt guilty for not spending time with them.

She claimed that her marriage was an "arrangement." She met Darin in medical school; they had been married eleven years. She was the breadwinner and Darin was her "house husband." He was also a physician, but never practiced because he "hates to work." She liked this arrangement as they had little contact. She reported that it was at his urging that she decided to re-enter therapy. She had begun to have memory lapses again. Darin informed her she had lately been acting "strange and weird." However, she did not want him to know she was re-entering treatment because of financial problems due to her compulsive spending. She frequently forgot to pay taxes and owed the government thousands of dollars.

As she continued to talk, she put a large pillow in front of her. This gesture became a regular pattern. As she slid behind the pillow, there would be a drastic change. A child's voice would speak to me about being embarrassed and fearful I would not like her. There would be a shift, and she would continue the conversation without the pillow as the *Competent Doctor*. This identity stated that she knew several other identities. She claimed to have "inside people" who talked to her. Violet said, "I'm spacey a lot and don't remember what I did or said."

She told me about her private practice, advising me she treated several DID patients. Her current secretary was a multiple who recognized Violet's identities. She informed me her secretary saw a therapist in another town. There was a sense of desperation when she confided she was fearful her patients might be aware of her switching. At this point, I suggested it was inappropriate for her to be treating DID patients if she believed she suffered from the same disorder.

My suggestion met with the emergence of the very defensive *Practicing Doctor* identity. The *Practicing Doctor* informed me she had been managing Violet's situation for several years; she did not intend to harm her patients by "referring them to someone less qualified." The *Practicing Doctor* claimed not to have the problem with dissociation like "The Others." She reported she did not attend conferences on trauma and dissociation, had no training in treating DID, nor did she seek consultation. Her premise was: since her IQ confirmed she was in the genius category, she needed no training by people who could not match her intelligence. She believed reading one book was enough training. The *Practicing Doctor* advised she would question everything I said or did. She did not believe I was competent; she did not make the appointment to see me, and would investigate "who made such a stupid mistake." A different identity immediately made an appointment for the next week and abruptly left. At the door, the *Competent Doctor* wanted reassurance that no one would know she was seeing me.

After the session, I realized I was stressed. I felt drained and wondered why she made the second appointment. I felt bewildered and considered whether or not she would remain in treatment if she believed I was "incompetent." I had an eerie suspicion I was being manipulated, but attributed that to feelings of confusion at the moment. She let me know she would not tolerate confrontation on any level; because she knew more than I did. She advised she would compete with me and argue about anything whether she knew the subject or not. Her statements bewildered me since she knew I used structured, directed, and sequential treatment procedures which often included confrontation through art expression. I wondered if structure and confrontation was what she wanted since she discussed how little structure or direction she incorporated in her life.

During her first session, I described how I worked. I explained, that part of my treatment involved structured art therapy, journal writing, imagery, and hypnosis if indicated. During the discussion, she was compliant, and agreed to follow the structure. I advised that recovery was based on articulating images of traumatic experiences. She reported the only trauma in her life was a violent rape at age 24 while in medical school. She described a pleasant, uneventful childhood and adolescence with loving parents and a sister she adored. She did not find it unusual that she had few memories prior to age 12. Her parents sacrificed to put her through medical school and were well respected in their community.

Due to my experience, her testimony about the rape in adulthood, and few memories prior to age 12, aroused my suspicious. I wondered what might have happened to her before age nine if she indeed suffered from DID. I asked about the aftermath of the rape or any patterns she had observed. Patterns can include incest, rape and an abusive relationship in varying

sequence. She was not aware of "any such pattern" and denied any problem until age 24. She acknowledged ongoing sexual fantasies and nightmares about animals, and being photographed as a child having sex with dogs. After she told me this, she wanted to know if I had made a diagnosis yet. When I said no, she was upset that it was taking so long, "If you were any good, you would have made the diagnosis before this hour was up."

At this point, I outlined my diagnostic procedures. Two self-reports and five specific drawings accompanied by a written autobiography were required. She was advised that this procedure took at least six weeks dependent upon her working pace; that I did not intend to discuss the diagnosis again with her until the assessment and observations were finished. She agreed. I knew I had passed the first test. At this point, she appeared motivated and excited that something was happening. She praised me for holding my ground and not being swayed by her defiance and arrogance.

During the next weeks, Dr. Strickland brought in a stack of writings and her journal completed over a period of years. She waved the materials at me, threw them on the floor, and immediately hid behind the pillow while the little girl talked to me. The writings reflected internal conversations between and among various identities that she described. I already recognized several of those she described. She managed the structured assignments over the six weeks.

I reviewed the materials she completed, recorded and evaluated the consistent switching of identities observed in each session. I considered she might be malingering but could not figure out a reason. I had already encountered several child identities, one adolescent, a young adult who appeared to be the one who held the rape memory, a defiant argumentative adult, and two doctors. Later, I would learn there was a large cluster of doctors who managed different parts of her current practice, along with those who had managed medical school, internship, and residency. There were voice changes consistent with emergence of particular identities. Identities varied in gender, vocabulary, general knowledge, and affect. She had different wardrobes, several make-up styles, and hair color. Each identity had a different history, self-image, function, and name.

On her seventh visit, Dr. Strickland came from behind the pillow and asked if I thought she had DID. I answered affirmatively. Amidst rapid switching, she immediately denied everything previously communicated, and said, "prove it."

> Violet, from your Self-Reports you match almost every symptom in the diagnostic manual. I have observed switching in all prior sessions; your handwriting has drastic changes. You report losing time. The memories of your childhood are non-existent before age 12, plus you report hearing inside

> head voices. If a patient gave you that information and congruence was observed, what would your diagnosis be?

"Dissociative Identity Disorder," replied the *Practicing Doctor,* "but that's for the rest of them, it does not apply to me. I want you to get that straight right here and now."

We established the diagnosis, but not without denial and argument which she enjoyed. Later in treatment, she told me she was amazed by my ability to just go right on, and not let her deter, nor sidetrack me from important issues in treatment. From that point on, we had an understanding. She tested, denied, argued, attempted to intimidate me, and prove I was incompetent. I stayed on course, and she kept coming back. I admired her intelligence, tangled with her contrariness, and respected her struggle as a professional woman who had survived severely traumatizing experiences in childhood and adolescence in a cult-type group involved in making pornographic movies about children and bestiality.

We continued on this course for two years. She improved, gave up recreational and prescription drugs, became more involved with her children, and struggled with her marital relationship, her compulsive spending, and her constant self-inflicted isolation. She learned to respect my abilities and enjoyed not being able to "outsmart me" in treatment sessions. Her game of intellectual chess gave me reason to stretch and improve my skills to keep up with her. There came a time when the treatment plan included finding a friend and breaking her isolation.

Violet came in one evening very excited. She announced she had a female friend. They had been going to lunch, and taking their children to the park for picnics. Her friend had been visiting her at home and liked Darin, her husband. They planned a camping trip which included all three children. I was flabbergasted. There was no mention of this relationship prior to this moment. I experienced a foreboding feeling. My intuition said something was missing; this friendship happened too quickly. She wanted to know if she could bring the friend to a session to work on the relationship. She contended she did not want anything to happen to her first adult female friendship. Since the treatment plan included her seeking friendships to disrupt her isolation, I considered this part of her treatment due to her long-term problems with relationships. She explained she had questions about her sexual attraction to this friend. I wondered if she had a lesbian identity that might complicate the relationship. She wanted to know if these were normal feelings when "you really like someone?" We discussed normalcy in relationships. The conjoint session was arranged.

Dr. Strickland brought Melinda to the next session. Melinda was introduced as her secretary. I remembered she told me her secretary had DID and

was seeing a therapist in another town. Melinda was opposite to Violet, much younger, personable, talkative, gracious, compliant, and tended to have a positive effect on the psychiatrist. During the session, they discussed the interaction of their identities, the supportive understanding they received from each other, and how much they enjoyed working together. I was not responsible for any personal relationship Dr. Strickland had with her secretary but found myself feeling uncomfortable with their arrangement.

Following this conjoint session, Dr. Strickland discussed her sexual feelings towards Melinda. A male identity, attracted to Melinda, was discovered. This identity reported he was attracted to Melinda from the first day she came to the office but had not acted on any impulses.

A few periodic conjoint sessions were held to focus on education about healthy relationships, communication, and parenting skills. The primary interaction was between the mother identities who discussed child rearing and family dynamics. Both women seemed to garner insight and awareness from these sessions. The male identity, attracted to Melinda, did not emerge in any of these sessions. Dr. Strickland and Melinda went on their camping trip

Following the trip, Dr. Strickland stated that Melinda wanted to participate in the up-coming psychoeducational group for specifically referred DID patients. I had no objection to Melinda coming to the group.

Melinda came to the group. She appeared to gain insight into her disorder and improve self-confidence from her interaction with other group members. She made friends in the group and received positive feedback. Following completion of the group, Dr. Strickland requested a conjoint session with Melinda to discuss changes taking place in their relationship. She implied that the changes were positive and exciting, but they wanted to discuss some specific issues.

When they arrived for the session, I observed tension between them. Melinda appeared angry. The reason for the session, and the tension I had observed was due to evolving problems among their children. Dr. Strickland was jealous about the attention Darin was showing Melinda. I remembered the first feelings and thoughts I had about this relationship from the beginning and realized I continued to be uncomfortable.

This session changed the course of my life and theirs. From this point on, I found myself caught in a prearranged drama orchestrated to trap me in a situation that bound me to both women. The deceptive nature of the drama caught me off guard. It involved me in a professional dilemma that took on monumental proportions. The trickery, complicity, hypocrisy, and camouflage that was a part of the drama was beyond my comprehension. I *relearned* the meaning of the awesome impact that sexual and physical abuse has on individuals to re-enact abuse, and manipulate their environment to get what

the universe has to provide at any one moment in time. I learned how quickly a clinician can be mislead. I experienced the isolation and vulnerability of treating a controversial disorder in a small backward town with few resources.

During this session, I was advised that Dr. Strickland had been Melinda's therapist for the past two years. During the course of therapy, Melinda was hired as Dr. Strickland's secretary. She was given large doses of a combination of drugs which Dr. Strickland administered only in the office. I was informed the reason for this was Melinda's proneness to overdose on prescription drugs. Dr. Strickland admitted to prescribing large doses to "keep Melinda under control." She refused to discuss the dosage, or the combination of drugs she was administering. Melinda claimed she did not know the dosage, nor the names of the medications since she did not get the prescriptions filled. She took whatever Dr. Strickland presented. Her treatment and medication was paid through both a state and federal program.

Because Melinda was destitute when she entered treatment, Dr. Strickland had taken her into her home where she currently lived and performed household chores. I learned more about this complex arrangement over a period of time by confronting bits and pieces of information. Various identities knew about different parts of this arrangement, and how it had been so intricately woven. Not only did Melinda have a salary as Dr. Strickland's secretary, but she performed household tasks and ran errands to offset the costs of food and utilities for her and her son, Billy, to live in the Strickland household.

Melinda told me her 10-year-old son, Greg, had been made a ward of the court and taken away from her after she began seeing Dr. Strickland. There had been a bitter custody battle involving Melinda, Billy (4), and her parents. Dr. Strickland, the physician of record, convinced the court that Melinda could care for her young son. The court was aware Melinda lived with Dr. Strickland. A social worker performed a home visit and recommended the living arrangement; the court approved it. There was no reference to a dual relationship between physician and patient.

I advised Dr. Strickland and Melinda this was a dual relationship and Melinda was to be transferred to another clinician immediately. In the beginning, I was tricked into believing Melinda saw a clinician in another town. Prior to this time, I had no reason nor right to question Melinda about her treatment. Dr. Strickland refused to change the relationship as she contended it was "legal" and appropriate; the court had approved it. The *Practicing Doctor* was outraged that I defined this relationship as unethical and could not continue in its present form. This was a difficult ethic to argue because the living arrangement was approved by the family court as being in the "best interest of the child."

At Dr. Strickland's next session, the unethical situation was discussed. Again, I insisted that Melinda be immediately transferred. The *Practicing Doc-*

tor insisted she could manage the situation and continued to see nothing wrong with the arrangement. After lengthy debate, she agreed to refer Melinda rather than risk my reporting her to the Medical board. The transfer was the only agreement I would accept if she was to continue in my care. I felt relief.

Two nights later, I received a frantic call from Dr. Strickland. She called to inform me there had been an incident with Melinda at the local fair. She had been arrested for causing a disturbance about the way the goats were being treated. Dr. Strickland claimed to have managed the situation. Melinda was released in Dr. Strickland's custody. No charges were filed because Dr. Strickland convinced the arresting officer she would be personally responsible for taking Melinda to her therapist. The officer wanted to know the name of the therapist for the record. Dr. Strickland gave him my name. I was furious with her; this was unacceptable. She assured me she knew, but "I just didn't know what to do." Her excuse to me was, Melinda had not had time to find another therapist and the situation had extenuating circumstances.

Later, I learned these circumstances related to Melinda's long history of admissions to the local mental health unit that did not believe in DID diagnosis. Melinda also had a record of arrests for various and sundry misdemeanors along with substance abuse problems over the years. This was part of the reason her oldest son, Greg, was made a ward of the court. Although Melinda's former husband attempted to get custody of Greg, the judge chose placement in a county facility with regular visitations and weekend passes to visit his mother and maternal grandparents. His father could only visit him at the facility.

Mental health admissions and arrests were also the reason used by Melinda's parents to attempt to get custody of Billy. Melinda retained custody. Her parents filed an appeal to this court decision. Melinda had not married Billy's father, but chose to raise the child alone. This information seemed reasonable at the time. I knew such situations can have enormous consequences in a small town.

Dr. Strickland and I discussed the situation at her next session. She was informed I would not engage in any future conjoint sessions unless Melinda's clinician was present. If there was any follow-up by the police department, I would advise I was not the clinician of record, and explain how that happened without my permission. Fortunately, there was no follow-up by the police, and no more public incidents. Only later would I learn the deliberateness of Dr. Strickland's maneuver.

Dr. Strickland continued her individual therapy. She reported Melinda had moved into her own apartment; she was no longer treating Melinda. I relaxed and went on with the business of treatment. She seemed to be progressing, claimed she and Darin were working on their marriage, and might

want to engage in marital counseling in the future. I was lulled into believing Melinda was seeing another therapist but did continue to work as Dr. Strickland's secretary. There was no contact with Melinda, nor any further mention of her by Dr. Strickland. Treatment moved along. There were no crises, and Violet's dissociation seemed to lessen. The obstacle was her continued treatment of dissociative patients and her refusal to transfer those patients. I continued to insist that she stop treating dissociative patients until she was integrated. Periodically, she would refer patients to me which appeared to be compliance.

I called the Medical Board to inquire about Dr. Strickland's treatment of DID clients which paralleled her own disorder, and what I believed to be an over medication problem with this population. I was told, with emphasis, that there was no rule about what type of patient she could treat; that depressed doctors treat depressed patients all the time without incident. They wanted to know why I thought this case was any different. My argument was negated. The Medical Board was not concerned about the medication problem if the physician felt justified in maintaining a patient on a high dosage. I was criticized for addressing a problem outside my scope of practice; I was not a physician. It was not my job to play policeman. I decided to concentrate on Dr. Strickland's treatment. I had performed my ethical duty. It was apparent, the Medical Board had no interest in the case and did not believe my concerns were valid.

When my emergency service contacted me in the early morning hours with a call from Melinda, I was baffled. My first thought was that something had happened to Dr. Strickland and took the call. Melinda was threatening suicide, homicide, or both. There was rapid switching defined by the many voice changes. She was lost and at a pay phone. She could not remember how she got there or what had happened. I encouraged her to call 911; she refused because she knew she would be taken to "lock-up." I continued to respond to Melinda with the intention of finding out where she was and then calling 911 for assistance. She was unable, or unwilling, to give me any clues as to her location. There was a young identity present much of the time that had, without my knowledge, become attached to me. She attempted to tell me where she was, but kept referring to "the mean woman, Violet, who would not leave her alone." I was alert to the chaos in the internal system. Some identities wanted to die; others wanted to kill or harm the "mean woman." I told Melinda she would have to call her clinician, or give me the name and I would call. This situation was obviously volatile; I wanted nothing to do with it. To my amazement, Melinda reported she did not have another clinician, that I was her therapist. Shock!

This was not a time to argue with Melinda. She claimed to have a razor blade and a knife. There was too much confusion for me to put the pieces

together. I could not figure out how to get aid to her since I had no idea where she was. During the conversation on the phone, she stated she was angry enough to harm Dr. Strickland. I was aware Melinda knew where Dr. Strickland lived and might have a key. I was concerned for Dr. Strickland's safety should Melinda decide to act upon her threats. I was, at the same time, concerned about Melinda's safety and possible harm to herself. I knew I had to warn Dr. Strickland, then alert the police.

In desperation, while still on the phone with Melinda, I asked to speak to an identity who knew where my office was. An adolescent responded and said, "I can drive everyone to your office." I said I would meet her there so we could decide what to do. My intention was to get her to a safe place and get the weapons out of her possession. I asked to speak to someone who would take charge of the razor blade and knife; that the weapons and her purse would have to be given to me before I would let her into my office. An identity agreed to take charge of this task. Next, I asked for another identity to call me if someone decided to go to another place other than my office; if they were longer than twenty minutes getting to my office, I would alert the police to be on the lookout for her. Obviously, this was an empty threat since I had no idea what kind of car she was driving, or from which direction she would come. I hoped she would not figure this out until the situation was under control. If she did, then I would admit the tactic used for safety reasons. I knew this was a leap of faith.

With these procedures in place, I called Dr. Strickland's home; there was no answer. I called the small town police department to alert them to the situation. They informed me that no crime had been committed, and they could not dispatch a unit to a house when no one was home. I informed them of the threat of homicide (Tarasoff, 1976) against Dr. Strickland as I am mandated to do. They informed me to call them again if the situation worsened. I felt totally frustrated and isolated in this dangerous drama.

I thought I knew Melinda well enough that if she made a promise to me she would keep it. I had to keep that faith for my own sanity and not become so frightened I would be immobilized. I considered several methods to convince Melinda to admit herself to the local psychiatric hospital. Before I left home, I called the hospital, where I was on staff, and alerted them to a possible admission. This was before the advent of cell phones. Since I knew Melinda's history with the mental health unit, I knew admission there would not be in her best interest but would use it as a last resort.

During those frantic twenty minutes, I viewed this situation as a crisis intervention and considered the information currently available to me. I realized what had begun as a positive goal for the psychiatrist to find a friend had turned into a dangerous situation, as well as a professional dilemma for me. At the time, I agreed to meet Melinda at my office, I was unaware of the rest

of the story. I felt trapped, scared, coerced, and manipulated due to circumstances beyond my control; angry at a police department that claimed to know nothing about the Tarasoff mandate; frustrated with the lack of resources; confused and concerned about two women on a collision course with me in the middle.

My drive to the office seemed like hours. This was another rainy October night, two years after I began treating Dr. Strickland. There was no one on the road; the stillness of the early morning hour seemed to carry a chill that intruded upon my mind, body, and spirit. I thought, "How ridiculous to take such a risk. Am I nuts?" Yet, I felt bound to do what I could to preserve life, perhaps two and at the same time do no harm. This may have been arrogance on my part, but it did not feel that way at the moment. There was too much fear of the unknown. I felt responsible and alone in a small town that operated on a traditional philosophy of restrain, medicate, and lock up. My self-inflicted criticism for taking the emergency call was overwhelming. All I could depend on was my years of experience in crisis intervention and knowledge of DID.

When I arrived at the office complex, the darkness seemed to consume my soul. The heavy rain with its penetrating sounds on leaves and pavement added a bizarre element; reminded me of a scary movie. I was not just watching this, I was in it! But, there was no security of cameramen, directors, props, or technicians. This was real, not an illusion. I walked into the office, turned on the lights and felt a sense of security. This was my territory. The dark and the rain was outside. There was a phone, a security system, and familiarity.

Melinda arrived. I spoke to her through the door. I told her to lay all the razor blades, the knife, and her purse on the sidewalk by the door as I watched through the window; to move back to the main sidewalk while I picked them up. She followed my instructions. I opened the door, picked up the weapons and purse, closed the door, locked it, and put the weapons in a safe place. I searched her purse for any additional weapons. Afterwards, I let her inside.

Melinda was disheveled; Billy was not with her. She reported he was with the Stricklands. That seemed odd. The identity who expressed anger was present, but not the ones who were threatening suicide and homicide. The angry identity said she only carried the rage; others carried threats of violence, and other identities would tell what happened. The violent and rageful identities agreed to listen because they wanted my help. An agreement was reached, Melinda would not leave my office until I heard the entire story, and a decision reached as to what to do. If she left before we finished, I would call 911. She gave me her license plate number before we continued.

Young identities were put in a symbolic safe place; the situation calmed down. Although, I felt apprehensive, I was no longer fearful of violence.

Melinda was frightened, anxious, and angry, but compliant. She expressed her trust in me; I believed her. We both relaxed, joked a bit to ease the tension, then moved on to remaining negotiations.

The negotiations included the stipulation that Melinda would see another clinician and give permission for me to speak with the new one. This required Melinda to sign a confidentiality release form on the spot. A young, naive, and sad identity emerged, looked at me and said, "but you're my therapist; Violet said so. She told me you had been too busy to see me; that you would be calling me for an appointment time. I've been waiting for your call." I was stunned I just sat there for awhile with Melinda staring at me. She had been waiting for months for a call that never came. Obviously, this was a messy situation. I still did not know the rest of the story. I could sense that various identities trusted me to do what was in the best interest of all concerned, even though some would not like it. I sensed there was an urgency for Melinda to tell the rest of the story.

I said, "Perhaps you need to tell me what this is all about and what happened to get you to this place." Melinda then told a story that kept me spellbound for the next two hours. Prior to the goat incident at the local fair, Dr. Strickland rented an apartment for Melinda. Then Dr. Strickland and her daughter, Betty, moved in with Melinda and her son, Billy. Dr. Strickland's son, Luke, stayed with his father, Darin. Melinda and Dr. Strickland had been involved in a lesbian relationship for two years. I calculated that Dr. Strickland began seeing me about the same time. At the beginning, the sexual encounters took place in Dr. Strickland's office. When Melinda began living in the Strickland household, she engaged in a sexual relationship with Darin, the psychiatrist's husband; at times the sexual encounters included Dr. Strickland. When Dr. Strickland and Melinda lived together in the apartment, the sexual relationship continued.

Melinda and Dr. Strickland lived together in the apartment for about four months before the disagreements began. Melinda then told of her affiliation with a multi-generational Satanic cult that practiced for years just outside of town. This cult was known to city officials and law enforcement. Her father was a Captain in the Police Department, her mother was a court reporter, her sister was a nurse in the mental health unit, and one brother was a reporter for the local newspaper. The judge who ruled on both of her sons' cases was a cult member and close to her family. Dr. Strickland had, at times, conversed with Melinda's father, although Dr. Strickland did not participate in the cult. Melinda claimed she had no contact with her family but occasionally saw them around town. She did not tell me there was on-going communication through mail and telephone calls.

She discussed another brother who left the family on his mission to start his own cult on the East Coast. This was not the brother who worked for the

local newspaper. She claimed her children had been indoctrinated; that her future mission was to form her own cult to keep the network going. The friction between Melinda and her family was about her promise to keep her children in the cult. She claimed she struggled to break the bonds with her family and free her children. This was the reason her parent's attempted to gain custody of Billy. The judge had previously given permanent access to her older son, Greg.

Current problems had begun on Halloween when Melinda and Dr. Strickland had donned costumes and designed rituals for their Halloween celebration. She claimed Dr. Strickland became overly controlling; Melinda became angry. They began pushing and shoving each other; violence erupted. Dr. Strickland called Darin to come to her aid. By the time he arrived, Melinda had a razor blade and was threatening suicide which increased Dr. Strickland's hysteria. Darin attempted to intervene. One of Melinda's violent identities grabbed a knife which she defined as an "athame" (ritual knife) that was kept in a special drawer. Melinda threatened to cut Dr. Strickland. The Stricklands ordered Melinda to leave the apartment or they would physically harm her. No one called the police because of the position of Melinda's father in the police department and Dr. Strickland's standing in the community. Melinda chose to flee without her son, then called my emergency service. She said, "I memorized your number a long time ago just in case anything happened. I knew you would know what to do, even if I didn't like your decision."

She alleged Darin had been part of the drama from the beginning. He had informed Melinda that Dr. Strickland was always involved with her patients, and over the years had brought several home to live with them. However, Melinda was the first one to become violent, the only one Dr. Strickland cared enough about to leave him. Much later, he told me the same thing, and stated he "enjoyed the rest from my crazy wife while she lived with Melinda."

I wrestled with the validity of what I was hearing. It seemed delusional to me. What possible reason would Dr. Strickland have to ruin her career? What was Dr. Strickland's reasons for choosing me for involvement in this drama? Did she think I would not report her? How could I extricate myself from this surrealistic drama? How could I manage this situation with the best interests of both women in mind, and protect myself?

My intention, at the moment, was to find a safe place for Melinda, see her later in the day to check on her stability; assist her to find another clinician; and find a therapist for Billy. From Melinda's report, Billy was traumatized by incidents over the past months. He was having severe nightmares, anxious most of the time and frightened. My next thought was how to manage the confidentiality of the current incident since no "real" crime had been com-

mitted. I needed to report the sexual relationship between Dr. Strickland, her husband, and Melinda. However, these were adults, it was consensual, and I was not the victim. The Medical Board was not going to pay attention to me. Only the victim's (Melinda) report would be relevant.

In the small town, there were few clinicians with expertise to manage sexual trauma cases; none believed DID was a valid diagnosis I could imagine the response if I attempted to explain the collision course of *two* women with this disorder! The situation was complicated by the various positions Melinda's family held in the small town, Dr. Strickland's medical reputation, and the professional consequences for me.

Considering all of that, it seemed more important to ascertain the safety of Melinda's young son, where Dr. Strickland was, and whether or not Melinda would consider going to the local shelter until later in the day. She refused to go to the shelter, then called her apartment. Billy answered the phone; he was alone and scared. Dr. Strickland, Darin, and Betty had left. Melinda called the Strickland residence. Darin answered the phone and verified they were at the Strickland home. Melinda did not divulge her whereabouts nor attempt to speak to Dr. Strickland. After an appointment was scheduled for later in the day, she left to be with her son and I went home.

I called an intern in my practice who treated children. She agreed to see Billy on an emergency basis. Melinda was informed. Arrangements were made for Pam Churnosky to see Billy while Melinda attended her check-in session with me. During this time, there was no contact with Dr. Strickland. She was scheduled for her appointment at the end of the week. I saw this as an opportunity to seek consultation and make decisions about dealing with this extraordinary situation.

The purpose of the later session with Melinda was to find an appropriate clinician. As possibilities were explored, Melinda decided she wanted to relocate to another state due to the complexity of her situation. I agreed to assist her to find a qualified therapist. She explored the idea of filing a complaint against Dr. Strickland to the Medical Board. She wanted to make her move within four months. During this conversation, she reported Dr. Strickland bought the car she was driving and paid for it with cash. She would have to get the title changed before she could leave the state as Dr. Strickland was listed as the second owner. I wondered if this was the last of the complications.

My dilemma was whether to treat Melinda until she was ready to leave as it related to stabilization. If I did, how would I manage the situation with Dr. Strickland? My immediate action included seeking several consultations, and discussing my concerns with several attorneys.

I called several out-of-state, trusted, and knowledgeable colleagues. I received different perspectives on the case. All agreed that I must report the case of the dual relationship and sexual involvement to the Medical Board

whether they wanted the information or not. None thought this was a conflict of interest, but a case involving relationships similar to an abusing family, a complex divorce case, or other complex family situation. I was advised to consider whether or not I could be accused of abandoning Dr. Strickland if I refused to see her. Since I had intervened in a crisis situation, was Melinda now considered my patient, and if so, would I also be abandoning her? I was advised that when Dr. Strickland was told that I intended to report her, she might voluntarily terminate treatment with me. Since Melinda had agreed to seek treatment out of state, it seemed reasonable that I should assist her to find a clinician in her choice of a new hometown. The time spent in the interim could be considered a transition period and preparation for relocation due to unusual circumstances.

One consultant told me to terminate both clients based on the bizarre circumstances; to give each of them three referrals by telephone and refuse to see either one of them again. Another consultant believed I was at risk because I intervened in the crisis situation whether or not I had adequate information. However, he acknowledged that the lack of resources and knowledge about dissociative disorders in the area left me at risk if I had done nothing. The third consultant thought I should choose which patient I wanted to see and "dump the other one." In the end, the decision was solely mine.

Next, I spoke with several attorneys. I was advised that there was no reasonable case against me. My actions were consistent within the range of what any "prudent therapist" would do under the same circumstances. I had exercised reasonable judgment in a complex situation. I may have taken an unreasonable personal risk to myself, but did not put either woman at risk. All agreed that my mistake was taking the emergency call from Melinda, but I had acted reasonably and was in no way negligent. They could not see any reason why either woman would want to sue me because of the nature of the situation and publicity resulting from a high profile case if it went to court. Dr. Strickland would reasonably be determined to protect her career and reputation. The conclusion was, the worst that could happen to me was a "slap on the hands" for what could possibly be construed as conflict of interest, but that would be a stretch considering the situation. It was doubted this would come to fruition due to the bizarre circumstances of the case.

All attorneys agreed: at this time in history, there was no absolute answer to dealing with the dilemma in which I found myself. However, the controversial diagnosis might cause me grief since currently, there was no published standards of care for dissociative disorders. It was up to me to decide how to resolve the case based on the best interests of all concerned. There was only a slight risk of a blight on my career. I was advised I had three options: (1) keep treating both, (2) terminate both, or (3) terminate one. I considered

a fourth option, closing my practice, leaving the clinical field, and moving back to my home state to have the safety of my family.

There were a lot of variables to consider. I had been thrust into this unusual situation through manipulation, calculation, and Dr. Strickland's intention to keep the dual relationship concealed. At the beginning, I was not aware of the manipulation and malice of forethought with which I became involved, nor was I aware of the dual relationship between doctor and patient. I had not agreed to take Melinda as a client; severe circumstances involved me because Dr. Strickland was in my care. When the emergency call came in, I had no way to know the circumstances. The crisis presented a situation that needed to be handled at the moment. I did not consider a conflict of interest during the confusion of crisis intervention but felt obligated to attend to the crisis. My attention was on the safety of both Dr. Strickland and Melinda. I considered my actions to be reasonable due to the situation and circumstances. I was more concerned about negligence and standards of care related to threats of homicide and suicide than other factors in the case. There were minor children at risk due to threats by adults, and in a very broad context, this was a volatile family situation. I was fearful that both, or either of the people involved might act on the threats of harm to self or others. Lastly, I could not get all of the facts in the case due to Melinda's dissociation and lack of contact with Dr. Strickland. The resources of the small town were limited and complicated by the position of Melinda's father in the police department. The cult aspect of the case presented an unusual dimension, along with Dr. Strickland's position as the only female psychiatrist in town.

At the moment of crisis and its sudden interruption of my life, I made a clinical judgment to intervene. I believed the immediate situation outweighed the detriments of my sudden withdrawal from the unstable situation. I believed the situation presented indicators for violence which could lead to a tragedy of some magnitude and have tremendous impact on several lives. I attempted to get assistance in the way I had been trained; it was not available. I considered the trust issues involved with Melinda and her young identities, and my long treatment relationship with Dr. Strickland. My goal was to manage the immediate situation to the best of my ability to allow time to assimilate information and make an informed decision as to the next step. Taking time for contemplation and investigation, I hoped to arrive at an equitable, honorable, and sagacious conclusion.

This complicated drama involved multilevel consciousness of two women who were emotionally wounded by complex traumatic experience over a long period of time. As you wander through the chapters that follow, it is important to consider the three options presented. How would you manage this complex case? How would you deal with the involvement of some 300 identities, three minor children, a long-term marriage, a lesbian relationship,

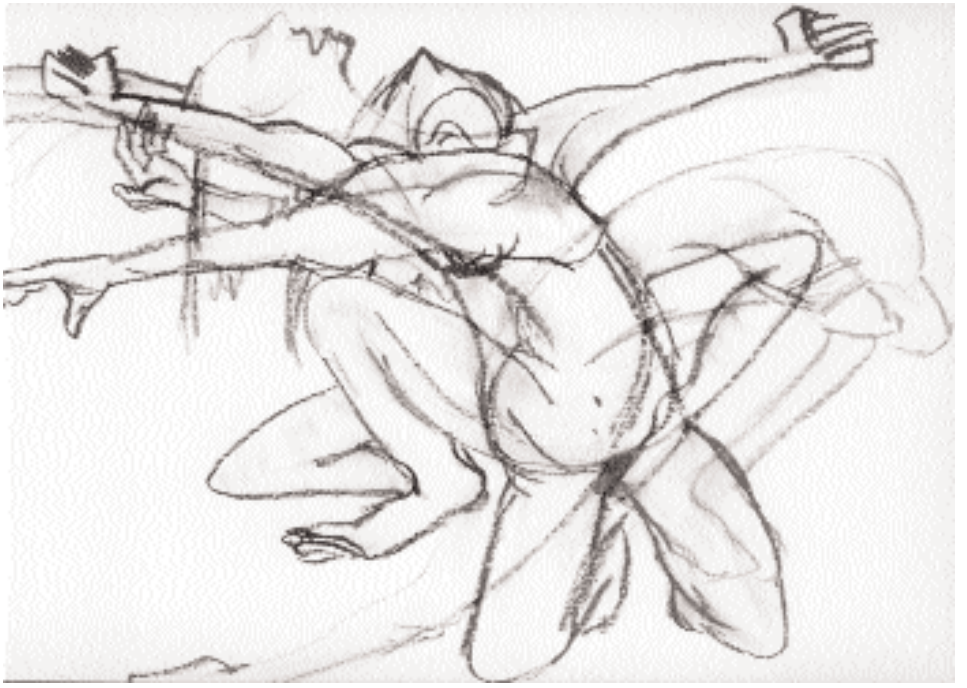

Figure 1. Entangled

sexual abuse perpetrated by an attending physician, and ethical dilemmas created by the situation? Which one of the three options would you choose as the most equitable?