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