

Extending Blatt's two-polarity model of personality development to dissociative identity disorder: a theory-building case study

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ABSTRACT

In this theory-building case study, we investigate Blatt's two-polarity model of personality development according to which psychopathology is a consequence of an unbalance between the two developmental lines of interpersonal relatedness and self-definition. Anaclitic psychopathology, such as schizophrenia, histrionic, dependent, and borderline personality disorders, is associated with an excessive and rigid emphasis on interpersonal relatedness. In this theory-building case study, we examine whether this model can be extended to dissociative identity disorder (DID). The patient is a 23-year old Caucasian man who suffers from periodic episodes of dissociation. Consensual qualitative research for case studies is used to quantitatively and qualitatively describe the interplay between symptomatic and interpersonal evolutions throughout 41 sessions of supportive-expressive psychoanalytic psychotherapy. In line with the two-polarity model of personality development, close associations between symptoms of dissociation and dependent interpersonal dynamics were observed. Psychoanalytic interventions focusing on elaboration of the subjective meanings of (past and anticipated) dissociations, and on working through core interpersonal conflicts, are followed by transformations in the patient's interpersonal stances and subjective well-being. No new dissociative episodes were reported during the follow-up assessment three and a half years after the completion of treatment. This case study demonstrates that DID is a form of anaclitic psychopathology as it is associated with a predominant tendency to interpersonal relatedness.

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Key words: Two-polarity model of personality development; theory-building case study; dissociation; interpersonal relatedness.

Introduction

Within psychoanalytic psychotherapy, symptoms are not approached as detached, meaningless entities that 'fall upon' the subject at arbitrary moments in time, or as undividedly shared by 'fellow sufferers'. The subjective meaning of symptoms within the patient's broader psychic functioning should be central in the approach to psychoanalytic diagnosis and treatment (Vanheule, 2014). According to the two-polarity model of personality developed by Blatt and colleagues (Blatt & Zuroff, 1992), psychopathology is associated with two interpersonally oriented tendencies that underlie personality development. The tendency towards *interpersonal relatedness* reflects a person's capacity to establish and maintain mature, meaningful and satisfying interpersonal relationships. The tendency towards *self-definition* refers to a person's ability to attain a healthy, solid, diversified, and well-integrated sense of self (Blatt, Shahar, & Zuroff,

2001). According to Blatt, personality development proceeds through a continuous process of interaction between these two tendencies, as people try to find a balance between relatedness and autonomy (Luyten, 2017). It is possible, however, that one tendency starts to dominate the other and creates an unbalance in the organization of the personality. Blatt and colleagues (Blatt *et al.*, 2001) use the term *anacletic* to refer to individuals in whom the tendency towards interpersonal relatedness predominates. Individuals in whom the tendency towards self-definition is most present are referred to as *introjective*. According to Blatt (2008) psychopathology is a consequence of an extreme unbalance between the two tendencies, and different configurations of psychopathology can be associated with each tendency. Anacletic psychopathology, associated with an excessive and rigid emphasis on interpersonal relatedness, includes schizophrenia, histrionic, dependent, and borderline personality disorders. Introjective psychopathology, associated with exaggerated attempts to install a sense of self and autonomy, includes paranoid schizophrenia and paranoid, obsessive-compulsive, and narcissistic personality disorders (Luyten, 2017).

The present study investigates the two-polarity model of personality in a case study of the successful treatment of a patient suffering from dissociative identity disorder (DID) (American Psychiatric Association, 2013). DID is defined as a *'disruption of identity characterized by two or more distinct personality states [...] accompanied by related alternations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning... with recurrent gaps in the recall of everyday events, personal information and/or traumatic events'* (American Psychiatric Association, 2013, p. 261). From a psychoanalytic point of view, Meganck (2017) has argued that DID is typically associated with a hysterical subject structure. A hysterical subject structure is characterized by a tendency to interpersonal fusion as the subject *'attempts to meet the desire of the Other, yet interprets the message of the Other in the sense that what is given is not enough, that the subject does not meet the desires of the Other'* (Meganck, 2017, p. 6). The hysterical subject is oriented towards finding out what the Other wants and will identify with that wish. In other words, the sense of identity of the hysterical subject becomes dependent on the desire of the Other. Aspects of the subject's personality that don't fit the Other's desire become a threat to the sense of identity. This is where psychopathology can emerge, including symptoms of dissociation. The central mechanism in hysterical symptom formation is repression of conflicting wishes and desires leading to an inability to recognize oneself in these wishes and desires (Merskey, 1995). In the case of dissociation, conflicting impulses are literally split off through fragmentation of memory. These conflicting impulses can literally reappear in what seems like a different personality state.

Meganck's (2017) description of the hysterical subject

position highlights the importance of interpersonally-oriented personality features that underlie the formation of psychopathology. On the basis of her formulation about the link between DID and the hysterical subject position, we formulate the hypothesis that DID is a form of anacletic psychopathology and will therefore be associated with a tendency towards interpersonal relatedness as defined in Blatt's two-polarity model of personality. Blatt's model describes a complex interaction between psychopathology and personality over time. Therefore, we choose to investigate this complex process on the basis of longitudinal, clinical data that allow co-variations to be studied throughout the course of a therapy process. Most studies on Blatt's model are: i) cross-sectional in nature and describe *static* associations; ii) search for *invariant* patterns in participant groups, while within-subject variability and (significant) contextual factors are disregarded as noise or error; and iii) rely solely on patient-reported, quantitative assessment of symptomatic and interpersonal well-being, which have previously been argued to be subject to a variety of biases (Desmet, 2018).

Hence, Cornelis *et al.* (2017a) concluded that there might be a need to apply a case study approach to the study of Blatt's model. Case studies can be used for different research purposes, and the idiographic case study approach covers important areas that might be overlooked in nomothetic designs (Kaluzeviciute & Willemsen, 2020). By integrating information about intra- and extra-therapeutic events into a thick description of naturally unfolding processes, rigorously conducted case studies complement statistical sample-based research. In systematic case studies, data from different sources (*e.g.*, self-report, observations,...) are gathered in a naturalistic setting and a research team is involved in the analysis of the data (Willemsen, Della Rosa & Kegerreis, 2017). Systematic case studies can be used for hypothesis-refinement and 'theory building' (Stiles, 2017). *'Theory-building research seeks to test, improve, and extend a particular theory by comparing it and reconciling it with observations, working towards a unified best account within the domain of the theory'* (Stiles, 2015, p. 159).

Recently, this theory-building case study approach has been applied in two case studies of psychoanalytic psychotherapy with patients with obsessional symptoms (Cornelis *et al.*, 2017a; 2017b). These studies resulted in a refinement of Blatt's two-polarity model of personality in relation to introjective psychopathology (obsessional symptoms in particular). In line with the Blatt's model, close associations were observed between the patients' obsessional symptoms and their interpersonal tendency towards self-definition, as well as between therapist interventions focusing on interpersonal conflicts and symptomatic alterations. Contrary to the predicted predominance of the tendency towards self-definition, the patients' obsessions proved to be embedded within profound ambivalences between tendencies towards interpersonal relatedness and self-definition.

The present study is an extension of Blatt's model to a form of psychopathology that previously hasn't been associated with the model: DID. Based on Meganck's (2017) work, we postulate the following predictions with respect to the association between psychopathology and personality in the present case study:

H1: At the start of therapy, we expect dissociative symptoms to be accompanied by a tendency to interpersonal relatedness.

H1a: Quantitatively, we expect the patient will show an overall higher dependent than autonomous sub-profile on the Inventory of Interpersonal Problems (IIP-32; Desmet, Meganck, & Vanheule, 2013).

H1b: Qualitatively, we expect the following dependent core conflictual relationship theme (CCRT)-components (Luborsky & Crits-Cristoph, 1998, pp. 46-48) to underpin the patient's relational exchanges: 'Wishes' to be respected, liked, dependent, close, have trust, help, be helped, avoid rejection, not be hurt; a particular sensitivity to the following 'Responses of Other': distant, not accepting, hurting, not trustworthy, not cooperative, and disliking the subject; triggering the following 'Responses of Self': feel dependent, uncertain, disappointed, angry, depressed, unloved, anxious.

Given the fact that psychopathology is rooted in personality functioning (Blatt *et al.*, 2001), psychotherapeutic interventions that focus on underlying personality transformation are hypothesized to bring about symptomatic alterations:

H2: Throughout the therapeutic process, we expect supportive-expressive therapy to reduce exaggerated strivings towards interpersonal closeness, and dissociative symptoms to diminish.

H2a: Quantitatively, we expect that scores on the IIP-32 will decrease progressively throughout therapy, and that decreasing IIP-scores will be correlated with declining scores on symptomatic and general ill-being.

H2b: Qualitatively, we expect that changes in the dependent CCRT's throughout therapy (particularly in the RO- and RS- components, *e.g.*, Grenyer & Luborsky, 1996) will be accompanied by changes in dissociative symptoms.

Methods

This study adopts a case study approach in which a phenomenon of interest is investigated within its real-world context. This approach is particularly useful when studying complex phenomena with no clear boundaries between the phenomenon of interest and the context in which they appear (Yin, 2014). In this study, the phenomenon of DID is studied within the context of a patient who underwent psychoanalytic psychotherapy. In contrast to a clinical case study, we rely on a systematic case study approach in which data were gathered from different sources and a research team was involved in the analysis of the

data (Willemsen *et al.*, 2017). The current study is set up as a theory-building case study that aims to test whether Blatt's two-polarity model of personality can be extended to DID (Stiles, 2017).

Participants

The patient, referred to as James in this paper, was a 23-year old (at the time therapy started) Caucasian man who suffered from periodic episodes of dissociation, during which he engaged in actions that were out of character and of which he had no memory afterwards. His childhood was marked by verbal and physical aggression from his father towards him and his older brother. He was a secondary school graduate and worked as a salesman in IT business. At intake, he met *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (American Psychiatric Association, 2013) criteria of dissociative identity disorder and posttraumatic stress disorder (no personality disorder was diagnosed). The patient was selected from a larger Single Case Study research project at the Department of Psychoanalysis and Clinical Consulting at Ghent University (Belgium). In this project, naturalistic data are gathered for the purpose of doing psychotherapy process research at the level of single cases. The current patient was selected because the therapy process provided rich data in relation to interpersonal functioning, allowing us to code the CCRT on the basis of the session transcripts. This patient has been the subject of a previously published manuscript which focused on interpersonal functioning (Van Nieuwenhove, Meganck, Cornelis, & Desmet, 2018). The current paper investigates a different research question and relies on more extensive data.

The therapist was a 30-year old (at the time therapy started) Caucasian man who holds a PhD in clinical psychology, received three-year postgraduate training in Freudian-Lacanian psychoanalytic psychotherapy, and had four years of clinical experience at the start of therapy.

The research team that carried out the data-analyses consisted of two assistant professors (one male, one female), two postdoctoral researchers (one male, one female), and two female PhD students. They were all trained in or training in Freudian-Lacanian psychoanalytic psychotherapy. All research members were Caucasian and were between 24 and 35 years old.

Therapy

The patient received 41 (40- to 60-minute) sessions of supportive-expressive psychoanalytic psychotherapy (Luborsky, 1984) over 11 months, conducted in the therapist's private practice without interference of the research team. Session frequency varied between twice a week and once every three weeks (towards the end of treatment) with an average frequency of once a week. In accordance with Luborsky's manual (1984), the therapist used both supportive and expressive interventions. The therapist

used these techniques in response to the spontaneous material brought up by the patient, showing the explorative rather than directive nature of the treatment approach. Supportive interventions aim towards fostering a good working alliance. Supportive interventions can vary depending on the amount of support the patient needs at a specific moment in treatment. Expressive techniques focus on identifying, interpreting, and working through of unresolved conflicts. The focus is on the central relationship pattern (core conflictual relationship theme) and understanding symptoms within this relational context.

Measures

Symptoms and general well-being

The *General health questionnaire - 12* (GHQ-12) (Koeter & Ormel, 1991) is a 12-item self-report questionnaire used to assess general psychological distress. Items are scored using a 4-point Likert scale. The GHQ's validity and reliability was demonstrated by Koeter and Ormel (1991), and by Vanheule and Bogaerts (2005) for the Dutch version.

The *Symptom checklist-90-revised* (SCL-90-R) (Derogatis, Lipman, & Covi, 1973) is a 90-item self-report questionnaire assessing general psychological and physical functioning with good psychometric qualities (Derogatis, 1994). Items are scored on a 5-point Likert scale.

The *Global assessment of functioning* (GAF) scale (APA, 1987) is a widely used clinician- or researcher rated measure of psychiatric symptom severity and functioning on a psychological, social and occupational level. The scale can be used to track clinical progress of individual patients in global terms. The overall GAF scale scores range from 0 to 100 and are divided into ten deciles of functioning. GAF rating involves selecting one single decile that best reflects the patient's overall level of functioning at the time of evaluation.

Saliva stress hormone levels: concentrations of cortisol ($\mu\text{g/dL}$) were measured in saliva samples by means of mass-spectrometry. At different time points during therapy (see Procedure below), a series of saliva samples was gathered, following the standard practice in salivary hormone research (Kirschbaum, Bartussek, & Strasburger, 1992). Cortisol - popularly termed 'the stress hormone' - is considered a biomarker of an activated stress response. It plays a key role in numerous models that link (chronic) stressors to psychiatric as well as medical disease (Miller, Chen, & Zhou, 2007).

Health care costs: via the patient's health insurance fund all health care costs were retrieved, spanning a period from four years before treatment onset until 3 years and 4 months after completion of treatment. Costs include medication use (*i.e.*, psychotropic and other), medical consultations (ambulant and residential, excluding the psychotherapy sessions discussed in this paper) and job absenteeism.

Semi-structured change interview (SCI) (Elliott, 1999;

Elliott, Slatick, & Urman, 2001) is an in-depth qualitative outcome interview to assess the way the patient experienced the therapeutic process. It was administered by a researcher at follow-up (3 years and 4 months after completion of treatment). The patient is asked about what changes occurred during therapy, the processes that might have brought about these changes, whether any of the changes were surprising to him/her, and what aspects of the therapy he/she experienced as helpful, difficult, hindering, or missing.

Interpersonal functioning

The *Inventory of interpersonal problems - 32* (IIP-32) (Horowitz, Alden, Wiggins, & Pincus, 2000) is a 32-item self-report questionnaire with eight subscales reflecting different interpersonal problems. Items are scored on a 5-point Likert scale. Psychometric properties of the Dutch version were positively evaluated by Vanheule, Desmet, & Rosseel (2006).

Core conflictual relationships theme method (CCRT) method (Luborsky & Crits-Christoph, 1998) is a qualitative, systematized and reliable measure of the central relationship patterns that pervade social relations (Wilczek, Weinryb, Barber, Gustavsson, Asberg, 2000). The method is based on the theory that a subject's relational exchanges are generally underpinned by a typical 'core conflict', which consists of three major components: i) the 'Wishes' (W) with which the subject enters relational exchanges; ii) the subject's appraisal of how the other person reacts to these wishes ('Responses of Other', RO); iii) his/her own reactions to these ROs ('Responses of Self', RS) (Luborsky & Crits-Christoph, 1998). These components can be coded on the basis of discrete episodes in the patient's narrative in which the patient spontaneously speaks about concrete relational exchanges (*i.e.*, 'Relationship Episodes' or RE's). The most typical W's, RO's and RS's constitute the final CCRT-formulation.

Procedure

Data were collected in the following way: i) therapy sessions were audiotaped by the therapist, and transcribed verbatim by graduate students; ii) after every session the patient completed GHQ-12 and IIP-32 questionnaires in the therapy room in the presence of the therapist; iii) after the first session, after every eighth session, and at follow-up (*i.e.*, 3 years and 4 months after treatment termination) iii-a) patient completed a more extensive set of questionnaires at home (*i.e.*, GHQ-12, IIP-32, SCL-90) and provided a set of 8 saliva samples (gathered on 4 consecutive days prior to the day questionnaires were filled out; one morning and one evening sample each day), and iii-b) GAF-scores were administered by a research team member; iv) at follow up, SCI was administered by a research team member, and health care cost information was retrieved. This procedure has been applied in other theory-building case studies involving patients with obsessional

complaints (Cornelis *et al.*, 2017a; 2017b). CCRT has been used in case study research by Oasi *et al.* (2017).

Data analysis

All outcome measures for symptoms, general well-being and interpersonal functioning were plotted in order to visualize the patient's evolution throughout therapy. The ACORN Toolkit (specifically designed to help clinicians and researchers calculate change related statistics for a variety of outcome measures; Brown, Simon, Cameron, & Minami, 2015) was used to calculate reliable change indices (RCI) (identical to RCI formula of Jacobson and Truax, 1991, but with one-tailed 95% confidence intervals; see Brown *et al.*, 2015) and severity adjusted effect sizes (SAES) (Brown *et al.*, 2015). Longitudinal intra-subject associations (*i.e.*, correlations between two series of repeated measures within the same subject) between the patient's symptomatic, general and interpersonal level of functioning were calculated.

For the qualitative data analysis, consensual qualitative research for case studies (CQR-c) (Jackson, Chui, & Hill, 2011) was applied as an overarching data-analytic approach. Two research team members (first and fourth author) attentively listened to audiotapes and read the transcripts. Both were equally informed of relevant patient demographic information and therapy characteristics (Hill, 2012), but author 4 was blind to the quantitative measures. Both researchers separately identified all events where the patient explicitly referred to his symptoms, and marked symptomatic evolutions throughout therapy with respect to intensity, content or form. In case of divergence, members engaged in discussions in which they questioned each other on their ideas, so that every opinion was fully expressed and understood until both members agreed on the best representation of the data (Jackson *et al.*, 2011). A concise qualitative description of symptomatic evolutions was provided by author 1, reviewed by the third author (familiar with the raw narrative data), and consequently refined.

Next, author 1 and 4 conducted CCRT analyses for the first therapy sessions, the sessions in the middle, and the last sessions. In a first step, both researchers attentively re-read transcripts of the identified sessions, individually selected all RE's that were suitable for CCRT coding (*i.e.*, RE's that contained W's, RO's and RS's), and then met to select by consensus the most informative RE's. In a second phase, selected RE's were then written down in a separate document and coded using the standardized coding system (Standard Category List, Edition 2; Luborsky & Crits-Christoph, 1998, p. 26). The researchers strived towards consensus on identified RE's and CCRT-codes of identified RE's. In case of divergence, researchers engaged in extensive discussions, and gradually refined initial ratings until consensus codes were reached (Hill, 2012). Judges' proportions of agreement (RE's: 0.93, W's: 0.80, RO's: 0.89, RS's: 0.70) indicated high correspondence for initial ratings.

Next, the first author engaged in a 'thick description' (Pontoretto & Grieger, 2007) of the longitudinal, clinical interplay between both levels throughout therapy, in which changes in quantitative measures were linked to the treatment narrative (Dattilio, Edwards, & Fishman, 2010) and significant therapist interventions and extra-therapeutic events were discussed. Several precautions were taken to reduce the researcher's biases and expectations and to present a 'truer' account of the data (Hill, 2012): prior to writing, the first author orally presented provisional analyses to members of the research team, who extensively questioned her in order to focus findings more clearly in response to research questions; during the writing process, the first author continually returned to raw materials to stay close to the patient's narratives, and included sufficient detail and literal quotes of the patient to validate presented findings. The therapist was not involved in the analysis of the data.

Results

Narrative account of the course of the treatment

Following one year of couple therapy with his girlfriend Rebecca in 2008, James was referred in 2010 for individual treatment owing to dissociative episodes during which he had cheated on his girlfriend and bought expensive IT equipment. He had no memory of these episodes, but his girlfriend confronted him with indisputable evidence. Despair about the end of his relationship with Rebecca, combined with intense feelings of uncertainty, confusion and instability had mobilized suicidal ideas. He hated himself for what he had done during the dissociative episodes and was frightened he would keep dissociating uncontrollably for the rest of his life.

During therapy, changes took place in James' coping with past dissociative episodes, which were no longer the central focus of discussion from session 2 onwards. Dominant themes were instead: profound feelings of abandonment, imbalance and worthlessness that monopolized his inner world. Up to session 12, James reported declining occupational functioning, intense sleeping problems, neglect of self-care (*e.g.*, barely eating, bathing or dressing properly), loss of energy, and limited social engagement (*i.e.*, restricted to desperate attempts to 'get Rebecca back'). Only the concern shown by colleagues towards him incited him to get up in the mornings. During sessions 7, 9, 10 and 11, he described temporary, minor upsurges in his well-being and renewed (though feeble) feelings of 'having more grip on what is happening'. In session 12, however, the news that Rebecca had already engaged in a new romantic relationship put him off balance again and briefly revived suicidal ideas. Yet, as depicted in Figure 1, his state ameliorated again between sessions 13-20: he rebuilt former friendships, started going out again, slept better, increasingly took care of himself, regained the 'drive to move on and make something of my life', set

new occupational and personal ambitions (*e.g.*, resuming the studies he had interrupted in college), and experienced novel feelings of 'inner calm' and 'maturity'. However, in session 18, numerous enjoyable contacts with his former 'soul mate' Holly incited feelings of 'guilt' and 'confusion' (since 'it is a completely different, unprecedented type of feeling good'). Then, during the week preceding session 20 (*i.e.*, *tipping point* session), James made a (failed) suicide attempt after the umpteenth rejection of Rebecca. His initial disappointment of having been unsuccessful, however, soon made room for remarkable positive changes in his general and interpersonal well-being that remained stable until follow-up. He engaged in a romantic relationship with Holly, widened his social network, increasingly described novel feelings of happiness, purposiveness, energy, calm and self-worth, no longer suffered from head-aches, successfully passed examinations at work, and progressively started to remember significant childhood events.

Though most childhood memories remained blank and clear images of what had happened during the dissociative episodes did not recur during therapy, James' stance towards these gaps had changed considerably: 'I used to have a hard time accepting what has happened, but now I can peacefully embrace the way things have turned out'. His fear that dissociations would frequently and uncontrollably reoccur throughout his life similarly vanished. After contentedly declaring that 'everything is falling into place,' a new appointment was scheduled, but James did not show up anymore. During the follow-up interview three and a half years later, he confirmed that he was doing very well, that no new dissociative episodes had occurred, and that he had 'a much more mature manner of dealing with things'.

Instrumental evaluation of outcome

Figure 1 shows an overall decreasing trend over the course of therapy in *self-reported* general psychological and physical malfunctioning (GHQ-12 and SCL-90

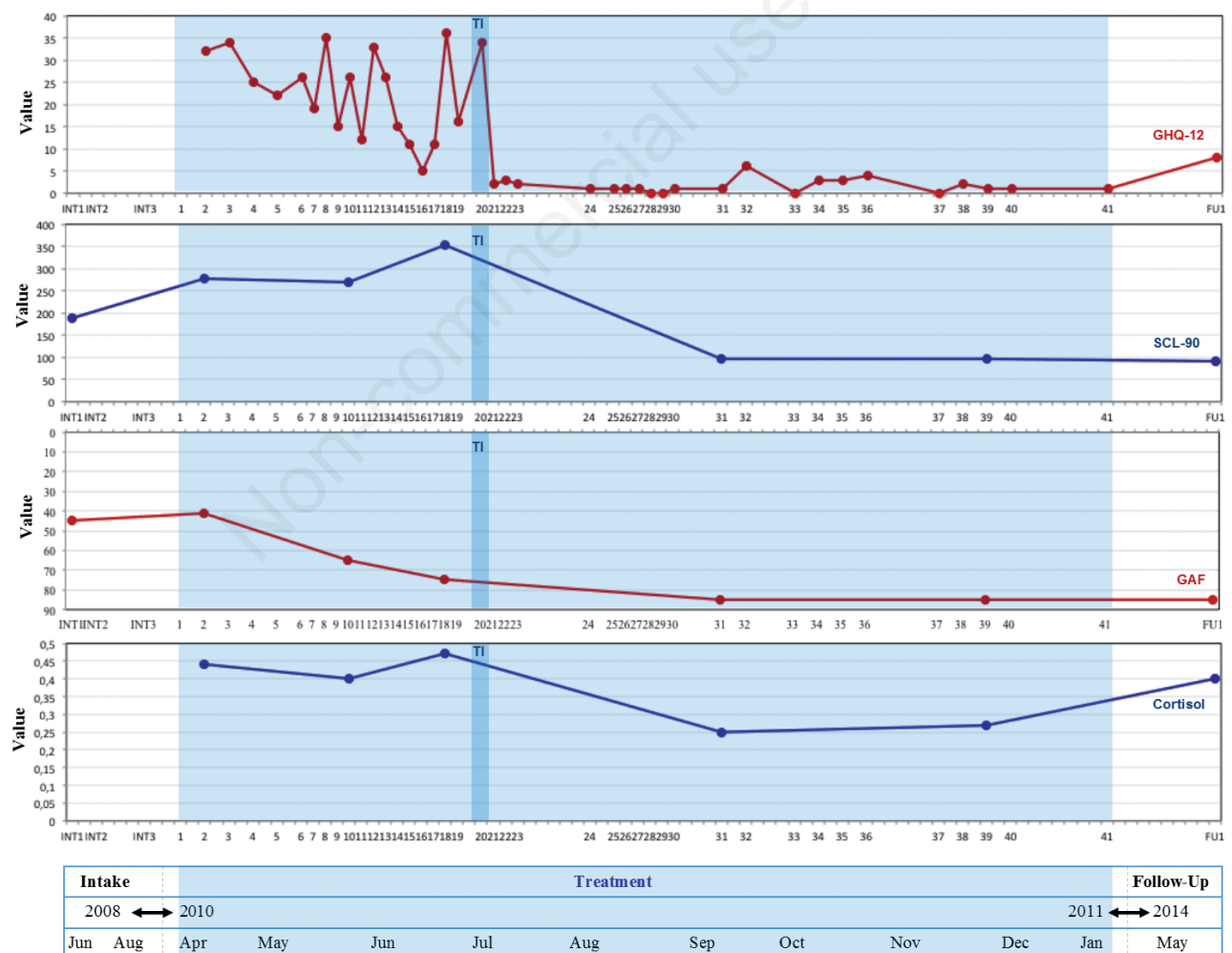


Figure 1. Evolutions in patient- and researcher-rated well-being and saliva cortisol concentrations from intake to follow-up. GHQ-12, general health questionnaire-12; SCL-90, symptom checklist-90-revised; GAF, global assessment of functioning; TI, tipping point session; Cortisol values: $\mu\text{g/dL}$.

scores), in *researcher-rated* psychological, social and occupational ill-being (GAF-scores), and in *biological* cortisol concentrations. Decreases in self-reports reached significance when assessed by means of RCI, both at treatment termination (GHQ-12: RCI= -14.60, $P<0.05$; SCL-90: RCI= -11.99, $P<0.05$), and at follow-up (GHQ-12: RCI= -11.30, $P<0.05$; SCL-90: RCI= -12.33, $P<0.05$). In addition, large SAES were observed at treatment termination (GHQ-12: $d=8.76$; SCL-90: $d=2.94$) and at follow-up (GHQ-12: $d=6.78$; SCL-90: $d=3.02$). Changes are maintained at follow-up, yet, cortisol concentrations rise again to early-treatment levels, and GHQ-12 scores slightly increase (but still coincide with a large effect size).

Figure 2 depicts a variety of health care costs made in a period spanning about eight years. The first peak (December 2007) reflects costs due to dentist consultations. The second peak (December 2010) reflects expenses due to the two-day hospitalization after the patient's suicide attempt (*i.e.*, between sessions 19-20). The last peak period (June 2012 - January 2013) refers to costs of multiple medical analyses performed on the patient's daughter (thus, not reflecting his individual health care usage). There were no periods of job absenteeism due to a physical or psychological condition.

In terms of average health care costs per month, costs were highest during the treatment period (€91/month; owing to the above-mentioned peak in costs related to the patient's suicide attempt), compared to pre-treatment (€22/month) and post-treatment (€51/month; reflecting his daughter's health care usage).

Hypothesis 1a: the patient will show an overall higher dependent than autonomous sub-profile on the IIP-32

At the start of treatment, James had a score of 49 on the IIP-32, which is above average. His score on the dependent sub-profile (26) was much higher than his score on the autonomous sub-profile (6). He scored highest on IIP-32 subscales 'Nonassertive' (12) which suggests that he has significant lack of self-confidence in interactions. Further, he scores above average on the subscale 'Overly Accommodating' (9), indicating he would go to great lengths to please other people. These results confirm our hypothesis H1a that James showed an overall higher dependent than autonomous sub-profile on the IIP-32.

Hypothesis 1b: dependent core conflictual relationship theme-components will underpin the patient's relationship episodes

Table 1 contains CCRT's from the first three therapy sessions. The Wishes, Responses of Others and Responses of Self that are consistent with Hypothesis 1b are underlined. In accordance with Hypothesis 1b, we found five out of nine expected Wishes: be respected, be close, help, be helped and not be hurt. If we sum together the instances where one of these five Wishes appear, we find that 18 out of a total of 22 Wishes expressed in the RE's are consistent with Hypothesis 1b. This means that James' Wishes in relationships are consistent with the pattern we predicted in our hypothesis.

In accordance with Hypothesis 1b, we found two out of six expected Responses of Other: distant and not trust-

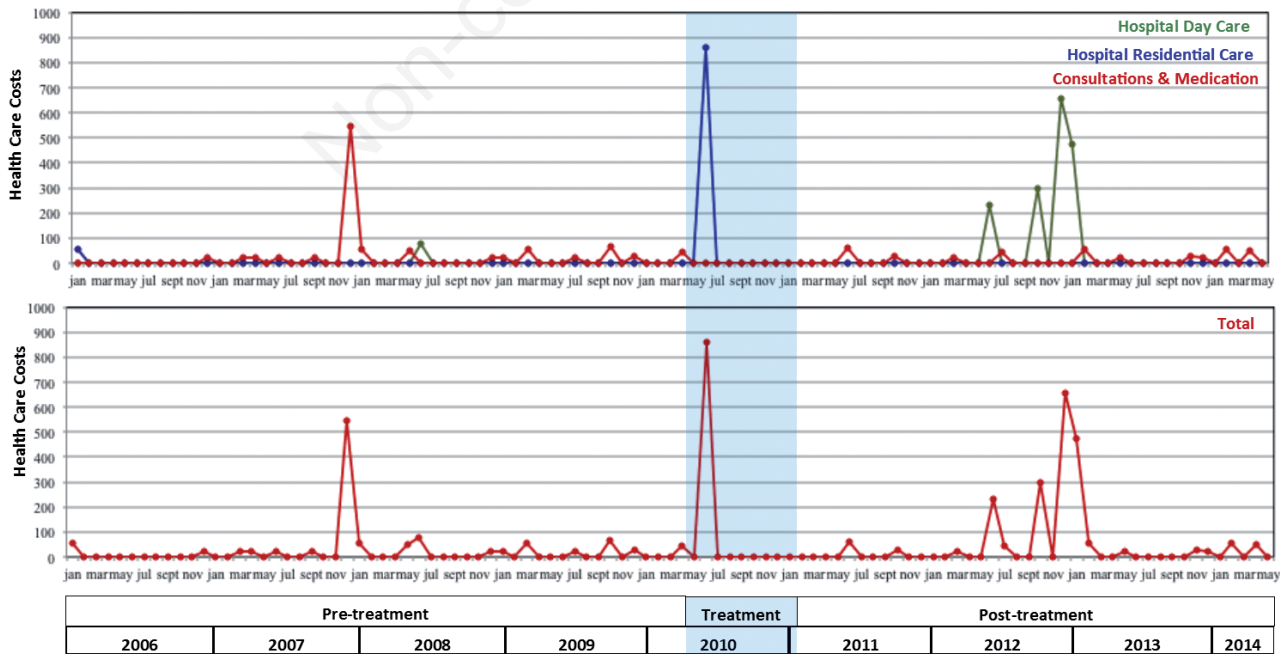


Figure 2. Evolutions in patient's health care costs (euro) from four years before onset of treatment until follow-up.

worthy. If we look at the number of instances in which these two RO's appear, we find that 9 out of a total of 20 instances are consistent with Hypothesis 1b. This means that the RO's described by James in the RE's are partially consistent with our hypothesis.

In accordance with Hypothesis 1b, we found seven out of seven expected Responses of Self: feel disappointed, dependent, unloved, depressed, angry. These RS's amount to a total of 22 instances on a total of 26 instances of RS's. All the negative RS's are consistent with our hypothesis. This means that James' RS's are in line with our prediction.

Hypothesis 2a: scores on the IIP-32 will decrease progressively throughout therapy, and this decrease will be correlated with declining scores on symptomatic and general ill-being

In accordance with Hypothesis 2a, we found a generally descending trend in IIP-32 scores throughout therapy and during follow-up (see Figure 3), which reaches significance when assessed by means of the Reliable Change Index (at treatment end: $RCI = -9.47$, $P < 0.05$; at follow-up: $RCI = -8.65$, $P < 0.05$) and corresponds with large severity adjusted effect sizes (at treatment end: $d = 3.79$; at follow-up: $d = 3.46$).

Table 1. Patient's wishes, responses of other, and responses of self throughout therapy.

	#	W	RO	RS
Session 1-3	9	<u>Be respected</u> (6), <u>be close to others</u> (5), <u>be loved</u> (4), <u>help others</u> (3), <u>not be hurt</u> (2), <u>be helped</u> (2)	Negative: Rejecting (6), <u>distant</u> (6), <u>not trustworthy</u> (3), not understanding (3), don't respect me (2)	Negative: <u>disappointed</u> (7), <u>dependent</u> (5), <u>unloved</u> (4), <u>depressed</u> (4), <u>angry</u> (2) Positive: understanding (2), helpful(2)
Session 20-22	10	<u>Be respected</u> (7), <u>be close to others</u> (7), <u>be liked</u> (4), to be understood (2)	Negative: anxious (3), <u>not trustworthy</u> (2) Positive: respects me (7), helpful (4), accepting (3), likes me (3), open (3), loves me (3), understanding (2), gives me independence (2), happy (2)	Negative: <u>uncertain</u> (4), <u>disappointed</u> (3) Positive: respected (6), comfortable (6), loved (6), happy (4), independent (4), accepted (3), open (3), helpful (2)
Session 37-41	10	<u>Be respected</u> (10), <u>be close to others</u> (6), be opened up to (5), to assert myself (4), have control over others (3), respect others (2), <u>be liked</u> (2), <u>help others</u> (2)	Negative: don't respect me (4), opposing (3), don't trust me (2), <u>distant</u> (2), out of control (2), bad (2) Positive: open (5), understanding (4), respect me (4), accepting (3), like me (3), cooperative (3), give me independence (2), dependent (2)	Negative: <u>disappointed</u> (3), <u>angry</u> (3) Positive: self-confident (5), respected (4), open (4), comfortable (4), self-controlled (3), accepted (2), likes others (2), helpful (2), controlling (2), happy (2), loved (2)

#, Number of relationship episodes; W, wish; RO, response of other; RS, response of self; dependent W's, RO's, RS's specified in Hypothesis 1b are underlined; (x) amount of REs in which the conflictual relationship theme component occurs.

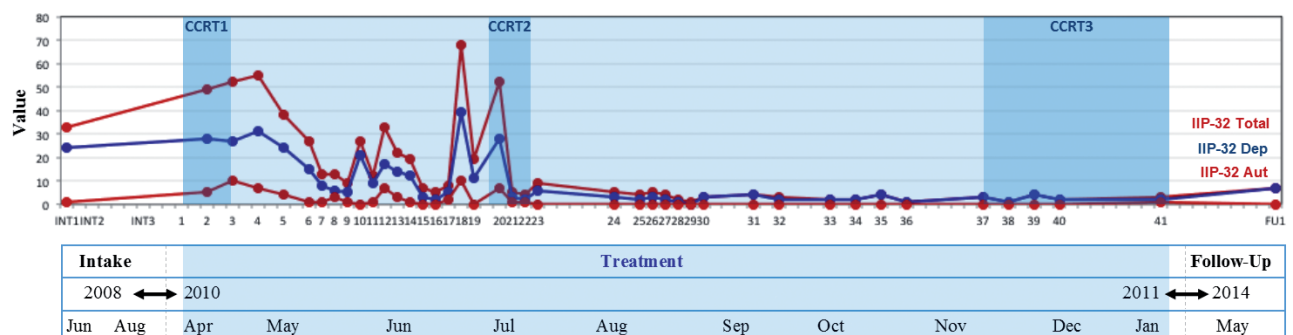


Figure 3. Evolutions in patient-reported interpersonal problems from intake to follow-up. IIP-32 Total, inventory of interpersonal problems-32 total scores; IIP-32 Dep, inventory of interpersonal problems-32 subscores dependency; IIP-32 Aut, inventory of interpersonal problems-32 subscores autonomy; CCRT1, conflictual relationship theme codings of first three sessions; CCRT2, conflictual relationship theme codings of tipping point sessions; CCRT3, conflictual relationship theme codings of last five sessions.

Also in accordance with Hypothesis 2a, longitudinal intra-subject correlations between IIP-32- scores on the one hand, and GHQ-12-, SCL-90-, GAF- and cortisol values, on the other hand, document positive, high associations between the patient's interpersonal dynamics and his symptomatic and general well-being ($r=0.87$ with GHQ-12, $P<0.01$; $r=0.95$ with SCL-90, $P<0.01$; $r=-0.56$ with GAF, ns ; $r=0.83$ with cortisol, $P<0.05$).

Hypothesis 2b: changes in the dependent core conflictual relationship theme's throughout therapy will be accompanied by changes in dissociative symptoms

Table 1 summarizes the CCRT's for the begin, middle and end of the treatment. With regard to Wishes, we find little change from beginning to end of treatment. In the beginning of treatment, we find 5 different dependent CCRT's, in the middle of treatment we find 3 different dependent CCRT's, and at the end we find 4 different CCRT's. If we look at the number of instances, we actually see an increase: from 18 dependent CCRT's in the beginning to 20 at the end of treatment. At the same time, however we can also point out that many non-dependent Wishes appear at the end of treatment while these were almost absent at the beginning and middle of treatment. When we look at the RO's and RS's, we see a considerable evolution, in the sense that dependent RO's and RS's change from being very present at the beginning of treatment to being only marginally present at the end of treatment, both in terms of variety and total number of instances.

We will now discuss key moments in the therapy process, in order to clarify how changes in interpersonal relations were accompanied by changes in the dissociative symptoms. In reference to Luborsky's (1984) manual of supportive-expressive therapy, concrete therapeutic interventions are italicized and designated as 'expressive technique' (ET) or 'supportive technique' (ST), including the related manual page.

The patient had contacted the therapist in a state of despair, intense confusion ('I cannot even trust myself anymore'), and fear that he would uncontrollably 'keep on dissociating'. During the intake sessions, the therapist mainly *asked James to concretize and elaborate on his disclosures* (ST, p. 87, p. 89). As such, James also explained about troubles concerning longstanding 'gaps' in his memory about childhood events prior to the age of fifteen. *Asked to expand on this subject* (ST, p. 87, p. 89), he immediately linked these gaps to 'early incidents at home' that he had 'repressed'. Based on a few, vivid memories of seeing his older brother being harshly punished by his 'physically aggressive father', school psychologists had once suggested that the voids in James' memory had probably been due to 'abuse'. This had soon become a burning mystery that troubled him and hampered him in his relationship with his father. James painfully disclosed he had

'never really known why my brother had been punished so harshly by my father,' as the reason had always been kept secret by his strict, short-spoken father. 'Feelings or emotional stuff' had never been discussed in his family. His mother (who worshipped his father) had always turned a blind eye and had shrugged off her children's retorts of indignation by airily justifying that 'he must have had his reasons'. To fill this lack of explanation, James had ascribed these cruel punishments to his brother's disappointing school results.

As the therapist next picked up on the newly raised theme (ET, p. 94, p. 97, p. 114; ST, p. 87, p. 89) of aggression during former fights with Rebecca, and *inquired about determinants for James' behavior* (ST, p. 87; ET, p. 114, p. 131), while *marking the contrast* with a series of previous examples that revealed his overall compliant nature towards others (ET, p. 110, p. 114, p. 121), James disclosed deep-rooted feelings of 'being a failure' and 'not being good enough'. He claimed that these feelings were rooted in former parental reactions of harsh rejection, and were triggered by Rebecca's remarks on his housekeeping abilities. When the subject next landed on Rebecca's longstanding absence of sexual desire, and the lack of sexual activity between them, the therapist *inquired whether this had also incited anger or frustration in him* (ET, p. 94, p. 114). James replied halfheartedly that he had 'wanted to be angry, but couldn't,' as 'she had not behaved like that on purpose' (i.e., 'she couldn't really help it'). *As the therapist suggested that* (ET, p. 114, p. 121; ST, p. 82) 'unexpressed anger often finds another way out', James assented and immediately added a second reason that had motivated him to refrain his anger: 'out of fear that she would otherwise leave me'.

Whereas James initially linked his dissociative episode to 'distress' following a car accident in the preceding week, *therapeutic incentives to illuminate the surrounding context* (ET, p. 121; session 1) revealed how the dissociation had taken place 'during the period Rebecca had increasingly started to go out, in the company of other men, leaving me all alone at the house'. Whenever he had prudently tried to discuss his resulting frustrations with her, he had hit a solid wall. *Asked about his parents' habitual openness to discussion* (ET, p. 110, p. 118; session 2), James remembered that his 'father's word had always been the law' ('without any room for discussion'), and his mother had always obeyed the latter in admiration, without ever sticking up for her children. 'The only thing I was ever allowed to do at home, was to follow orders, which I did, but with a head that was boiling with suppressed anger'.

James entered session 6 with the statement that he had suddenly remembered an earlier episode of dissociation during the relationship with his ex-girlfriend Patricia. She had also found chats between him and another woman (though not sexually explicit and without actual adultery). During that period, he 'had spent money like water',

which had incited Patricia to closely monitor his financial expenses. *As the therapist pointed to the similarity with Rebecca's financially controlling behavior*, and further inquired whether his parents used to control his expenses (ET, p. 94, p. 118, p. 131; ST, p. 89), James revealed he had 'always bought stuff behind their back'. James had never been allowed to take on a student job. Consequently, James had never had any money to spend while going out with friends. *Encouraged by the therapist to elaborate on this theme of restriction* (ST, p. 87, p. 89; ET, p. 94), James told that sexuality as well had been taboo. Talking about it 'had completely been out of the question', and the television screen had always been hastily covered up each time a sexual interaction ('so much as a little kiss') had been displayed. *As the therapist punctuated the tight financial and sexual restrictions, installed by his parents and former partners as a common denominator* in James' recited examples (ET, p. 110, p. 118, p. 131; ST, p. 89), James acknowledged interestedly. Upon further inquiry into his habitual reactions to this restricting behavior (ET, p. 110, p. 118; session 7), James admitted his repeated 'refusal to simply obey their rules', 'since they would have taken that for granted'. He continued by saying that his early experiences of injustice had motivated him later on to help vulnerable people (motivating his choice to study occupational therapy).

In session 11, James declared with surprise that memories 'I used to have no recollection of' were 'suddenly coming back', stimulated by renewed contacts with old friends. In other words, besides therapeutic work during sessions, James also applied himself diligently to the effort of 'working through' between sessions. *Asked to concretize* (ST, p. 87, p. 89; ET, p. 94), he recalled online conversations with a female friend to whom he had 'spoken ill of Rebecca' during the period she had stubbornly deprived him of sexual interaction. Stressing his experience of a *supportive alliance*, he pronounced himself pleased with 'the progress we have made thus far' and reported feeling increasingly less fearful about future dissociations. This is reflected in his lowest score since the onset of treatment on GHQ-12, SCL-90, GAF, and IIP-32 (see Figures 1 and 3).

In session 15, he declared (in a notably calmer way than before) that his 'dissociative episode had probably been triggered by the dawning feeling that our relationship was drawing to a close anyway'. Increasingly acknowledging the dissociations as reactions to things that had been going wrong for a while in his relationship, he stated: 'Rebecca had started going out again with numerous male friends. The dissociation is not - as I used to think - connected to the car accident, but to the indignation and impotent rage I felt about her behavior'. *Next, drawing attention to James' recurrently declared desire to help others, the therapist prudently suggested a link with James' father's profession of physician* (ET, p. 94, p. 98, p. 114; ST, p. 89). James confirmed that he had 'al-

ways been very proud of and respectful towards'. Cracks started to appear in the longstanding image of his father as the inscrutable 'bogeyman', for James had recently got wind of 'my father's own brutal upbringing' that had 'not set a good example to him', and made 'a reasonable explanation - though not excuse - for why he ruled us with an iron hand'. Moreover, James narrated how his hitherto secretive mother had started 'to increasingly approach me as an adult' (i.e., 'confiding more in me') and how his father had become more accessible 'with old age'.

During the week preceding session 20, however, James' mother informed the therapist that James had made a suicide attempt, and currently resided in the hospital to recover from an overdose of tranquilizers. Thereupon, *the therapist phoned the patient at the hospital* (ST, p. 82), which was experienced by James as 'immensely beneficent'. *He repeatedly incited James to precisely describe the thoughts and feelings that had provoked his act* (ET, p. 97, p. 110, p. 114; ST, p. 87; session 20). James explained how Rebecca had failed to call him after the last session, how she had retorted his indignant reprimand by sending him the text message 'you are not the most important person in my life right now'. The feeling of 'no longer meaning anything to her' had made him so outraged and despaired that he attempted to take his life and, thereby, make her feel guilty. However, the worried and loving reactions of his parents, his friend Holly, and his colleagues made him 'so glad the suicide attempt had failed' and 'I suddenly realized there really are people who care about me'.

From session 21 onwards, James recurrently described feelings of inner calm, energy, balance and being loved (clearly reflected in stable, low ill-being scores in Figures 1 and 3). He started a romantic relationship with Holly. *Tying these disclosures up with the anger discussed in session 20* (ET, p. 94, p. 97, p. 114; ST, p. 87, p. 89), *the therapist recognized that 'something had changed in your aggression regulation'* (i.e., aggressive impulses had become more tolerable). James confirmed this by recounting a recent incidence in which his father had angrily stormed out of the house. 'For the first time ever, I had recognized myself in him. Now it is obvious where I got it from. I always said I did not want to be like my father, but apparently I already was'. He continued by reminiscing a (suddenly arisen) memory of his father calling him 'a wrapped up piece of shit' at the age of fifteen years, which 'had always had a great impact on the rest of my life'. *Further egged on* (ST, p. 87, p. 89; ET, p. 114), he proceeded by recalling numerous memories of his brother being punished by their father. He described how memories 'of my past' had gradually started to come back (i.e., images of how his parental home and grade school had looked like). In reply to the therapist's referral to previous remarks of James' mother's recent assumption of a more open stance towards him (ET, p. 94, p. 118; ST, p. 89; see session 15), James narrated how (upon persistent incite-

ment from his side, in marked contrast to his former defeated stance towards her secretiveness) she had recently revealed a crucial piece of information to him concerning the reason for these punishments. It turned out his brother's depressing school results had been 'the expression of his maladaptive life pattern, which consisted of drugs and male prostitution', and 'that was why they punished him and restricted me in going out with friends'. The acknowledgment of 'the impotence my father must have felt seeing this maladaptive behavior of one of his sons, for whom he had big plans' had steadily lessened his initial indignation and perplexity, and made him see the hard-handed parenting principles in a new light. *Upon referral to James' earlier phrasings concerning 'feelings of injustice' and 'desires to rise against it' (ET, p. 94, p. 118; ST, p. 89; see session 7), James disclosed in session 23 about the anger he had felt as a child seeing 'the unjust treatment' of the brother he had cared for. 'For he had been the one who had looked after me and nurtured me, as my parents had rarely been at home'.*

Throughout the rest of the therapy (sessions 24-41), James mainly talked about past, disappointing interactions with Rebecca, in contrast to current, enjoyable exchanges with Holly, old friends and his parents. He disengaged from making desperate attempts to regain Rebecca's love. While James reflected upon the changes that increasingly colored his life since his failed suicide attempt, *the therapist mainly assumed a supportive, incentivizing stance, helping to define general remarks more precisely, appraising therapeutic gains, pointing to recurring patterns or significant distinctions and helping James to integrate all discussed elements in a coherent, meaningful 'story' (ST, p. 87, p. 89; ET, p. 94, p. 114).*

In session 25, James admitted to 'no longer ponder over the dissociations' and appended that 'they were related to financial and sexual issues, which were precisely the points at which Rebecca was very restrictive, without any room for discussion. Rebecca had always been very dominant and controlling'. In addition to Holly's apparent enjoyment of his efforts to care for her (emotionally) and please her (sexually), the thing James most appreciated about her is 'the ability to talk openly about everything, which is the principal strength of our relationship. I have nothing to hide from her'. This resulted in increasing confidence that dissociations would not reoccur in his current, satisfying relationship. Then, *inquired after his former experiences during couple therapy (ST, p. 87, p. 89), James explained how he had been imposed to 'learn strategies to better comply with each other's needs' and ('now I come to think of it') how this had fanned the flames of (bottled-up) rage even more. Rebecca had started to consent to sexual contact, but 'with such distaste, it had felt like rape'. For him, wishes to please her, and enjoy these contacts together, had always prevailed upon mere satisfaction of erotic longings. The first dissociative episode had indeed occurred soon after.*

During the follow-up interview, James confirmed having maintained the earlier mentioned gains, reported professional satisfaction, and talked about Holly, their house and lovely children in a positive way. He added laughingly that they annually joined his parents to spend the summer holidays together, and how he 'would have never dreamed it possible before'. He claimed to be 'very grateful' towards the therapist, whom he had always experienced as very supportive.

Discussion and Conclusions

This theory building case study aimed to examine Blatt and colleagues' two-polarity model of personality (Blatt, 2008; Blatt *et al.*, 2001; Blatt & Zuroff, 1992) in a systematic case study of a patient suffering from DID. Building on the psychoanalytic perspective on dissociations as hysterical symptoms (Meganck, 2017), we hypothesized that DID would be associated with a tendency towards interpersonal relatedness (Hypothesis 1). We found that, indeed, James showed an overall higher dependent than autonomous sub-profile on the IIP-32 (Hypothesis 1a) and that most of his Wishes and Responses of Self (to a lesser extend also his Responses of Others) were consistent with a tendency towards interpersonal relatedness (Hypothesis 1b). Next, we hypothesized that supportive-expressive psychoanalytic psychotherapy would change this interpersonally-oriented personality profile and decrease the dissociative symptoms at the same time. We found that, indeed, the reduction in IIP-32 scores throughout therapy was strongly correlated with an increase in symptomatic and general well-being (Hypothesis 2a) and that the predominance of dependent Responses of Others and Responses of Self disappeared throughout the therapy (Hypothesis 2b). With regard to dependent Wishes, we find little change from beginning to end of treatment. We did find, however, that many non-dependent Wishes appear at the end of treatment while these were almost absent at the beginning and middle of treatment. The overall conclusion of this systematic case study is that DID is associated with the tendency towards interpersonal relatedness as defined in Blatt's two-polarity model of personality.

What are the clinical implications of this case study? The present case study draws attention to the clinical importance of *giving free rein* to the entire scope of a patients' *subjectivity*, in its various and often conflicting facets, when treating patients who suffer from dissociations (Meganck, 2017). A supportive therapeutic stance (Luborsky, 1984) in which one acknowledges the patient as an *essentially divided subject*, characterized by aggressive and sexual impulses that trigger shame and guilt (Verhaeghe, 2004), and helping him/her to *voice* conflicting experiences and urges, allows the patient to *reintegrate* ward off material into his/her subjective functioning. As formerly blocked psychic material progressively re-

circulates within (newly constructed) meaningful frameworks, it's frightening load diminishes. Whereas this holds in essence for all hysterical (and, in general, neurotic) symptoms, it pre-eminently pertains to dissociative phenomena, which can be viewed as 'exaggerated' attempts of disintegrating rejected material from conscious awareness. Tackling the symptom directly (as is common in mainstream health care) or 'cooperating' with the patient's 'good' ego in finding more adaptive (*i.e.*, less symptomatic) ways to defend against 'undesired' or anxiety provoking impulses (or identity layers or alters) entails the danger of reinforcing the patient in his current tendency of misrecognizing these essential parts of his personality (Meganck, 2017). This is clear from James' disclosures about previous couple therapy, during which he and his partner had learned strategies to conform more adaptively to each other's needs, while the structural determinants for their relational behavior remained (once again) untouched. This eventually culminated in his first dissociative episode (in marked contrast to the relief he felt by 'finally being allowed to speak about what truly matters to me' with the current therapist).

However, in this process of re-integrating rejected material into subjectivity, the question of whether or not these 'recalled memories' are 'true' (*i.e.*, actually happened), seems, from a *clinical* point of view, *irrelevant* (Merskey, 1995, p. 329). The main therapy goal should not be to recover 'lost' memories into a presumed 'unitary' self, but to allow the subject to construct new (*i.e.*, less 'forced'/symptomatic, more flexible/'freely chosen') means of functioning (*i.e.*, not 'Is it true?', but 'Is it effective?' and 'Is it meaningful?'). In this respect, clinicians should also be careful in their response to disclosures of traumatic experiences during childhood. In the case of James, it is clear that a suggestion, made by a school psychologist, about possible (verbal and physical, possibly sexual) abuse had seriously troubled the patient and had hampered his contacts with his father (see also 'false memory syndrome', *e.g.*, Merskey, 1995, p.329; Verhaeghe, 2004).

Limitations

In an effort to test whether DID is underpinned by a tendency to interpersonal relatedness as defined by Blatt, we conducted a systematic case study. There are several limitations to this approach. The research took place in a naturalistic setting and all treatment decision were made by the therapist. As a consequence, the results might be less reliable. Second, the length of the treatment creates opportunities for multiple causes, both from inside and outside of the therapy, to influence the process. Therefore, we need to be cautious when drawing a conclusion about the causal link between the supportive-expressive interventions and the treatment effects (hypothesis 2). Finally, as in any case study research, the generalizability of our findings to broader populations of patients with dissociation or hysterical

symptoms is limited. Therefore, it would be valuable to contrast our results to findings from other (single/multiple) case studies (from psychodynamic or other perspectives) or to explore the possibility of comparing and synthesizing case studies (Willemssen *et al.*, 2015).

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