DYNAMIC THERAPIES FOR PSYCHIATRIC DISORDERS

Psychodynamic Psychotherapy of *Multiple Personality* Disorder and Allied Forms of *Dissociative Disorder* Not Otherwise Specified

Richard R Kluft

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Richard R Kluft

HISTORY AND DEVELOPMENT

Clinical psychoanalysis begins with the *Studies on Hysteria* (Breuer & Freud, 1893-95/1955). The first case in that work is that of Fraulein Anna O. In the words of Ernest Jones (1953), Freud's preeminent biographer:

> More interesting, however, was the presence of two distinct states of consciousness: one a fairly normal one, the other that of a naughty and troublesome child, rather like Morton Prince's famous case of Sally Beauchamps. It was a case of double personality. The transition from one to the other was marked by a phase of autohypnosis from which she would awake clear and mentally normal. This phase happened by luck to be the time when Breuer visited her. (p. 223)

Thus began the uneasy, uncomfortable, and often mutually avoidant relationship between psychoanalytic thinking and the study of multiple personality disorder (MPD). It is ironic that as Freud developed the concept of repression and made it a cornerstone of psychoanalytic thinking, both clinical and theoretical, he distanced himself from the importance both he and Breuer had accorded to dissociation, hypnosis, and the use of MPD as a paradigmatic

condition for the understanding of mental structure and function. In their 1893 paper on the mechanism of hysterical phenomena, they wrote:

> The longer we have been occupied with these phenomena the more we have become convinced that the splitting of consciousness which is so striking in the well-known classical cases under the form of "double consciousness" is present to a rudimentary degree in every hysteria, and that a tendency to such a dissociation, and with it the emergence of abnormal states of consciousness (which we will bring together under the term "hypnoid") is the basic phenomenon of this neurosis, (p. 12)

They further noted that a susceptibility to altered states, severe exogenous trauma, and massive suppression was an etiological factor.

However, as Freud found his own voice and metapsychology, he left behind his interest in dissociation and dissociative phenomena. He came into conflict with Janet, the master scholar of dissociative conditions, and later Jung, whose own psychology bore striking parallels to dissociative models of mental function and psychopathology (Ellenberger, 1970; Noll, 1989; Satinover, 1993). Freud's later observations on MPD are perfunctory and dismissive. In "A Note on the Unconscious," Freud (1912/1958) acknowledged the reality of MPD but vehemently rejected the notion that there could be a "consciousness apart."

> I venture to urge against this theory that it is a gratuitous assumption, based on the abuse of the word "consciousness." We have no right to extend the meaning of this word so far as to make it include a consciousness of which its owner is not aware.... The cases described as

> splitting of consciousness ... might better be denoted as shifting of conscious .. . oscillating between two different psychical complexes which become conscious and unconscious in alternation, (p. 263)

Berman (1981, p. 285) notes that Freud's defensive and polemical tone suggests that he was worried that cases of MPD might promote views contradictory to his own, a concern Freud voiced later when he stated that such cases "prove nothing against our point of view" (1915/1957, pp. 170-171). However, when not on the defensive, Freud made it clear that he was less than satisfied with his ability to explain dissociative phenomena. In "A Disturbance of Memory on the Acropolis," he notes: "Depersonalization leads us on to the extraordinary condition of 'double conscience,' which is more correctly described as 'split personality.' But all of this is so obscure and has been so little mastered scientifically that I must refrain from talking about it anymore to you" (1936, p. 245). He also made contributions of lasting importance to our understanding of MPD. In "The Ego and the Id," he noted that "the character of the ego is a precipitate of abandoned object cathexes and that it contains the history of those object choices" (1923, p. 29), an observation used to explain aspects of the formation of the personality system by Kluft, Braun, and Sachs (1984). He went on to make another vital observation about the ego's object-identifications:

> If they obtain the upper hand and become too numerous, unduly powerful and incompatible with one another, a pathological outcome will not be far off. It may come to a disruption of the ego in consequence of the different identifications becoming cut off from one another by resistances; perhaps

> the secret of the cases of what is described as "multiple personality" is that the different identifications seize hold of consciousness in turn. (1923, pp. 30-31)

The psychoanalytic scholarship relevant to MPD is sparse and of uneven quality, although it contains many significant insights and at times is remarkable for its anticipation of recent findings. For example, Fairbairn (1952, 1954) envisioned the structural model of the mind as only one of the ways the mind might differentiate and speculated that the processes of differentiation that create the id, ego, and superego might in other cases give rise to other independent formations, among which were separate personalities. This hypothesis has been explored recently by Fischer and Pipp (1984), who introduced the term "growing up strangely" to describe alternative pathways of development. The term has been applied to MPD in a thoughtful essay by Armstrong (1994).

Readers interested in the classic psychoanalytic attempts to grapple with MPD are referred to Berman's (1981) scholarly review. Notwithstanding these contributions, it would not be an exaggeration to state that for three generations psychoanalysis has dissociated MPD and the study of dissociation from its mainstream. This is not the place for a lengthy exploration of why this occurred, but two relevant observations may help the reader to place this intellectual dissociation in context. First, the emerging Freudian paradigms were inimical to the work of Janet and Jung, which was profoundly influenced

by dissociation and related concepts. Kuhn's classic study *The Structure of Scientific Revolutions* (1970) notes that scientific progress is not a smooth process but rather a saltatory one characterized by the embracing of a series of new paradigms. A scientific revolution is "a noncumulative developmental episode in which an older paradigm is replaced in whole or in part by an incompatible new one" (p. 91). "After a revolution scientists are responding to a different world" (p. 111). The proponents of different paradigms "are looking at the world, and what they look at has not changed. But in some areas they see different things, and they see them in different relationships to one another. That is why a law that cannot even be demonstrated to one group of scientists may occasionally seem to be intuitively obvious to another" (p. 150). In sum, the emerging psychoanalytic paradigm had no place for dissociation and MPD. Unable to be reconciled with the psychoanalytic paradigm, these subjects were treated as unscientific and effectively were eliminated from the rank of topics deemed appropriate to psychoanalytic study.

The second factor is psychoanalysis's traditional uneasiness about the role of exogenous traumatic abuse in development and psychopathology. Such antecedents are reported by as many as 97% of MPD patients (Putnam, Guroff, Silberman, Barban, & Post, 1986). It has become fashionable to "bash" psychoanalysis and psychodynamic psychotherapy as blind to the horrendous impact of child abuse and its consequences. Although it is clear

that such attacks are egregious overstatements with regard to the realities of daily practice, it is also quite clear that generations of psychoanalytic publications have given the subject short shrift. A psychoanalytic literature search will unearth more about incest fantasies than about incest; it is only in recent years that more than a few psychoanalytic authors have begun to accord importance to abuse-related topics.

Therefore, MPD, a dissociative disorder usually emerging in the context of antecedent child abuse, has long been far from the central concerns of psychoanalytic scholarship. Among recent psychoanalytic and psychodynamic contributors of note are Armstrong (1994), Berman (1981), Counts (1990), Gabbard (1994), Grotstein (1981), Kluft (1987a, 1991a, 1992a, 1993a, 1994a), Lasky (1978), Loewenstein (1993), Loewenstein and Ross (1992), Marmer (1980, 1984, 1991), Smith (1989), Stolorow and Atwood (1982), Ulman and Brothers (1988), and Wilbur (1984). *Psychoanalytic Inquiry* (1992), *Psychoanalytic Dialogues* (1992), and the *Bulletin of the Menninger Clinic* (1993) have devoted special issues to the study of such patients and their treatment from a psychodynamic perspective. Gabbard's (1994) discussion of the psychodynamic psychotherapy of dissociative patients is an excellent overview.

The modem psychodynamic psychotherapy of MPD includes analysts' descriptions of encountering and treating such patients in unmodified

analyses (Lasky, 1978; Marmer, 1980; Kluft, 1987a) and descriptions by psychodynamic psychotherapists of their efforts with such patients. Because very few MPD patients can tolerate a classical analysis, and many MPD patients are known to have had unsuccessful analyses or even to have remained undiagnosed while in analysis (Kluft, 1987a), the latter literature is of most relevance. Schreiber's *Sybil* (1973), a lay book that describes the treatment of a young woman by the late Cornelia B. Wilbur, MD, offers a vivid description of the problems encountered in working with MPD. Dr. Wilbur had to contend with amnesia, fugues, suicide attempts, self-injury, hallucinations and quasi-psychotic symptoms, evasions, massive resistances, regressions, somatoform symptoms, prolonged and refractory depression, periodic incapacity to function, reenactments of traumatic scenarios, traumatic nightmares, accounts of repugnant abuse—all in a patient without a unified and available observing ego whose "autonomous" ego functions were distributed across many alters. Owing to the often opaque amnestic barriers, work with one alter did not necessarily impact on the others until late in the treatment. This series of difficulties has been discussed in detail elsewhere (Kluft, 1984a).

Most of these difficulties are considered contraindications or relative contraindications for psychoanalysis or a purely expressive psychodynamic psychotherapy. Furthermore, trauma victims in general and MPD patients in particular do poorly with a relatively passive and technically neutral therapist

(Kluft, 1994a). They may develop traumatic transferences early and perceive the therapist as abusive (Kluft, 1994a; Loewenstein, 1993). Unless he or she is "real" enough to be seen through (or in tandem with) such negative projections, there is strong potential for stalemate in or interruption of the therapy. Also, this group of patients is highly hypnotizable, and the dissociative defenses indeed have the auto-hypnotic dimension first noted by Breuer (Breuer & Freud, 1893-95/1955). Not infrequently, their symptoms are refractory to interpretive defenses yet yield readily to hypnotherapeutic interventions or interventions derived from hypnotic techniques (Kluft, 1982). It is hard to be a traditional psychodynamic therapist with this highly traumatized population, although psychodynamic concepts are increasingly appreciated to be essential for their optimal treatment. Such considerations dictate that most MPD patients will receive a psychotherapy that is psychodynamically informed rather than conventionally psychodynamic in form and structure (Kluft, 1992a).

My current approach to the treatment of MPD patients has developed gradually over the last 25 years. I began working with them while still in training and made energetic efforts to apply the models of therapy I had been taught. I pored over texts and asked senior clinicians for advice. Very little was helpful. My early learning was retarded by the authoritatively delivered misinformation that *Sybil* (Schreiber, 1973) was a fraud, so I never considered calling Cornelia Wilbur for advice. Years later I discovered that I

had deprived myself of a wonderful resource and mentor. I found that my basic psychodynamic approaches were adequate to initiate a therapeutic dialogue with most MPD patients. They were of some help to all, and of considerable help to those who had the most conventional ego strength and coconsciousness across alters.

In one instance, an analytic control case showed no signs of MPD that I recognized. Midway through her fifth year of analysis, however she rose from the couch and told me, "You can analyze *her,* but I'm leaving." I responded, "You are in analysis too. Please return to the couch and let us continue. Please say whatever goes through your mind, withholding nothing." To my utter astonishment, she complied, and we were able to complete an unmodified analysis. However, more often my psychodynamic approach was insufficient to deal with the clinical problems I encountered. Frequently I was unable to access personalities essential to the progress of the treatment, had to contend with patients leaving the session in alters ill-equipped to manage the remainder of their day (or even find their cars!), and was confronted with scared-child alters huddled in a corner, unwilling to speak or leave their refuge, even when the session was at an end. Furthermore, somatic memories and the physical discomforts associated with abuse experiences that had not yet been recalled or resolved often disrupted treatment and /or greatly inconvenienced the patient.

I became aware that all of these were problems with which I was familiar from my training in hypnosis, and I wondered whether I might supplement my psychodynamic therapy with hypnosis. Despite receiving discouragement from those I consulted, and even though many famous authorities in the world of hypnosis warned that I would iatrogenically worsen my patients' plights with such a misadventure, my determination to find some way to help my patients compelled me to attempt such a synthesis.

Fortunately, I vaguely recalled the successful treatment of an MPD patient described by Ellenberger in his classic *The Discovery of the Unconscious* (1970). I found that Antoine Despine, a French general practitioner, had combined hypnosis with a number of other modalities in the treatment of a child with MPD in 1834. Therefore, in the absence of a contemporary mentor, I learned from Despine and was able to find part of the second edition of his original publication (Despine, 1840; see also Fine, 1988).

In this manner, I developed a style of working psychodynamically, with three major modifications. First, I used hypnosis to access alters and make them available in the therapy sessions. Second, I used hypnosis to facilitate coconsciousness across the alters so that whichever alter was "out" could report the comments from other alters that it heard inwardly about the subject under discussion. Elsewhere I have observed: "Paradoxically, the more of the mind one can access in this manner, the more alters one can

persuade to simultaneously listen in on the psychotherapy, the more the therapy resembles a standard psychodynamic treatment" (Kluft, 1991a, p. 4). I used hypnosis to catalyze the strengthening of ego capacities and the availability of ego contents. Third, I used hypnosis to alleviate distressing symptoms and to put distressing materials aside between sessions to minimize the likelihood that the patient would be overwhelmed by them in the absence of the therapist. In this manner, I was able to convert most therapies from crisis-ridden efforts with frequent hospitalizations to more mundane and manageable enterprises. It is often stated that one MPD patient is enough for a practice—such patients are too time-consuming and difficult. With these modifications as a foundation, and others I used as needed, I was able to carry an average of approximately 40 MPD patients in my practice for a period of 12 years, after which I undertook some administrative responsibilities and cut back my hours of private practice proportionately. These techniques are described in detail elsewhere (Kluft, 1988a, 1989a, 1993b; see also Fine, 1991).

INCLUSION/EXCLUSION CRITERIA

The fourth edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* has renamed MPD dissociative identity disorder (DID) and promulgated revised diagnostic criteria (APA, 1994). I strongly disagree with the name change for two reasons. First, I think that

"identity" is as problematic a concept as "personality," and I would prefer a change that offers a solution rather than a new set of problems. Second, the name change was in large part a political concession to those hostile to the MPD field. However, I concede that the name change may have the potential to move MPD more smoothly into the psychiatric mainstream because it puts much of the controversy that has surrounded MPD behind it.

The *DSM-IV* criteria are reasonable for clinical and research usage:

1. The presence of two or more distinct identities or personality states, each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self.

2. At least two of these identities or personality states recurrently take control of the person's behavior.

3. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

4. Not due to the direct effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play. (APA, 1994, p. 487)

There is some difference of opinion among experts as to whether to make the diagnosis on the basis of history, without having encountered alter

personalities on one or more occasions (Coons, 1984). One does not wish to be duped by a factitious disorder patient or some other form of "wannabe." However, the overtness of MPD fluctuates over time in 80% or more of MPD patients (Kluft, 1985, 1991b), and it is rather precious to withhold the diagnosis in an otherwise well-documented case that is currently rather covert. There is much to be said for being flexible and for using criteria more stringent than *DSM-IV* only for specialized research purposes.

Most MPD patients do not fulfill *DSM-IV* criteria at all times during their illness, and there are a great many patients who suffer dissociative disorders with the structure of MPD but never appear to fulfill diagnostic criteria (Kluft, 1985; Boon & Draijer, 1993). Nonetheless, these patients respond very well to the type of treatment used for full MPD. For this latter group, dissociative disorder not otherwise specified (DDNOS) includes a subclassification: "Clinical presentations similar to Dissociative Identity Disorder that fail to meet full criteria for this disorder. Examples include presentations in which: (a) there are not two or more distinct personality states, or (b) amnesia for important personal information does not occur" (APA, 1994, p. 490). It is unfortunate that section (a) is not further elaborated, because such cases include patients who have well-articulated alters that never emerge, whose alters are vaguely delineated, and whose alters are crisply delineated but not very elaborate (and often present in large number).

Diagnosis may be made on the basis of overt phenomena and/or characteristic symptom complexes spontaneously manifested (Kluft, 1991b), elicited in response to questions about suggestive signs (Kluft, 1991a, 1991b), clarified by the use of a specialized mental status (Loewenstein, 1991a), brought out in a structured interview (Ross, 1989; Steinberg, 1993), or found with the exploratory use of hypnosis or drug-facilitated interviews (Kluft, 1991a, 1991b). The Dissociative Experiences Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1992; Carlson et al., 1993) is a useful 28-item screening measure; most overt MPD patients attain a score of 30 or more, and 99% of those scoring less are not likely to have MPD. Sophisticated psychological testing protocols (Armstrong, 1991; Armstrong & Loewenstein, 1990) now allow the discrimination of MPD patients from other clinical groups.

Of the two structured interviews, the Dissociative Disorders Interview Schedule (DDIS) (Ross, 1989), which consists of 236 yes or no questions, is easier and quicker to administer and score (45-75 minutes). However, the Structured Clinical Interview for the Diagnosis of DSM-IV Dissociative Disorders (SCID-D) (Steinberg, 1993) is a more complex and flexible instrument. Although it requires more time to administer and must be studied to be used well, the SCID-D yields incredibly rich data about the patient's dissociative experiences and subjective perspectives. The Dissociative Disorders Unit I supervise uses the DDIS on all admissions, but

on the few occasions when I feel the need to use a structured instrument in my private practice, I use the SCID-D because it gives me a wealth of data about the patient's inner life that is immediately relevant to treatment, even though it was not designed to generate such information.

I have not found it useful to employ psychodynamic criteria in approaching the MPD diagnosis because traumatized patients in general may have strong reactions and apprehensions that the psychodynamic clinician may find difficult to appreciate as a trauma response rather than as an indicator of some other form of severe psychopathology. Also, this group of traumatized patients demonstrates phenomena characteristic of many diagnostic groups (Bliss, 1980; Kluft, 1991b), including neuroses, psychoses, and character disorders. Inferences may be drawn that the psychodynamics of those conditions are present.

Overgeneralizations may be drawn from early findings before the patient is completely understood. MPD is a layered psychopathology. Not uncommonly, each layer suggests another type of difficulty. This has been particularly troublesome with regard to borderline personality disorder and MPD (V.I.), which will be discussed in greater detail below. Furthermore, there may be extensive co-morbidity—the average MPD patient qualifies for two or more additional *DSM-III-R* or *DSM-IV* diagnoses (Kluft, 1991a, 1991b). It may be difficult to discern which dynamics are more prevalent. In addition,

the languages of psychodynamic psychotherapy and the dissociative disorders field have yet to become compatible and mutually enriching. What is implied by a term in one context can lead to unfortunate misapplication when applied in the other.

Early transference phenomena (or established transference paradigms in patients with prior therapy experiences) may prove quite deceptive. MPD patients have transference patterns that may mislead, perplex, or even frighten the clinician. These include: (1) traumatic transferences in which the clinician is perceived as an abuser; (2) flashback transferences in which the clinician is seen as reenacting a circumscribed role in a specific scenario; (3) quasi-positive submissive transferences in which the therapist is seen as an abuser who had to be told he or she was loved (almost always misunderstood until the rage emerges); (4) multiple transferences across alters in which the therapist has the uncanny feeling of being perceived several ways either simultaneously or in rapid succession; and (5) dissociative transferences in which the patient's hypnotic capacities lead to misperceptions of the therapist or abrupt intensifications of affect toward the therapist (Kluft, 1994a; Loewenstein, 1993). It is my experience that many clinicians misinterpret these as borderline or psychotic phenomena.

Armstrong (Armstrong, 1991, 1994; Armstrong & Loewenstein, has demonstrated that MPD patients are often thought to have very severe

characterological pathology based on the chaos caused by the switching of the alters, when the actual compromise of ego integrity is far less extensive. Of the first 50 patients tested and thought to suffer both MPD and borderline personality disorder (BPD), only one appeared to be truly borderline. In my study of 30 patients who appeared to have both conditions (Kluft, 1991a), one-third stopped demonstrating BPD phenomena as soon as therapy settled down (a matter of months), one-third gradually lost their BPD phenomena as their MPD integrated, and one-third showed core borderline phenomena even after integration of their MPD. Horevitz and Braun (1984) noted that although 70% of their MPD cohort satisfied diagnostic criteria for BPD, the remainder did not, and that fulfilling BPD criteria was most correlated with overall dysfunction and distress.

The chaos of MPD may generate phenocopies of conditions with which the clinician is likely to be more familiar, and the assumption that those conditions' dynamics are present may be made erroneously. Although many attempts have been made to link MPD to specific developmental stages and phenomena, it is my experience that none of these formulations has demonstrated generalizability beyond the case under study. I often find myself questioning whether the formulations offered fit the data or have been imposed upon them by a clinician finding what he or she is looking for and disregarding alternative hypotheses (i.e., confirmatory bias).

Pragmatically, the treatment of a traumatized individual must begin with stabilization and the attainment of safety (Herman, 1992). Only then is extensive exploration reasonable. The decision as to whether the patient will be able to profit from a psychodynamic psychotherapy often must be deferred until the initial interventions have improved the patient's function and diminished the chaos that often attends the MPD patient's entry into treatment. I well recall a patient whose first three years of treatment resembled a three-ring circus more than psychotherapy but who became an almost classic analytic patient for the remainder of the work.

DYNAMIC ISSUES IN MPD/DDNOS

Patients with MPD and related forms of DDNOS are a very diverse group in terms of their levels of function, Axis I co-morbidity, and Axis II findings (Fink, 1991; Kluft, 1991a). This is hardly surprising because dissociation is among the normal responses to exogenous trauma, even in nonpatient cohorts (Spiegel, 1993), and severe trauma can befall anyone at any age. MPD has been linked most frequently with the impact of untoward events from infancy through latency; it is unusual for it to be attributed to a first traumatization occurring after age eight. It may begin in children whose prior development was either smooth or troubled and whose maturation along lines of psychodynamic development has been either successful or stifled in one manner or another.

Marmer observes:

> Trauma, conflict, and deficiency all play a contributing role in the genesis of MPD. The blend of each of these ingredients may account, in part, for the different levels of function from one patient to another, as well as among alters within a particular patient. When trauma alone, without much conflict or deficiency, is the causal factor for a patient, there is greater likelihood of higher function, greater chance of well-functioning internal self-helpers, and more health to work with in the integration process. (1991, pp. 678-679)

Elsewhere (Kluft, in press a) I have reviewed the major competing theories of etiology and models for understanding MPD. Here I will summarize the most widely taught theory of etiology, the four-factor theory (Kluft, 1984b, 1986a), but I will not explore the several hypothetical models that are currently being discussed in the literature.

The four-factor theory is generally accepted because of its flexibility and capacity to encompass most other credible models (e.g., Braun & Sachs, 1985; Stern, 1984) in a relatively simple, pragmatic, and therapy-relevant frame. It holds that the individual who develops MPD will have (1) the biological capacity to dissociate, which will be mobilized when (2) the nondissociative defenses are traumatically overwhelmed by unfortunate life experiences, and (3) will develop alters in a manner consistent with his or her unique shaping influences and substrates. This type of adaptation will become relatively fixed and stable if there is (4) an inadequate provision of stimulus barriers to further overwhelming experiences and/or an absence of sufficiently

restorative experiences from significant others. Data are available to confirm the relevance of each of these factors (Kluft, 1986a, in press a).

Factor 1 indicates the importance of a biological diathesis, largely coextensive with hypnotizability but representing dissociativity, a somewhat different construct. Both are very high in those who develop MPD. Factor 2 indicates the role of exogenous stressors. It has often been equated with child abuse because 97% of MPD patients report such histories (Putnam et al., 1986). However, it refers as well to stressors other than intentionally inflicted abuse, such as object loss; exposure to the death of a significant other; witnessing violence, accidental injuries, or dead bodies; illness with pain, debility, and/or near-death experiences; cultural dislocation; brainwashing by embattled parents in a custody battle; being treated as if one were different genders by different caretakers; or extensive family chaos. It is clear that certain factors may lower the threshold for dissociation: illness, fatigue, pain, observable congenital anomalies or difficulties, problems with separation-individuation, and severe narcissistic hurts.

Factor 3 refers to those developmental lines, mental structures, inner conflicts, and external influences that determine the form taken by the dissociative defenses and the alters. Their combination appears to be unique in each MPD patient. Of particular importance is the constellation of significant others, which often is recapitulated in the alter system (Kluft,

Braun, & Sachs, 1984), either explicitly or implicitly.

Many have studied the formation of alters in terms of splitting (seeing MPD as related to borderline personality disorder) or dissociation (distinguishing the two conditions on this basis). There has been some conflict between those who espouse different perspectives. As of this writing, problems with imprecise definitions, decontextualized inferences, and adherence to different paradigms of understanding the mind (often to the point of disregarding clinical data) have prevented a fruitful synthesis. This has left the dissociation paradigm predominant within the dissociative disorders literature, and splitting more commonly referred to by psychoanalytic clinicians trying to build bridges from psychoanalysis to the dissociative disorders.

Clinicians and scientific investigators familiar with large numbers of MPD patients generally concur that MPD patients "divide" to preserve connectedness rather than to create distance (Kluft, 1984b, 1991b; Armstrong, quoted in Marmer, 1991). Armstrong summarizes her extensive experience in testing MPD and BPD patients:

> The MPD/DD group exhibits many attributes that contradict predictions one would make from a borderline perspective, and which support Kluft's assertion that the majority of these patients have a more complex and structured personality system. Rather than holding oversimplified attitudes, they are attuned to the subtleties of experience. Their generally introversive personality style reflects a capacity for internalization, for

> ideational organization of anxiety, for taking analytic distance from themselves and others in a complex and empathetic fashion. . . . Although at gross level certain vulnerabilities resemble borderline characteristics, the processes underlying these phenomena are quite distinct. Moreover, unexpected areas of strength and maturity also exist. These findings suggest that we are not viewing a developmental arrest, but rather are seeing the signs of what developmental psychologists call a "strange development" [Fischer & Pipp, 1984], i.e., an atypical developmental pathway created by unusual interactions with the world. (Armstrong, 1991, p. 544)

One of the major difficulties psychodynamic thinking has encountered in the study of MPD has been based on a fundamental disregard of the nature of the personalities and their relationship to consciousness, a problem Freud (1912/1958) grappled with when he peremptorily disregarded the possibility of a consciousness of which its owner was unaware. The alters may be mutually aware or unaware of one another, or Personality A may be aware of Personality B, which lacks awareness of A. Much as Bollas (1987) described the study of the structures postulated by Melanie Klein as the analysis of the "unthought known," I would like to imitate his felicity of expression and propose that in MPD the therapist faces the analysis of the "elsewhere thought known." Instead of a traditionally understood unitary ego and consciousness, the therapist contends with the patient's ongoing, simultaneous parallel processing of information and thought in several channels, each working with somewhat different operating principles, drawing upon different autobiographical recollections and using somewhat different cognitive processes. These enacted channels, or personalities,

generate alternate views of reality based on the stances, information, and thinking patterns with which they are associated. Thereby, multiple personality disorder generates multiple reality disorder (Kluft, 1991a, 1991b), and living in alternate versions of reality in turn reinforces and appears to validate the structure of the multiple personalities.

The personalities develop "when an overwhelmed child who cannot flee or fight adverse circumstances takes flight inwardly, and creates an alternate self-structure and psychological reality within which and or by virtue of which emotional survival is facilitated. This involves the elaboration of alters, which allows the enactment of alternative approaches to trying circumstances" (Kluft, 1991b, p. 610). For example, a female abuse victim might form an alter that is amnestic for the abuse, or to whom all recollection of abuse would be delegated. In this manner, it would be possible to live in difficult circumstances without appearing to react to them or be troubled by them. Likewise, the formation of a male alter in a girl might not reflect a core gender identity problem but rather the strategy of wishing to be a boy in the belief that if she were a boy, she would not be abused.

Factor 3 also includes cultural influences and the impact of the media and treatment. Here the therapist sees the influences of the patient's social situation and background. For example, Native American MPD patients frequently have alters based on animals that have unique meanings in their

tribe or clan. Some patients are impacted by what they have learned from the media—an interesting example was a young boy who formed alters based on identification with the Teenage Mutant Ninja Turtles. In addition, the expectations of the therapist may influence manifestations of the condition.

The first three factors indicate how MPD may be created. Factor 4 speaks more to how it is solidified and maintained. Without protection from further mishap, the MPD adaptation may be reinforced and solidified. Without restorative experiences of solace and comfort, the MPD child has nothing to substitute for such inner consolation as he or she has achieved by creating the alters. This factor speaks to the issue of deficit as well. Barach (1991), Liotti (1992), and Gabbard have addressed the importance of the mother-child bond in this group and noted how its failure may contribute to the initiation or maintenance of MPD.

MPD patients are preoccupied with safety and relatedness. Since they usually have been hurt by those to whom they were forced to turn for care and comfort, they develop patterns of testing and seeking for reassurance that often prove exasperating to those who treat them. It is not unusual for them to be preoccupied with controlling the therapist. A particularly difficult trait is their tendency to provoke critical and/or rejecting responses from the therapist by exasperating and/or outrageous behaviors, and then to insist that the therapist's response is proof that he or she really does not care about

them. When the therapist can access the personality system comprehensively, he or she usually can determine that this testing pattern is either due to some alters' efforts to sabotage the therapy (which they feel will eliminate them or expose them to long-shunned painful material) or is the expression of the patient's efforts to actively bring about what he or she fears—rejection. Another common rejection enactment occurs when the therapist is pursuing a theme that causes the patient to feel or fear criticism. A switch is made to a particularly vulnerable child alter. If the therapist pursues the inquiry or does not welcome the child alter, the patient then switches to an alter that angrily berates the therapist for his or her cruelty. Such maneuvers usually are best managed by gracefully greeting the child alter but firmly insisting that the previous conversation be continued. Allowing the therapy to be sidetracked in the ostensible interest of the needs of a child alter acts out in the countertransference what Ogden (1992) has called the tyrannizing transference. Also related to these themes are pressures from the patient to establish regressive dependency in the doctor-patient dyad. In one case known to me, the therapist went so far as to adopt the MPD patient legally.

MPD patients also develop specific transferences that challenge the clinician. Among them are multiple transferences from several alters at once (Wilbur, 1984), which can prove affectively confusing and cognitively overwhelming. Traumatic transferences (Kluft, 1994a; Loewenstein, 1993; Spiegel, 1991) in which the therapist is repetitively seen as an abuser are also

quite common and usually associated with repetitive cycles of projective identification in which the therapist must contain, and return in modified form, the most malevolent forms of the patient's identifications with abusive individuals (Gabbard, 1994). Some forms of traumatic transference have been called flashback (Loewenstein, 1993) or scenario-based (Kluft, 1994a) transferences: events more than object relations are experienced as being reenacted in the treatment. One also encounters submissive false-positive transferences in which the therapist is experienced as an abuser who must be told he or she is loved and whose virtues must be praised. These are often mistaken for conventional positive transferences, and the course of therapy can become derailed.

Dissociation as a defense involves the segregation of some subsets of information from other subsets of information in a relatively rule-bound manner (Spiegel, 1986). In this it often resembles the obsessive-compulsive defenses of reaction formation, intellectualization, rationalization, and isolation (of affect from ideas, ideas from ideas, and affects from affects). The therapist can talk to one alter about something without impacting the others, experience the patient failing to register accurately what the therapist has said, or witness a patient's immediate forgetting of what has been under discussion.

Related but different are a series of autohypnotic defenses that are not

unique to MPD patients but are commonly encountered among them. Although autohypnotic defenses have been described in the analytic literature, it is unusual to encounter them in profusion except in patients with marked dissociative tendencies. Withdrawal into quasi-catatonic states, abrupt aphonia, redissociation of threatening material, abrupt amnesia for questions or interventions perceived as threatening, spontaneous age regression, and switching of personalities are quite common devices.

Furthermore, because the MPD patient encompasses several relatively autonomous vehicles for the expression of alternate conations, MPD patients may handle anxieties and fears of all sorts in terms of their subjectively-believed-in inner worlds, which can come to have a compelling reality. For example, some personalities punish others, battle with them, and deny them access to the therapy. Personality A may be in the process of telling the therapist something that Personality B wishes to keep from the therapist. A may hear B's voice threatening A, or suddenly a hand may strike the face while A is experiencing the pain of the blow. On occasion, B may control A or render A mute. Or C, D, and E, who see themselves as allied with A, may "imprison" B somewhere within the inner landscape to which the patient accords reality. More confusing still, in some patients one personality (B) can impose its feelings or experiences on another (A) or create in another an illusion, delusion, or hallucination to which the other responds as if it were reality.

Because the dissociative defenses leave the patient without a sense of ownership of much of life's experience, defensive disavowals of all sorts are common. One consequence of this relates to the issue of responsibility. MPD patients are notorious for refusing to own and accept the consequences of their actions, usually because the alter that has done the behavior in question is different from the one being confronted. The latter protests its innocence with tearful earnestness, conveying that it is deeply wounded by the unjustness of the accusation that has been made. It is often useful to be especially on guard for one's own potential countertransference exasperation and sadism when confronted with such dynamics. The therapist must gently but firmly insist that responsibility belongs to the entire human being, and that all alters "are in it together" and are held jointly accountable.

Identification is a major substrate for personality formation and serves a number of functions in each particular case. It is not uncommon for the family and the major protagonists in abusive scenarios to be recapitulated in the system of personalities, as are idealized protectors and ego ideals (Kluft, Braun, & Sachs, 1984). Some of these identifications are unprocessed introjects of important object relations, and some are internalizations of important objects who have been lost or whose loss is feared. In one extreme case, an Old Order Amish woman with MPD was shunned by her extended family and congregation when she accused her brother of incest. Shunned by her entire community, she formed alters based on over 70 relatives,

neighbors, and fellow congregants. Some alters are formed on the basis of identification with the aggressor, leading to the creation of internal persecutors. Although their initial defensive purpose was to deny the abject helplessness of the trauma victim, in the inner world of the alters these alters may repeatedly enact the role of abuser. Nor is it uncommon for alters to be based on persons who have been helpful or who, it is believed, could have been helpful. Also, alters identified with favored siblings, friends with nicer families, or fictional figures from literature or the media may be created in order to personify the wish to have escaped traumatization and to preserve the potential for growing up safely. The last type may prove a staunch resistance when the patient insists that they must be allowed to have actual childhoods of their own in which to grow up and attempts to get the therapist and others to enact this. My own stance is identical to that of Putnam (1989), who indicates that the proper persons to do this upbringing are the other personalities who are so eager for it to occur.

Projective identification is not uncommon in MPD patients, but it often takes a form that provides valuable information about parts of the mind as yet unknown to the therapy. That is, often what is projected into the therapist is an aspect of mind associated with an alter as yet unfamiliar to most of the personality system or the therapist. This is especially common with very negative projections early in the treatment, before the alter system is well known. For example, in the treatment of an MPD patient who not only had

been abused severely but had mistreated a younger sibling (but did not know the full details, which were very serious), the patient became convinced that I was a hurtful and mean person who probably hurt those entrusted to his care. Her efforts to push me into such a role were heroic and sustained. When I was able to explore, I found I was being perceived as the alter who had done the worst abuse. Once that alters existence became known to the alter system, these projections came to a halt.

A final note on the dynamics of the MPD patient regards the ubiquity of shame. The traumatized person often suffers exquisite shame (Nathanson, 1989). The typical MPD patient avoids openness and revelation because a recounting of his or her history would involve sharing incident after incident in which he or she experienced intolerable humiliation and mortification. Furthermore, most alters manifest one or more of the patterns of coping with shame that Nathanson (1992) has described as "shame scripts": responding to shame by attacking the self, attacking the other, avoidance, or withdrawal. An appreciation of the shame scripts and a willingness to engage the patient in discussing them often relieves what otherwise might become an impasse in the therapy.

TREATMENT GOALS

Several factors make it difficult to determine the overall goals early in

the treatment. Often the patient is first diagnosed while in a state of incipient decompensation and appears healthier than he or she will appear after treatment has begun. A young lawyer with a glowing reputation was seen in consultation after she had been diagnosed with MPD and become unable to work. I learned that she had begun to have severe flashbacks of childhood abuse that distressed her and disrupted her professional life. When her MPD was diagnosed, she had already become incapacitated; shortly thereafter, she required hospitalization. It took years for her to restabilize. Conversely, the patient is often diagnosed when severely decompensated and showing little evidence of the hidden strengths that reside within. I have brought to integration several patients who, although they had spent years on the back wards of state hospitals misdiagnosed as refractory schizophrenics, went on to earn doctoral degrees and practice in the healing professions.

Also, it is not unusual for the patient to begin treatment in a state of denial of the diagnosis, or with an unrealistic or derealized perception of MPD and what the treatment entails. The patient may crave nurture and/or symptomatic relief, often associated with an initial preference that the other alters be removed and/or that all traumatic material be banished from their minds. These wishes generally survive well into the treatment process, even though more appropriate goals may be verbalized. Although there are exceptions, it is common to find that the goals of both therapist and patient have been revised repeatedly over the course of the therapy.

In addition, the treatment of MPD often resembles a series of short-term therapies imbricated within the structure of a single long-term therapy. It is not unusual for some of those briefer therapies to have different goals and foci. For example, a period of work on a specific issue that requires a gentle uncovering emphasis may be followed by energetic directive and structured approaches to a particular symptom or traumatic scenario. This period may give way to a time of working to resolve conflicts among particular alters, which in turn may yield to working on the patient's adaptation in the here and now.

From the perspective of the therapist, the unification of the MPD patient, despite its drama and subjective significance to the patient, is only one aspect of the overall treatment and becomes an incidental consideration in many therapies.

The tasks of the therapy are the same as those of any reasonably intense change-oriented approach. However, these tasks are pursued in an individual who lacks a unified personality (and hence observing ego). The several personalities may have different perceptions, memories, problems, priorities, goals, and different degrees of involvement with and commitment to the treatment and one another. It usually becomes essential to replace dividedness with unity, at least of purpose and motivation, for any treatment to succeed. Work toward this goal and possible integration of all personalities

distinguishes the treatment of MPD. (Kluft, 1984b, p. 11)

To summarize research reported elsewhere (Kluft, 1984b, 1986b, 1993c, 1994b), although there is considerable sympathy with attempting to help the MPD patient become more adaptive without integrating—and many patients refuse to work toward integration—integrated patients are more stable and more likely to make an adaptation they find gratifying. Patients who remain multiple are more likely to become dysfunctionally multiple under stress. In my series, most patients who opted for functional multiplicity returned for integration, while only 4% of the stably integrated patients chose to reactivate their MPD on a standing basis. All those who chose to restore their MPD were suffering severe physical illnesses and wished to escape their life circumstances.

Dissociated patients were subject to repeated revictimization (Kluft, 1990), while integrated patients were less likely to suffer such incidents. This outcome for dissociated patients is due to the secondary loss associated with the ongoing use of defenses that do not allow the mind access to all its autobiographical memory, rendering the patient differentially vulnerable and unable to learn from experience. Also, dissociating individuals are less likely to be consistently appropriate in their parenting functions. Kluft (1987b) found that although 38% of MPD mothers were competent or excellent parents, 16% abused their children, and 46% were impaired in their

parenting functions.

The goals set at the beginning of the treatment rarely emphasize either integration or the working-through of traumatic material, although these are two of the major foci of the treatment, because (1) safety, stabilization, and enhancing the patient's strengths take priority early in the therapy; (2) the patient is usually terrified at the thought of facing known and unknown past traumata; and (3) the alters often experience themselves as separate people and hear integration as a strategy to annihilate them rather than to include them in the reuniting of the mind.

The early stages of the psychotherapy prioritize safety, adaptation, and learning to work together. This goal has been articulated most completely by Fine (1991) and Kluft (1993b). The treatment of the traumatized individual is triphasic, an observation first made by Janet (1889) and studied in depth by Herman (1992). In brief, the first stage of treatment emphasizes establishing safety for the patient. This involves containing troublesome symptoms and behaviors, mastering adaptive strategies, contracting for safety, and learning to work with the therapist. In essence, the patient is stabilized and shown how further mastery of what he or she had experienced as out of control will be possible. The patient is strengthened and learns how to deal with the type of traumatic material likely to be encountered in the next phase. Such goals are often at odds with those of the first phase of an expressive psychodynamic

psychotherapy, which is most likely to involve the loosening of troublesome superego injunctions against allowing material to emerge in preparation for the exploration of fantasy and transference material.

The goals of the second stage in the treatment of the traumatized patient involve the exploration and metabolism of the patient's overwhelming experiences. Fortified by the accomplishments of the first phase, the patient is helped to abreact what has occurred to him or her and to correct the damaged sense of self and the maladaptive patterns associated with these experiences. The therapist must attempt to titrate the process to prevent the patient's becoming destabilized. Many patients require the assistance of many nonpsychodynamic techniques in order to manage this work (Kluft, 1982, 1988a, 1989a, 1993a, 1993b, 1993c).

The third phase involves integration—the integration of the self, the patient's interpersonal relationships, and the trajectory of the patient's life. Once most of the alters near and achieve integration, traditional psychodynamic psychotherapy is invaluable in helping the novice "single personality disorder" patient work through what has been learned in the other phases. Transference and its interpretation become less suffused with traumatic expectations and more the focus of contemplative inquiry. The therapist must encourage a patient who wants to believe the treatment has already reached its conclusion to do the working-through that will stabilize

the gains of the treatment and to approach residual difficulties that have not yet been addressed and/or resolved. An elegant description of this type of treatment has been published by Fink (1992).

It is important to note that although the decision as to whether to do any part of the work is the patient's, the therapist who is informed about the consequences of particular choices may wish to indicate the potential pluses and minuses associated with various decisions and should try to do so when the patient is considering available options, but before the patient has taken a strong stance from which he or she will find it difficult to retreat.

THEORY OF CHANGE

In the course of a successful treatment, the dissociative defenses that separate the alters are understood to become more porous and to collapse. This intrapsychic change is both simultaneous with and subsequent to the alters' increasing empathy, cooperation, and identification with one another and to their coming to share one another's autobiographical memories. The alters come together in one or several pathways to integration.

The modem treatment of MPD has developed from the collaboration of psychoanalytically oriented clinicians with colleagues who were more eclectic and used hypnosis as a major therapeutic modality. The concepts of integration and fusion evolved side by side, overlapping but not identical.

Integration involves the psychotherapeutic undoing of the dissociative defenses and structures. It speaks to the process of intrapsychic change. As such, it is understood to begin long before the alters begin to come together and to continue long after they have done so. Fusion refers to the coming together of the alters according to the patient's subjective experience and the clinician's phenomenologic observation. It is defined on the basis of three successive months of (1) continuous contemporary memory; (2) an absence of overt behavioral signs of MPD; (3) a subjective sense of unity; (4) an absence of alters on re-exploration; (5) a modification of the transference phenomena consistent with the bringing together of the personalities; and (6) clinical evidence that the unified patient's self-representation includes acknowledgment of attitudes and awarenesses that previously were segregated in separate personalities (Kluft, 1982,1993c).

The actual process of the alters' coming together is little understood, and extant descriptions are more metaphoric than explanatory. Six pathways have been described (Kluft, 1993c). In the first, gradual merging, the involved alters report that they are (and are reported by the others to be) gradually fading and becoming less distinct, or slowly blending into or joining others. This pathway is consistent with the erosion of dissociative boundaries across and between alters. They become more aware of one another, feel one another's feelings more and more, share more, and begin to experience identity diffusion and confusion; some simply retain their identities as they

fade.

In the second pathway, alters blend in connection with rituals facilitated by hypnosis that involve both an imagery of joining and suggestions toward unifying. It is important for the psychodynamic practitioner to appreciate that such techniques are never a substitute for the hard work of psychotherapy; they merely help alters over a dissociative hurdle that has not been surmounted pari passu during the treatment. They invariably fail or lead to only transient fusions if the alters involved have left important therapeutic work undone (Kluft, 1986b).

A third pathway occurs most frequently when there are many alters that encapsulate discrete traumatic memories. When their abreaction of their experiences reaches completion, they are found to have integrated spontaneously. This rarely occurs with alters that are elaborate or have substantial roles in daily life.

A fourth pathway occurs when alters say they have decided it is time to go, that they are not needed any longer or their functions are now being managed by other alters, and they are heard of no more. While this occurs, it is often a diversion so that the alters can remain secretly and return at will, or such a statement is offered in connection with the involved alters wish to evade further painful work.

A fifth pathway could be designated a brokered departure. An alters decision to cease being separate is negotiated among the alters in order to achieve a particular objective. For example, in a system constructed to defend a child alter against pain, a decision was made for strong protector alters to blend with that child alter before it would have had to work on painful material in order to spare it the full force of the pain.

The sixth pathway involves the consequences of calling alters out to temporarily integrate in the service of facilitating the attainment of specific treatment objectives. Usually after several temporary integrations, the involved alters find it impossible to restore the status quo and request help (often hypnotic) in effecting an integration. Again, all of the above descriptions are metaphoric.

The dissociative diathesis is understood to be constitutional, and its use is well practiced. It cannot be altered per se, but the likelihood of its remaining a primary mechanism of defense and adaptation can be diminished by the elimination of the delivery systems of the most extreme dissociative defenses, the personalities, and by the patient's developing more adaptive defenses and coping strategies. Follow-up studies demonstrate that without the alternate personalities, MPD patients can give up the use of dissociative defenses, but that when the personalities are allowed to persist in what is thought to be a healthier adaptation (a so-called resolution), under stress

they often recommence their dysfunctional autonomies (Kluft, 1984b, 1986b, 1993c).

Therefore, the models of therapy that have proven most successful have been consistent with the triphasic model noted above. They have provided the patient with alternatives to dysfunctional dissociative defenses long before focusing on traumatic materials, and they have attempted to bring about a degree of coconsciousness early on, familiarizing the patient, often more implicitly than explicitly, with the idea of functioning with a deep shared pool of data and resilient ego strengths without "leaving the scene." Elsewhere (Kluft, 1992a) I have tried to explain the psychodynamic and ego psychological underpinnings of such approaches. They attempt to create the facsimile of an observing ego that can withstand the pressure to switch by having the alters that are likely to be brought out under such circumstances already co-present and coconscious with the ostensible host. That works in the service of moving the preconscious MPD ego functioning, in systems with parallel distributed processing and unshared thinking, toward coconscious functioning in which the motivations for switching are partially preempted and the subjective experience across all alters of functioning with more data, resilience, and expertise is a powerful assault on the value the patient accords to dissociative coping strategies. Also, as alters share more and more, they become more and more alike and conflicts and narcissistic investments are mollified.

Related to this thrust toward more integrated ego function is the need to process traumatic memories and detoxify them so that they can be accepted without destabilization and/or redissociation; so that the distorted understanding of self and others associated with the traumatic material can be remediated; and so that the patient can appreciate the continuity of his or her personal history and use this in the construction of a cohesive self-image, self-representation, and identity.

It is a cruel irony for those who earnestly search for "the truth" about what has happened to such patients that the vicissitudes of memory rarely allow the desired degree of certainty to be attained. As of this writing, there is no way to distinguish between true and false memories. Nonetheless, recovery from MPD involves the patient's development of a sense of his or her autobiographical self and memory. The therapist cannot always make it possible for the patient to know the full truth, but the therapist can conduct the therapy in a manner that makes it possible for the patient to come to his or her own decisions about what seems to be his or her personal truth. I have addressed these thorny issues elsewhere (Kluft, in press c).

MPD patients rarely enter treatment with conscious awareness of the major pathogenic events of their lives. In my experience, notwithstanding the difficulties that surround the understanding of recovered memories of childhood traumata, the reconstruction of the autobiographical past is

essential to the development of a unified self, which is crucial to the healing of the MPD patient. Associated with the recovery of this material is the need to abreact it, or at least to allow the ventilation of the feelings associated with what is recalled to have occurred.

In my experience, circumspect abreaction associated with diligent efforts to process and integrate the material and study its implications has proven essential to the stable recovery of MPD patients, despite the fact that simply reliving the traumatic past without additional precautions and interventions can be disruptive, regressive, and counter-therapeutic. I know of no compelling evidence that affect associated with traumatic material is in some way strangulated and must be released in order for the patient to progress beyond the hurts of the past, but my clinical experience is that MPD patients behave as if this is so and do best if approached with this possibility in mind. Whether some sequestered strong emotion must be liberated or the abreaction of traumata is a healing ritual syntonic with my patients' culture and expectations is a question beyond my capacity to answer. Thankfully, however, clinical tools have been developed that allow the patient to be healed nonetheless. Therefore, I will discuss abreaction in the context of clinical experience with MPD, leaving aside unresolved theoretical issues.

I conceptualize abreaction as a procedure that unburdens the patient's ego functions and rehabilitates shattered self-esteem in that it replaces the

sense of passive victimization with one of mastery and self-efficacy, allows the patient to choose to participate in counterphobic and then well-disciplined mastery rather than live in constant fear of the return of the dissociated material, and convinces the patient that he or she can achieve skill at self-regulation. To use Nathanson's (1992) concepts, noted briefly above, it allows the patient to move from the paralyzing mortification of shame (and the enactment of dysfunctional shame scripts) to the active self-respect of hard-won pride. What once terrorized the patient and held him or her in thrall by threatening to reiterate the traumatic past in the present is detoxified and vanquished. It is impressive to complete the abreaction of the traumata associated with a particular alter and find it dramatically changed by the intervention. The first time this is achieved for any alter, and the other alters observe its relief and improved function and self-esteem, it is not uncommon for the therapeutic alliance and the patient's overall improvement to be enhanced substantially.

To summarize the above observations, it has been my experience that the MPD patient recovers when, strengthened with new coping and defensive assets and made comfortable enough to reveal what overwhelming pains and humiliations he or she has endured, the alters can risk moving beyond the massive dissociative defenses, pool their assets for certain tasks in the treatment, and dare to face and master what previously was intolerable. With the secrets revealed and the shame replaced with self-efficacy and pride, the

raison d'être for the alters becomes obsolete. Their blending ends the MPD, but not the need for treatment.

Notwithstanding the specific MPD-related observations above, it is essential to bear in mind that the MPD patient, once integrated, not only needs to complete the working-through of all that has been discovered and shared across the alters, he or she needs to deal with any residual single personality disorder issues. It is a rare patient who does not require additional years of treatment to complete the working-through process and to deal with concomitant problems and issues.

TECHNIQUES

No one paradigm of treatment is sufficiently comprehensive to address the full spectrum of clinical interventions useful in work with MPD. Therefore, although the treatment should be psychodynamically informed, the unique features of each individual case will dictate how closely a given therapy resembles traditional psychodynamic psychotherapy in technique. A high-functioning MPD patient may be able to share freely across coconscious alters and utilize psychodynamic psychotherapy with minimal modification. A disorganized and decompensated MPD patient may require an extensively structured treatment that rapidly contains any difficult subject matter or potentially destabilizing effect. Patients with extensive co-morbidity may

present problems that must receive attention before addressing the MPD—for example, a severe affective disorder or an active addiction.

In treating MPD, the therapist takes a warm, active stance and shows a range of affective responses. Traumatized populations have difficulty with a passive, neutral, and bland therapist. Already feeling flawed and unlovable, they experience such a therapist as confirming their worst fears about their acceptability by others. Furthermore, into the void left by the therapist's relative anonymity may flow a premature rush of negative transferences, which the passive therapist may perceive as proof of a borderline character structure. This creates many complications early in treatment, when solidifying the therapeutic alliance and avoiding a premature approach to unsettling materials is essential. Also, if the patient becomes drawn into a flashback and misperceives it as contemporary reality, the therapist who is not seen as a distinct individual may have more difficulty negotiating the reorientation of the patient than the therapist who has become a three-dimensional individual. Finally, it is good countertransference "insurance." It is difficult to avoid countertransference gaffes with MPD. However, countertransference insurance is not in the service of covering up the errors of the therapist. When errors occur in a therapy in which the therapist has attempted to be fairly anonymous and bland, they are jarring and may disrupt treatment. Conversely, in a treatment in which the patient has come to expect a more involved and affectively diverse therapist, the deviation from baseline

at such moments is less likely to scuttle the therapeutic enterprise. To illustrate, I once undertook to treat a young woman whose previous therapist had made a fetish of strict neutrality and bland friendliness. However, when finally provoked by the patient's often outrageous behavior, she lost her composure and shouted at the patient, waving a clenched fist. The therapy, then in its seventh year, could not be salvaged. Appreciating the difficulty of working with this patient, from the first I allowed myself a considerable range of affective expression. When I myself became caught up in the craziness this patient could generate and expressed my anger, the patient's response was only, "Gee, you are even more grouchy than usual today." Therapy continued uneventfully, preserving the patient's considerable investment in our work together.

Another unusual technical feature is abstaining from making interpretations of what we might call the patient's drives. Trauma victims almost inevitably experience such interpretations as indictments, as proofs that they deserved the misfortune that befell them. A colleague covering a self-loathing MPD patient for me during my vacation correctly appreciated that she was very attracted to him. He interpreted her sexual feelings for him, and she decompensated, becoming highly suicidal. I found that the patient had understood his observation to mean that she had been harboring sexual urges toward the men who had exploited her, and that therefore the exploitation was her responsibility.

Another fairly unique technical issue is that any observations and interpretations should reflect the therapist's awareness of the double bookkeeping of the MPD patient: the therapist is simultaneously addressing the total human being and the several personalities. For example, I might say, "You seem to be conflicted about whether to share what you remembered with me. Perhaps that is why when Chrissie started to speak she was replaced by Christa, who immediately assured me that Chrissie was lying and that whatever she said could be disregarded." The personalities that express the conflict should be addressed as well as the dynamics.

This type of intervention promotes the push toward coconsciousness and unity while reducing the tendency of alters to act out if they are not acknowledged. Their narcissistic issues are addressed by their receiving explicit attention, yet every time alters listen in or respond to such a comment, they are implicitly acknowledging their participation in a single person who experiences himself or herself as divided rather than as a series of autonomous people.

The above leads us to yet another set of techniques and approaches. To promote the generalization of gains across alters and minimize having to engage each alter in a treatment of its own, it is useful to make regular outreach efforts to alters that are as yet unknown, inaccessible, or hostile to the treatment process. This process involves issuing serial invitations to the

alters to enter the therapy and to share their views on topics under discussion. *Absint* such gestures, it is not uncommon for alters that are not involved in the treatment to oppose it on the grounds that the therapist does not care about them. Although this observation may sound ridiculous to those inexperienced with MPD patients, experience has shown it to be a frequent problem. A relevant consideration is that parts involved in suicidal and para-suicidal behaviors often remain at a distance from the therapy because it opposes their agendas. As a result, such behaviors may occur without warning. Conversely, if such alters are involved rapidly, it may be possible to develop safety contracts and preclude such events. A facility in reaching and engaging such alters early in treatment is characteristic of the work of the most successful MPD therapists.

Useful techniques include "talking over" the alter ostensibly in control and addressing the others, using "you all" as a way of acknowledging them, and asking other alters who have something to say about the topic under discussion to make their comments inwardly so that they are heard by the alter "in control" as inner voices and can be repeated to the therapist. Often alters that decline to talk will write in a journal or draw and allow their drawing to be brought in. Not infrequently, they will emerge spontaneously when the therapist remarks on their contributions.

Many therapists have a great aversion to addressing alters directly, and

many MPD patients are eager to deny their condition. Under such circumstances, it is sometimes possible to work with mutually acceptable circumlocutions, but it must be emphasized that it is not unusual for this approach to lead to a stalemate that goes unrecognized because therapist and patient alike are colluding to avoid a main thrust of the therapy, the MPD. Therapists who proceed in this manner might express themselves: "Do you suppose that the part of yourself that holds your angry feelings is pressing to express itself because you find it so difficult to own these emotions?"

Work with MPD often confronts the therapist with such a bewildering and overwhelming deluge of material that it is difficult to decide what to prioritize and address. Although generalizations are difficult, I have found it useful to select for intervention those materials, dynamics, alters, or symptoms that pose the most immediate threat to adaptation and coping if the patient's stability is an issue, but otherwise to prioritize by keeping on track with the work on a particular alter or issue until closure has been reached. Otherwise, it is possible that more and more alters and issues will be brought into the treatment without being contained, and the patient may become overwhelmed.

The therapy must prioritize the maintenance of the therapeutic alliance and the stability of the patient. This often leads to rather aggressive and focused work on potentially disruptive symptoms and a treatment that often

gives the appearance of a series of short-term psychotherapies imbricated within the matrix of a superordinate long-term psychotherapy. Frequent target symptoms for such approaches are intrusive quasi-psychotic symptoms such as disruptive inner voices, passive influence phenomena, somatic memories, acute fugues, and the disruptive actions of particular alters (Kluft, 1984a, 1987c). Although hypnosis may be necessary to explore them, in many patients they may be accessed by inquiries that draw on what coconsciousness is available or that indirectly or implicitly call upon the patient's own autohypnotic talents.

For example, a patient with an acute headache may be asked to allow whatever is behind the headache—be it an alter trying to emerge, a memory, a conflict, a strong affect—to emerge or speak inwardly so that its message may be conveyed by the alter presently in control. Often it is then possible to resolve the matter, or to make a bargain to deal with the emerging issues at a later date. One patient with a severe migraine attack refractory to standard measures and narcotics was asked, "Who is behind the headache?" Another alter emerged and protested that its concerns were being neglected by the others and by the therapist. A deal was struck to allow that alter the majority of the next session, and the migraine ceased.

The abreaction of traumatic materials plays a major role in most MPD treatments. The emergence of traumatic material, usually triggered by

serendipitous events or the process of therapy, can be very painful and may disrupt the patient's ability to function for protracted periods of time. If the material exposes the patient to intolerable realizations, abrupt suicidal and para-suicidal behaviors may occur. The MPD patient often does not have the resilience to tolerate strong abreaction without considerable support and containment.

Therefore, for most MPD patients it becomes highly desirable to control occurrence of abreactions rather than allow them to take place naturalistically in the course of the therapeutic process. Practicing such containment often is difficult for a psychodynamic therapist because it is so contrary to the psychoanalytic paradigm. However, a few experiences of being unable to terminate sessions because an MPD patient has become so disorganized that hours are necessary to achieve restabilization will prompt reflection. Having to hospitalize an MPD patient who has become regressed and disorganized, "stuck" in a terrified child alter, or acutely suicidal owing to the impact of a long-dissociated trauma will also cause any therapist to reconsider his or her stance.

Pragmatism and concern for patients' safety usually dictate that the therapist try to prevent the MPD patient from moving toward abreaction late in the session and try to help the patient initiate abreactions early in a session designated for that purpose. If the patient is helped to do the abreactive work

in a contained manner, it is likely that the patient will gradually become convinced that the trauma of the past can be put to rest without contemporary retraumatization. In the MPD field, many clinicians take Kluft's rule of thirds (Kluft, 1991a, 1993a) quite literally: If you cannot get into the material that you planned to abreact in the first third of the session, so that you have the remainder of the first third and the second third to do the abreaction and the third third to process the material and restabilize the patient, do not begin the abreactive work. The adverse impact of the patient leaving the session destabilized is unacceptable and leads to another of the author's clinical rules: The slower you go, the faster you get there. All too often, the treatment of MPD must focus on cleaning up the aftermath of premature or uncontained work with traumatic material. Not only is such a focus unfortunate in and of itself, but it can cause the patient to be too afraid to continue dealing with the pain of the past for fear of retraumatization.

This experience has led to an approach to abreaction that focuses more on mastery and understanding than on the mere reliving of trauma and the release of associated affect. The techniques applied are most often associated with hypnosis; although their detailed exposition is beyond the scope of this chapter, a summary will be offered. (For a detailed exposition, see Fine, 1991; Kluft, 1988a, 1989a, in press b). In traditional psychodynamic psychotherapy, abreaction occurs in the process of the treatment without planning; conversely, in traditional hypnotherapy, the patient is helped to re-

experiencing the traumatic material until its impact is exhausted. My techniques of fractionated abreaction (Kluft, 1988a, 1989a) were designed for work with MPD. In these approaches, the patient is encouraged to approach the material bit by bit; hypnosis is used to titrate the percentage of the affect that is felt, the portion of the trauma to be dealt with at a given session, the number of involved alters that will participate, and so on. The patient is not allowed to proceed until the affect is exhausted because the patient is likely to become overwhelmed. Instead, the patient has a series of experiences in which the material is dealt with piecemeal until most of its pain is drained; the patient can then deal with the rest. After each experience of pain, the patient is restabilized and comes to expect that trauma can be mastered without decompensation. Hypnotic techniques are very useful here.

One MPD patient, unable to abreact without decompensation in a prior therapy, was allowed to have only 30 seconds of Re-experiencing a particular trauma in a single alter before being brought back to the present. In this manner, a time line of the trauma was established and the alters involved were identified. Then one alter at a time was brought through at only 10% of the pain. When each alter had gone through the sequence at pain increments up to 100%, it was possible to go through the whole event, to the relief of all involved alters. The material was then shared with the other alters, some of whom had to abreact it also.

Hypnosis can play a major role in containment during the treatment of MPD. Although hypnosis is thought by many to be most useful in retrieving repressed memories, recall that the treatment of MPD is the psychotherapy of the "elsewhere thought known," so that most material is retrieved simply by accessing the involved alters. The use of hypnosis for memory retrieval per se has a role in this work, but owing to the problems associated with the use of hypnosis in this context (the risk of confabulation and pseudomemory), it is less useful in gathering historical information than might be imagined. When hypnosis is used in this way, the patient should be informed of the possibility that what is retrieved, although it may be quite useful in therapy, may be historically inaccurate (see Kluft, in press c).

Hypnosis can play a major role in providing containment and support until the patient's increasing integration brings more strength. Often it can be used to bring order to a chaotic MPD patient's life and treatment. Here I will illustrate its usefulness, referring the reader elsewhere for the details of relevant techniques (Kluft, 1982, 1988a, 1989a, 1992a, 1992b). Hypnosis can be used to *access alters.* If the therapist is told that Alter A is suicidal, it is useful to be able to intervene with A. Hypnosis can be used to *substitute alters*. Not uncommonly, a major alter is on the brink of collapse, with potential adverse consequences. If the therapist can call out another alter to take over until the former alter is refreshed, the therapist can substitute an experience of mastery for one of incipient decompensation.

Closely related is *reconfiguration:* the therapist requests changes in the way the alter system is functioning in order to further the goals of the treatment. For example, if one alter is deeply distressed and its plaintive utterances are paralyzing the therapy, another alter can be assigned to be its companion and support. Also, if several alters are impinging on the one ostensibly in control, causing many quasi-psychotic symptoms, they can be encouraged to move far enough back in the mind so that they will not impair function.

Ideomotor questioning, the use of (usually finger) signals to answer inquiries, is profoundly useful in keeping in touch with the alters that are not playing a role in the ongoing therapy and in requesting answers in areas in which the patient fears to speak. There are many sophisticated applications, such as rendering the patient's signal hand anesthetic to all other alters so that the information's accessibility can be rationed. For example, for most patients I use the established signals to make weekly inquiry as to whether there is anything brewing that I need to know about and of which the alter currently "out" is not aware. For example, "If there is any part of the mind struggling with urges to kill itself or hurt the body, let the finger rise at the count of three."

It is possible to create the hypnotic image of a safe place in order to *provide sanctuary* for beleaguered and terrified alters. It is easier to create a

safe place for child alters than to struggle for months with their incessant requests for cuddling, play, and nurture or their inconsolable terror. Failure to address alters' requests for the therapist to address the needs of child alters can paralyze a therapy. By the same token, becoming overly involved with these needs will complicate treatment.

When strong affect threatens to overwhelm the patient, it is often possible to *bypass affect* by using hypnotic imagery to place it in a vault that will not open until the next session, or to use *slow leak techniques* to suggest that the affect will come through only at a rate and in a manner that will be safe. Allied with this are *techniques to curtail abreactions,* exemplified by creating the expectation that the abreaction, having gone on for the planned duration, will come to an end at the count of 10, by which time "all that needs to come out for today" will have done so. Also useful for abreactive work is *time sense alteration,* which allows the patient to experience events more slowly or more rapidly than clock time. Such alteration can be a real mercy when, for example, the therapist can either help a patient to have the subjective experience of an event completely relived in a lesser amount of time—allowing the processing of the event to be completed in a session of conventional length—or make more time for the processing of the traumatic event. The therapist can also intensify the affect with suggestion to allow *facilitation of the abreaction. Distancing maneuvers* are routinely used by many therapists (e.g., Putnam, 1989) who encourage the patient to review

traumata as seen on a screen rather than being fully relived. *Fractionated abreaction* techniques have been noted above; one of the most interesting is to create for patients the image and subjective conviction that they can control the percentage of pain they feel with a mental rheostat. It is a wonderful experience for a patient who experiences a spontaneous flashback or abreaction between sessions to find that he or she can turn off its disturbing qualities instead of becoming disrupted.

Hypnosis, as noted above, is wonderfully suited to the *exploration and resolution of the acute symptoms* that so often punctuate the treatment of MPD patients. Also, as discussed elsewhere here, it is very useful for *facilitating integrations.*

Other techniques quite useful in working with MPD are journaling and ancillary creative arts therapies. Journals often allow expression by alters that fear or refuse to enter the therapy until they can participate in a more conventional way. Also, many alters prevented by others from emerging in therapy may be able to express themselves freely. For example, many patients fear that their more hostile and/or seductive alters will ruin the therapist's opinion of them or destroy the therapy; for them, the journal may be their way to be heard. I advise the patient to write no more than 20-30 minutes per day and to bring in the uncensored material. More than that is unwieldy and can get out of hand. The censorship that will be exerted despite the

therapist's instructions is often an excellent guide to the resistances that will be encountered.

Group therapies are often unhelpful unless they are structured dissociative disorder groups run by therapists who know MPD well. Support groups are cherished by these patients but are almost uniformly counter-therapeutic. While the patients enjoy feeling less alone with their conditions and feel well understood and validated, the problems of contamination, contagion, and being decompensated ("triggered") by others' issues and the complications of the interpersonal relationships engendered in these groups have led me to refuse to treat MPD patients who insist on participating in them.

MPD patients usually benefit tremendously from art therapy and movement therapy groups with similar patients. They often are able to express issues in the nonverbal therapies long before they can put them into words. Unfortunately, few of these groups are available for outpatients.

Medications are not effective for MPD per se but may be very beneficial in addressing co-morbid affective disorders and post-traumatic anxiety symptoms. The interested reader may wish to consult an authoritative review by Loewenstein (1991b).

All of the techniques noted above are useful at most phases of the

therapy, with some obvious exceptions. In all but the simplest cases, the alter system is layered and becomes manifest bit by bit (Kluft, 1984b). For example, as the therapist is moving to integrate some alters, others are being readied for such work and others have just been met or remain unknown. Therefore, in many therapies aspects of several phases of treatment are in process simultaneously.

In general, the therapist would not be likely to use hypnosis to effect an integration before work on traumatic material had occurred, nor would the therapist use abreactive techniques prior to the establishment of safety and containment. However, some exceptions occur: when very complex cases are encountered and some integration of alters without traumatic memories can be done at an early phase in order to enhance ego cohesion, or when the patient enters treatment overwhelmed by traumatic flashbacks that elude containment and some preliminary abreactive work is necessary to stabilize the patient.

It is difficult to discuss the length of treatment for MPD in an era that prizes rapidity of results and praises the limited utilization of available resources. MPD patients are a very heterogeneous group. Some can be treated very effectively in two or three years of twice-weekly psychotherapy, or even less. However, many MPD patients have been traumatized so badly that they must proceed at a pace that may feel intolerably slow for patient and

therapist alike, and they are so fragile that very intense treatment of long duration is necessary to sustain them and move them forward. It is often useful to begin with a reflection that a single major physical and/or sexual assault may have such devastating effects that years of treatment may prove necessary to restore the victim to health. The average MPD patient reports abuse over a 10-year period (Schultz, Braun, & Kluft, 1989). If one assumes rather continuous abuse at a rate of twice a week over that period, it is not unthinkable that the patient may have experienced over 1,000 serious assaults from which to recover. Perhaps this figure will offer a useful perspective.

In some respects, the concerns raised by MPD patients most resemble those a therapist must take into account in working with patients who have been sexually exploited by prior therapists. Trust and safety concerns require that the treatment not outstrip the patient's tolerance. Many therapists have adopted my clinical adage, "The slower you go, the faster you get there." Often slower is not only better, it is the only safe option. Pressing the pace of the treatment often leads to crises and complications that prolong the treatment considerably.

The termination of MPD patients is little-studied, except by the handful of therapists who have concluded the treatment of more than a few such patients. On the basis of having integrated over 150 MPD patients during 24

years of clinical practice, I offer the following advice.

For patients who value the psychoanalytic ideal and have very good ego strength, a standard termination phase may be in order. For those without such concerns, and for those with strong attachment and separation issues, I have found it most useful to taper the frequency of sessions gradually until a transition is made to what I call follow-up status. By this I mean sessions at less than monthly intervals but of full-session length. After a year of sessions every two months, I might consider a year of sessions every three or four months. In this manner, I allow a tapering off to sessions every year or two years. It has been my experience that I need not push for a termination; most of my patients seize the right time for them to insist upon it or claim that it is useful for them to touch base periodically. There are three added benefits of tapering:

1. Coming in and reporting residual difficulties is perceived as less of a narcissistic blow than it is to patients who have convinced themselves that therapy is finally over and that any further need for help is a mortifying defeat.

2. Being able to return and discuss successes in normal life usually is stabilizing and enhancing to the patient's self-esteem.

3. It provides reinforcement for positive identifications with the therapist and the skills acquired in the course of the therapy.

CASE EXAMPLE

Christa, a 32-year-old psychiatrist, sought treatment for social inhibitions, difficulties in her career, anxiety attacks, and numerous phobias, obsessions, and compulsions. She had interviewed and begun with eight other psychiatrists over the previous 10 months, and her explanations of why she left each of my predecessors could be summarized as a vague but increasingly compelling sense that there was something not quite right or something uncomfortable in each situation.

Christa was an attractive mid-westerner of Scandinavian-German ancestry. An only child, she was brought up in an atmosphere of religious fervor by her parents, stalwart members of an ultraconservative church. She described her life as circumscribed. She had a salaried position and hoped to do research and contribute to the literature. However, much of her free time was involved in elaborate cleaning and washing rituals. She was almost always late to work because she changed clothes several times before she could leave the house, and she almost always had to return to make sure that electrical appliances had not been left on. She tried to read and plan her research in the evenings, but she often became agitated when she tried to study and almost invariably fell asleep by 9:00 P.M. Although Christa was well liked and respected, she always feared being fired because she never could bring herself to take full histories from her patients—she found it too

upsetting. She was unable to remain in a room with a man or men without severe discomfort unless other women were present. She chose clothing that did not reveal her figure. On several occasions, she had made implausible excuses and dashed out of the offices of male superiors. Her social life was restricted to attending bland movies and plays, concerts, and professional lectures with older female colleagues, to whom she related in a dependent and childlike manner. At times she became acutely anxious without any apparent precipitant. She was afraid of tools such as screwdrivers and wrenches and also feared fish. She would not go to a restaurant that had a fish tank or live lobsters on display.

Because of her high ego strength and psychological-mindedness, her many symptoms and characterologic concerns, and her stated preference, we decided to proceed with psychoanalysis. However, once on the couch, Christa became virtually mute. Weeks went by in which only a handful of words were spoken. Although Christa spoke of me in a quite positive and respectful manner and assured me she was confident that I had her best interests at heart, she responded to my tentative interpretations of her resistance and apprehensions about making revelations or losing control as if they were scathing criticisms that mortified her. Often she replied tearfully that she was doing the best she could; at other times she insisted she was working hard and I could not appreciate this. On still other occasions she wondered why I was not as polite as people in her hometown church, who would never

embarrass one another.

I noticed that often she responded to my interventions as if I had not spoken, or that she seemed to be addressing her remarks to a question I had asked some time before my last observations. At times her voice became small and childlike, which I attributed to regression. At times she would sit bolt upright and stare uncomprehendingly or fearfully at me, or cry wordlessly. Despite interpretation and encouragement, she rarely was able to speak a word after such events; often she would make an apology for her failure to speak just as she left the office.

After 13 months, she indicated that she had a secret that was too embarrassing to share. Two months later, she confessed that since her teens she had been involved with the married pastor of her church in a sexual liaison. She was mortified because she knew their affair was absolutely wrong yet accepted this man's convoluted use of biblical precepts to justify it. The relationship continued during her visits to her hometown and during his various trips across the country.

After two years of classical analysis, during which most sessions were dominated by silence, apologies, and the trivial accounting of the day's events, Christa had shown little if any ability to respond to interpretations. My supervisor and I decided that perhaps the patient could not tolerate the

couch. The patient was requested to sit up. Although she spoke more freely, her material provided little grist for the mill.

After several months the effort to undertake a classical analysis was abandoned, and I began to take a more active and supportive stance. Christa became more relaxed and open. I began to focus on particular here-and-now problems that concerned her, and she began to make slow but steady progress in some areas. She became more comfortable with male colleagues. After she failed to pass her psychiatry boards, I asked her a series of probing questions in what I thought would be an effort to reassure her of her competence (since I was sure she would answer them accurately). I was astonished to find how limited her knowledge was. Christa protested that I was embarrassing her with my inquiries. She told me that she was unable to study in a normal manner because she was unable to stay up later than 9:00 p.m. every night. We worked on this issue for some three months and explored aspects of her wish to fail, her wish to avoid growing up, her sense that the completion of the boards would be the final step in having outdone her parents, who were intelligent but uneducated people. Her father was a farmer and part-time mechanic on a large dairy farm, and her mother was a housewife. Although our explorations brought up useful material and elicited strong affect, it was clear to both of us that something was missing. I pressed more aggressively, and Christa began to have more periods of silence, during many of which she sat tensely, her eyes filled with tears, and her expression

suggesting she was about to scream.

Now approximately four years after beginning the treatment, I gave serious thought to a trial of hypnosis to explore her blocks and unvoiced concerns. Much to my surprise, Christa readily assented. After the induction of trance, Christa opened her eyes and began to talk about "Christa" in a somewhat different voice, and with a smiling, unruffled expression. When I observed that she was talking about herself as if she were someone else, I was informed that I was talking to "Chrissie." Chrissie and the others had hoped that I could treat Christa without discovering them, but after four years of failure it was clear that the secret would have to be shared. Chrissie went on to say that Christa was very sad, even suicidal at times. She knew part of her despair was related to the activities of the other personalities, which usually restricted their activities to between 9:00 P.M. and 1:00 a.m. When these alters had been triggered to emerge in therapy, they had tried to not talk or to pass for Christa. Chrissie said the majority of Christa's despair was due to events in her past of which she was unaware.

Christa had no recollection of my conversation with Chrissie. Over a period of weeks, I elicited from Christa a great deal of information suggestive of MPD. For example, she had clothing in her closet that she did not recall buying, her telephone bills included charges for calls that she did not recall making, and it was clear that things were being done in her apartment for

which she could not account. For example, one morning she awoke to find her living room furniture rearranged. She also admitted with great embarrassment that she suffered brief periods of time loss almost every day. She stated that during a recent visit from her mother she had inexplicably attacked and almost strangled her mother before she regained self-control. She was so confused and upset by these things that she had denied them and/or minimized their importance.

Confronted with this evidence, Christa became flustered and floundered helplessly. After several unsuccessful attempts to explain her situation to her, I used hypnosis to elicit Chrissie and other alters for part of each session. I suggested that Christa would begin to allow herself to become aware of these conversations as she could tolerate them, and that all parts of her mind could listen in to therapy whenever they were willing to do so. Gradually Christa became able to hear the voices of the other alters as voices within her own head, although she was unable to remember any difficult material they suggested for several months. I furthermore requested that whichever alter was out report what the others said inwardly, just as if these words were his or her own thoughts, and identifying the source when possible. This allowed therapy to address more and more alters at the same time and reinforced the unspoken principle that all of the alters and their ways of interacting constituted personality in the usual sense of the word. It also allowed therapy to proceed in a manner that required fewer and fewer specific interventions

to access the various alters. If Chrissie was out, for example, and Christa or another alter had an observation on the subject at hand, Chrissie would voice what she heard within, in effect sharing "the mind's" contents. To illustrate, I will contrast the comments made by Christa and Joan, a non-MPD patient, about nearly identical upsetting dreams of sexual traumatization. In each case, the dream, a traumatic nightmare, involved the experience of forced sexual intercourse with a figure previously regarded with unequivocal positive regard.

> Joan: That was a horrible nightmare. What could it mean? I remember him as kind and good. And yet I have the feeling that this may have happened. That would be horrible! I couldn't live with that. No, it can't be real. It has to be just a dream, just my imagination. Maybe it is really about you, you know, that I have these impulses toward you that I can't accept, so in the dream you force it upon me. My God! You know, I always was upset by his sexual jokes, and I wondered why he always tried to French kiss me instead of a normal kiss. Could this dream be a memory? Oh, God. I feel awful.

> Christa: It was awful to have a dream like that. Why should I have a dream of being raped by a man who was like a father to me? Yet I can't shake the sense it really happened. Chrissie says that's because it did happen. No, Chrissie, you must be lying. Or maybe it's your fantasies. She says, "No, Christa, I'm sorry, but it happened. To Ginny." Ginny says she wants to kill herself now that I know and you know. Dr. Kluft, don't you think it has to be transference? I don't have any feeling toward you, but maybe some other part does. Maybe it's a rape fantasy, you know, 'cause I always say I have no sexual feelings, so I give them to you? Chrissie is reminding me that I always was upset that he touched my breasts when he hugged me, and kissed me so hard I was uncomfortable. I told my mother, but she said it must be my imagination or a mistake—he would never do that. My God! What if it's a memory? Chrissie and Ginny are saying it is true, but I am afraid to even consider it might be true.

By virtue of the therapist encouraging the alters to be present and to contribute to the treatment and urging the alter that is out to regard the observations of other alters as mental contents it must report as if they were its own, the cooperative patient gradually raises the same types of issues and conflicts that might be expressed by a patient without this type of disorder and becomes amenable to a more familiar type of treatment, with every session implicitly encouraging integration of all mental contents and of the structures described as personalities.

Christa gradually accepted the presence of the alters, and she and they became coconscious for contemporary events, effectively eliminating the amnestic spells and the disremembered behaviors. The alters allowed one another time to pursue particular interests, and since their differences were not terribly extreme, each felt enriched by the others. In this process, the younger alters experienced themselves as growing more mature, and the male alters accepted that they were part of a female and ceased to demand a separate life.

While this process was going forward and being encouraged, in therapy the amnestic barriers were not eroded except by agreed-upon interventions. For example, many of the alters revealed extremely traumatic sexual abuse at the hands of her father, material Christa could not hear without becoming dysfunctional. He had not only violated and brutalized her, he tortured her by

inserting his tools into her vagina and inflicting great pain. Therefore, for some time I worked with the alters that held these memories outside of Christa's awareness. Only after Christa began to have frequent dreams of these experiences and spontaneous flashbacks of the traumatic material did she accept the necessity of dealing with the possibility she had been abused. Gradually she began to listen in to the material the other alters were working on and abreacting.

Christa arrived at one summer session extremely upset. She and a friend had visited a seaside town. After a pleasant day on the beach, they had gone to a picturesque restaurant on a pier at which fishing boats docked. On their way to dinner, they had passed a fisherman filleting his catch. She had immediately gone into a profound panic attack but tried to pretend it was not happening. She had gone on to the restaurant and, although she did not usually drink, medicated herself with alcohol.

As the alcohol took effect, she had just begun to relax when she had an awful flashback. She and her father were in a boat, fishing. She had always recalled these trips as idyllic and was perplexed by her fish phobias, which had not begun until she left home. In this flashback, her father had insisted she perform fellatio in the boat, and she had refused. He slapped her, and she continued to say no. At this point her father had pulled up the string of fish they had caught and hacked them to pieces with his knife, shouting that he

would do the same to Christa if she defied him. Kneeling in the gore, still hearing the wounded fish flapping and gasping, and terrified for her life, she had complied. She was flooded with images of the traumatic scenario and kept feeling the physical sensations associated with it, so-called somatic memories.

Christa was not stable enough to see her own patients that day. She was seen in an extra session that evening. Traumatic material was continuing to pour through. Christa was sensing the experiences of the other alters as genuine, and more memories were coming through. She was exhausted, and it appeared she would not be able to function. Hypnosis was used to sequester the intolerable material with permissive amnesia, and we used the image of putting all of the memories and overwhelming affect in a strong vault that was sealed with a time lock so that it would not open in between sessions. The alters that had experienced and previously sequestered the experiences now flooding Christa were conducted with hypnotic imagery to a safe place and put to sleep between sessions with a suggestion their sleep would be dreamless. Christa was also given hypnotic anesthesia for the somatic memories.

Thereafter, Christa would come to sessions and the hypnotic restraints were relaxed in order to work with the various alters and their materials. When an alter had abreacted and worked through a trauma, it was gradually

shared with Christa, who often had to abreact it herself as well. Usually Christa could then retain it in memory, and the involved alter would spontaneously integrate with Christa. It took several months for this material to be reabsorbed and worked through in a gradual enough manner so that Christa could continue her practice without interruption. Although she had many difficult days, she did not miss work after the initial flashback at the seashore.

Even as Christa and her alters continued their work, the pressure to deny that any of the material was true remained intense. Christa felt very guilty that she might be speaking ill of her father and often spoke of all the traumatic material as if it were derealized. However, Christa began to improve dramatically as the work was done. Her fish phobias abruptly disappeared; no substitute symptoms developed. After two months of work on this material, she was able to extricate herself from her relationship with the clergyman. After abreacting and working through the incident on the boat, her compulsions and cleaning rituals gradually diminished. She had been forced to wash the boat down after the carnage and had spent several hours in the shower trying to clean herself thereafter. Her compulsions with regard to electrical plugs and appliances abruptly disappeared after recalling and working through her father's frequent use of power tools to threaten her with mutilation if she ever revealed his abuse of her.

After two years of work on this material, Christa was comfortable with men other than her abusive father and the clergyman. Interestingly, she also saw me as terrifying and potentially abusive, a clear traumatic transference (Kluft, 1994a; Loewenstein, 1993). Although Christa knew her fear was transferential, it was so compelling, especially in some alters, that she would arrive at sessions late and try to leave early, as if to minimize the time at which she was at risk with me. She also became very sexually provocative with me, stated that she was very turned on by me, and said that she was so stimulated that she felt on the verge of orgasm in sessions.

I interpreted this sexualization as serving a number of functions and as carrying a number of messages. For example, I saw the erotization as a defense against perceiving the brutality of the assaults and as her way of rehabilitating her father by taking on herself the burden of sexual encounters between them (convincing herself and him that she wanted him). I also saw her as reenacting a style of behaving as if she welcomed and enjoyed her father's advances, a stance her father insisted upon, beating her when she did not manifest it. Although many alters and Christa admitted much of what I inferred, this sexual behavior persisted at a high level of intensity until I came to appreciate that her apparent erotic arousal was directly proportional to her suppressed rage. When I interpreted this, it was denied, but the patient became so aroused that she appeared to be having a vigorous orgasm with violent pelvic thrusting. I continued to interpret, and the patient dissociated

openly into an alter unknown to me or to the alters with which I had worked. This alter confirmed my hypothesis and told me that the other alters could not accept the rage Christa had felt and the actions she had taken. Indeed, Christa was without any overt anger and was profusely guilty and apologetic for any real or imagined inconvenience she caused anyone. In fact, Christa's response to overhearing this material was not only to dissociate it anew but to become suicidal because she was sure that in some way she was a bad person. Every time I raised the issue of anger, Christa claimed to be sexually aroused and proceeded to engage in orgasmic behavior with pronounced pelvic thrusting.

Gradually and gently I met a group of alters that had the rage. These alters included some that had planned to kill her father, and several had made attempts. To summarize voluminous material, when one alter tried to hurt or kill the father, another that loved him would take over and impede the attack. On several occasions, Christa had been rendered catatonic in the midst of attacking her father with a buck knife, or while setting the house on fire. Gradually the pattern of defending against the hostile alters by intensifying sexual arousal had become established. The angrier the total human being was, the more vigorous and aggressive was her sexual behavior with her abusive father. This was what had been reenacted in the transference.

Slowly, Christa owned her anger. While at an early stage of this work,

her father fell ill and Christa was abruptly summoned home. She was very conflicted about going but rapidly denied the reality of her abuse experiences and went home to see her father. Her father had neglected the early warning signs of a malignancy; now he faced a terminal illness. Apparently he was well aware of his impending death and spent all of his time reading the Bible and in prayer. On the last day of her visit, Christa's father called her to him and asked her to pray with him. After prayer, her father began to cry. He said that he was sure he was going to hell for what he had done to her and begged her forgiveness. Christa said she forgave him. She was absolutely stunned by his confession.

Christa's father died shortly after her visit. After grieving him, an especially painful process for Christa and those alters that initially had had no subjective experience of abuse at his hands, therapy accelerated, and most of the remaining alters integrated rapidly. After further work on her rage and the recovery of more episodes in which she had tried to strike back at her father, the remaining alters integrated and Christa began to become increasingly assertive and capable of appropriate anger. Her new strength became apparent at her workplace, and she was promoted to a prestigious position requiring the strong exercise of considerable authority.

After having been integrated for several months, it became clear that alters had integrated before dealing fully with their intense affects, and that

although Christa had no remaining alters, she had the sense of a sequestered area in her mind full of strong affect. When interpretive efforts failed to access it, hypnosis proved effective in allowing Christa to experience it within session. Gradually it was accessed, expressed, and owned. It rapidly entered the transference and resolved with interpretive interventions.

Christa remains in treatment at a reduced level of intensity to continue the working-through process and to manage the occasional emergence of additional traumatic materials. She is also working on her realization that her mother knew of the incest and did not intervene. Christa has confronted her mother on the basis of material recovered in therapy. After much denial, her mother admitted that Christa's recovered recollections are accurate. Christa is enraged that her mother then immediately insisted that Christa, as a devout Christian, was obligated to forgive her. She now appreciates that her attempt to strangle her mother many years before was based on her briefly recalling her mother's complicity during an argument on another subject. She had rapidly repressed the memory, recalling only that she had inexplicably begun to strangle the older woman.

Christa's treatment was quite prolonged, but it has resulted in her stable integration and the alleviation of all of her distressing symptoms. She is able to socialize easily with men and is involved in a constructive relationship. Her chief regret is that because she could not consider an

intimate, mutually respectful relationship with a man until she was past 40 and would not consider becoming a single mother by insemination or adoption, she has been deprived of the experience of motherhood.

TRAINING

I have spent two decades consulting with colleagues treating MPD (Kluft, 1988b, 1988c), teaching therapists to use my techniques, and counseling mental health professionals overwhelmed by their attempts to work with this group of patients (Kluft, 1989b). Treating the severely traumatized is not for everyone, and a minority of colleagues find themselves deeply troubled and distressed by their efforts to work with MPD. Some experience vicarious traumatization or counter-identification and develop post-traumatic symptomatology. The countertransference strains of working with MPD have been described by Kluft (1994a), Loewenstein (1993), and Watkins and Watkins (1984), among others.

It is not uncommon for therapists beginning to work with such patients to feel unskilled and insecure. The literatures of child abuse, post-traumatic stress, memory, hypnosis, and the dissociative disorders are not familiar to many psychodynamic clinicians who find themselves confronted with MPD, often in a patient whom they have treated for years under another diagnosis and are loath to transfer to another therapist.

Fortunately, the modem literature includes many excellent texts to study. Putnam's (1989) masterful *Diagnosis and Treatment of Multiple Personality Disorder* is an excellent starting point, followed perhaps by Kluft and Fine's (1993) *Clinical Perspectives on Multiple Personality Disorder* and the September 1991 issue of *Psychiatric Clinics of North America,* edited by Loewenstein.

Because MPD patients are highly hypnotizable, dissociative patients, and because hypnosis in the form of spontaneous trance and autohypnosis will pervade every MPD treatment even if the therapist never induces hypnosis deliberately (heterohypnosis), knowledge of hypnosis is highly desirable, even essential. Because I know hypnosis as well as I do, I often can avoid the use of formal hypnosis, exploiting instead opportunities provided by spontaneous trances and autohypnotic phenomena. Hypnosis cannot be learned from textbooks as well as it can be mastered in a workshop setting. Most psychoanalytic caveats about hypnosis are clinically and historically inaccurate.

Hypnosis is not a treatment in and of itself, it is a facilitator of treatment. In Freud's era, hypnosis was used to facilitate the authoritarian treatment of the day, and the failure to distinguish hypnosis from the interventions with which it was associated at the end of the nineteenth century persists to this day in the psychoanalytic literature. It is useful to get hypnosis education

from programs that teach about hypnosis rather than a particular school of thought within hypnosis. At the time of this writing, a profusion of organizations purport to teach hypnosis. However, among them, only the American Society of Clinical Hypnosis has adopted standards specifying that beginning workshops teach the topics I consider essential to a firm foundation in hypnosis. Its workshop schedule can be obtained by calling 708-297-3317. Other reliable sources are courses sponsored by the Society for Clinical and Experimental Hypnosis and by Division 30 of the American Psychological Association.

Specific courses on treating MPD are available through the meetings of the American Psychiatric Association and the International Society for the Study of Multiple Personality and Dissociation (ISSMP&D), among others. The many local study groups affiliated with the ISSMP&D are useful sources for training. Interested therapists can also seek individual consultation with more experienced practitioners.

EMPIRICAL EVIDENCE FOR THE APPROACH

Although no controlled studies on the treatment of MPD are available as of yet, sufficient data are available to advocate the use of psychodynamic psychotherapy facilitated by hypnosis, which, empirically, is the most widely practiced approach to such patients (Putnam & Loewenstein, 1993). The data

come from several studies by myself (Kluft, 1982,1984b, 1985,1986b, 1994b) and Coons (1986).

I followed 210 MPD patients (Kluft, 1985) for varying periods of time. Of those MPD patients who received no treatment, all had MPD on follow-up. Of those who were treated by therapists who did not believe in the MPD diagnosis, all had MPD on follow-up. Of patients in treatments in which the MPD was acknowledged but not addressed specifically, 2-3% were cured of their MPD. Of those treated by me with psychodynamic psychotherapy facilitated when necessary with hypnosis, there was a 90% treatment adherence; 90% who remained in treatment integrated, and several others were satisfied with results short of total integration. In Coons's series, 95% of the therapists were neophytes with their first MPD case. On an average 39-month follow-up, two-thirds of the patients were much improved, and 25% had stable integration (although many others were near this goal or had achieved it briefly). My patients were seen largely in private practice; Coons's were seen in an academically affiliated state hospital clinic.

These outcomes suggest that MPD has a very good prognosis when a highly motivated patient encounters a therapist with considerable experience in working with MPD, and that a neophyte therapist addressing the MPD directly will be more successful than a more experienced practitioner who tries not to deal with the MPD. However, the situation is not that simple. More

recent findings (Kluft, 1994b) suggest that several subgroups of MPD patients have rather different treatment trajectories. Studying my private practice, which may be a skewed sample, I found that one subgroup, among newly initiated treatments, and the largest (70%), quickly developed an excellent therapeutic alliance and began to move rapidly in therapy. A second, the smallest (10%), made little progress and had continued crises. The third (20%) ran an intermediate course and included patients who improved continuously, but at a low rate, and patients whose course fluctuated widely, with mercurial ups and downs for protracted periods of time. I think that my group of high-trajectory patients, many of whom are high-functioning MPD patients (Kluft, 1986c), was unlikely to be highly represented in Coons's state hospital clinic cohort, which probably included more patients with low or medium trajectories.

Members of the high-trajectory group most approximate the traditional expressive psychodynamic patient and often require relatively little in the way of hypnotic interventions beyond those used to access alters or to facilitate integration. The continuous but slow-to-improve intermediate group approximates this. However, the intermediate group with major fluctuations and the low-trajectory groups required much more structure and directive interventions, and their treatments were more psychodynamically informed than psychodynamic in form and structure (see Kluft, 1992a). As of this point, the research does not allow conclusions as to whether specific co-

morbid conditions are responsible for these differences. Additional explorations are in progress.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.

Armstrong, J. (1991). The psychological organization of multiple personality disorder patients as revealed in psychological testing. *Psychiatric Clinics of North America,* 14, 533-546.

Armstrong, J. G. (1994). Reflections on multiple personality disorder as a developmentally complex adaptation. *Psychoanalytic Study of the Child,* 49, 349-364.

Armstrong, J. G., & Loewenstein, R. J. (1990). Characteristics of patients with multiple personality and dissociative disorders on psychological testing. *Journal of Nervous and Mental Disease,* 178, 448-454.

Barach, P. M. M. (1991). Multiple personality disorder as an attachment disorder. *Dissociation,* 4, 117-123.

Berman, E. (1981). Multiple personality: Psychoanalytic perspectives. *International Journal of Psychoanalysis,* 62, 283-300.

Bernstein, E., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease*, 174, 727-735.

Bliss, E. L. (1980). Multiple personalities: Report of 14 cases with implications for schizophrenia and hysteria. *Archives of General Psychiatry,* 37, 1388-1397.

Bollas, C. (1987). *The shadow of the object: Psychoanalysis of the unthought known.* New York: Columbia University Press.

Boon, S., & Draijer, N. (1993). *Multiple personality disorder in the Netherlands: A study on*

reliability and validity of the diagnosis. Amsterdam: Swets & Zeitlinger.

Braun, B. G., & Sachs, R. G. (1985). The development of multiple personality disorder: Predisposing, precipitating, and perpetuating factors. In R. P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 37-64). Washington, DC: American Psychiatric Press.

Breuer, J., & Freud, S. (1955). Studies on hysteria. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2, pp. 1-305). London: Hogarth Press. (Original work published 1893-95)

Carlson, E. B., & Putnam, F. W. (1992). *Manual for the dissociative experiences scale.* Beloit, WI: Beloit College, Department of Psychology.

Carlson, E. B., Putnam, F. W., Ross, C. A., Torem, M., Coons, P., Dill, D. L., Loewenstein, R. J., & Braun, B. G. (1993). Validity of the Dissociative Experience Scale in screening for multiple personality disorder: A multicenter study. *American Journal of Psychiatry,* 150, 1030-1036.

Coons, P. M. (1984). The differential diagnosis of multiple personality. *Psychiatric Clinics of North America,* 7, 51-67.

Coons, P. M. (1986). Treatment progress in 20 patients with multiple personality disorder. *Journal of Nervous and Mental Disease*, 174, 715-721.

Counts, R. M. (1990). The concept of dissociation. *Journal of the American Academy of Psychoanalysis,* 18, 460-479.

Despine, P. (1840). *De l'emploi du magnétisme animal et des eaux minérales dans le traitement des maladies nerve uses, suivi d'une observation très curieuse de guérison de neuropathie* [On the use of animal magnetism and mineral waters in the treatment of nervous maladies, followed by a very curious observation on the cure of a neuropathy], Paris: Germer, Balliere.

Ellenberger, H. F. (1970). *The discovery of the unconscious.* New York: Basic Books.

Fairbairn, W. R. D. (1952). *Psychoanalytic studies of the personality.* London: Routledge & Keegan Paul.

Fairbairn, W. R. D. (1954). Observations on the nature of hysterical states. *British Journal of Medical Psychology,* 27, 105-125.

Fine, C. G. (1988). The work of Antoine Despine: The first scientific report on the diagnosis of a child with multiple personality disorder. *American Journal of Clinical Hypnosis,* 31, 33-39.

Fine, C. G. (1991). Treatment stabilization and crisis prevention: Pacing the therapy of the multiple personality disorder patient. *Psychiatric Clinics of North America,* 14, 661-675.

Fink, D. (1991). The comorbidity of multiple personality disorder and *DSM-III-R* Axis II disorder. *Psychiatric Clinics of North America,* 14, 547-566.

Fink, D. (1992). The psychotherapy of multiple personality disorder: A case study. *Psychoanalytic Inquiry,* 12, 49-70.

Fischer, K. W., & Pipp, S. L. (1984). Development of the structures of unconscious thought. In K. S. Bowers & D. Meichenbaum (Eds.), *The unconscious reconsidered* (pp. 88-147). New York: Wiley.

Freud, S. (1958). A note on the unconscious in psycho-analysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 255-266). London: Hogarth Press. (Original work published 1912)

Freud, S. (1957). The unconscious. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud (Vol. 14, pp. 159-215). London: Hogarth Press. (Original work published 1915)*

Freud, S. (1961). The ego and the id. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 19, pp. 3-66). London: Hogarth Press. (Original work published 1923)

Freud, S. (1964). A disturbance of memory on the Acropolis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 22, pp. 237-248). London: Hogarth Press. (Original work published 1936)

Gabbard, G. (1994). Dissociative disorders. In G. Gabbard (Ed.), *Psychodynamic psychiatry in clinical practice: The DSM-IV edition* (pp. 291-326). Washington, DC: American Psychiatric Press.

Grotstein, J. (1981). *Splitting and projective identification.* New York: Jason Aronson.

Herman, J. L. (1992). *Trauma and recovery.* New York: Basic Books.

Horevitz, R. P., & Braun, B. G. (1984). Are multiple personalities borderline? A study of 33 cases. *Psychiatric Clinics of North America,* 7, 69-87.

Janet, P. (1889). *L'automatisme psychologique.* [Psychological automatism], Paris: Felix Alcan.

Jones, E. (1953). *The life and work of Sigmund Freud* (Vol. 1). New York: Basic Books.

Kluft, R. P. (1982). Varieties of hypnotic intervention in the treatment of multiple personality. *American Journal of Clinical Hypnosis,* 224, 230-240.

Kluft, R. P. (1984a). Aspects of the treatment of multiple personality. *Psychiatric Annals,* 14, 51-55.

Kluft, R. P. (1984b). Treatment of multiple personality disorder: A study of 33 cases. *Psychiatric Clinics of North America,* 7, 9-29.

Kluft, R. P. (1985). The natural history of multiple personality disorder. In R. P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 197-238). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1986a). Treating children who have multiple personality disorder. In B. G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 79-105). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1986b). Personality unification in multiple personality disorder: A follow-up study. In B. G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 29-60). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1986c). High-functioning multiple personality patients: Three cases. *Journal of Nervous and Mental Disease,* 174, 722-726.

Kluft, R. P. (1987a). Uncommon multiple personality disorder: An uncommon source of protracted resistance, interruption, and failure in psychoanalysis. *Hillside Journal of Clinical Psychiatry,* 9, 100-115.

Kluft, R. P. (1987b). The parental fitness of mothers with multiple personality disorder: A preliminary study. *Child Abuse and Neglect,* 12, 272,280.

Kluft, R. P. (1987c). First-rank symptoms as a diagnostic clue to multiple personality disorder. *American Journal of Psychiatry,* 144, 293-298.

Kluft, R. P. (1988a). On treating the older patient with multiple personality disorder: "Race against time" or "make haste slowly." *American Journal of Clinical Hypnosis,* 30, 257-266.

Kluft, R. P. (1988b). On giving consultations to therapists treating multiple personality disorder: Fifteen years' experience. I: Diagnosis and treatment. *Dissociation,* 2(3), 23-29.

Kluft, R. P. (1988c). On giving consultations to therapists treating multiple personality disorder: Fifteen years' experience. II: The "surround" of treatment, forensics, hypnosis, patient-initiated requests. *Dissociation,* 2(3), 30-35.

Kluft, R. P. (1989a). Playing for time: Temporizing techniques in the treatment of multiple personality disorder. *American Journal of Clinical Hypnosis,* 32, 90-97.

Kluft, R. P. (1989b). The rehabilitation of therapists overwhelmed by their work with multiple personality disorder patients. *Dissociation,* 2, 244-250.

Kluft, R. P. (1990). Dissociation and subsequent vulnerability: A preliminary study. *Dissociation,* 3, 167-173.

Kluft, R. P. (1991a). Multiple personality disorder. In A. Tasman & S. M. Goldfinger (Eds.), *American Psychiatric Press Annual Review of Psychiatry* (Vol. 10, pp. 161-188). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1991b). Clinical presentations of multiple personality disorder. *Psychiatric Clinics of North America,* 14, 605-629.

Kluft, R. P. (1992a). The perspective of a specialist in the dissociative disorders. *Psychoanalytic Inquiry*, 212, 139-171.

Kluft, R. P. (1992b). Hypnosis with multiple personality disorder. *American Journal of Preventive Psychiatry and Neurology*, 3, 19-27.

Kluft, R. P. (1993a). Conducting the psychotherapy of multiple personality disorder. In R. P. Kluft & C. G. Fine (Eds.), *Clinical perspectives on multiple personality disorders* (pp. 19-50). Washington, DC: American Psychiatric Press.

Kluft, R. R (1993b). The initial phases in the treatment of multiple personality disorder. *Dissociation,* 6, 145-161.

Kluft, R. P. (1993c). Clinical approaches to the integration of personalities. In R. P. Kluft & C. G. Fine (Eds.), *Clinical perspectives on multiple personality disorders* (pp. 101-133). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1994a). Countertransference in the treatment of multiple personality disorder. In J. P. Wilson & J. Lindy (Eds.), *Countertransference in the treatment of posttraumatic stress disorder* (pp. 122-150). New York: Guilford Press.

Kluft, R. P. (1994b). Treatment trajectories in the psychotherapy of multiple personality disorder. *Dissociation,* 7, 63-76.

Kluft, R. P. (in press a). Multiple personality disorder: A legacy of trauma. In C. R. Pfeffer (Ed.), *Intense stress and mental disturbance in children.* Washington, DC: American Psychiatric Press.

Kluft, R. P. (in press b). The management of abreactions. In B. M. Cohen & J. A. Turkus (Eds.),

Multiple personality disorder: Continuum of care. New York: Jason Aronson.

Kluft, R. P. (in press c). An overview of the treatment of patients alleging that they have suffered ritualized or sadistic abuse. In G. A. Fraser (Ed.), *The phenomenon of ritualized abuse.* Washington, DC: American Psychiatric Press.

Kluft, R. P., Braun, B. G., & Sachs, R. G. (1984). Multiple personality, intrafamilial abuse, and family psychiatry. *International Journal of Family Psychiatry,* 5, 283-301.

Kluft, R. P., & C. G. Fine (Eds.). (1993). *Clinical perspectives on multiple personality disorders.* Washington, DC: American Psychiatric Press.

Kuhn, T. S. (1970). *The structure of scientific revolutions* (2nd ed., enlarged). Chicago: University of Chicago Press.

Lasky, R. (1978). The psychoanalytic treatment of a case of multiple personality. *Psychoanalytic Review*, 65, 355-380.

Liotti, G. (1992). Disorganized/disoriented attachment in the etiology of the dissociative disorders. *Dissociation,* 5, 196-204.

Loewenstein, R. J. (1991a). An office mental status examination for chronic complex dissociative symptoms and multiple personality disorder. *Psychiatric Clinics of North America,* 14, 567-204.

Loewenstein, R. J. (1991b). Rational psychopharmacology in the treatment of multiple personality disorder. *Psychiatric Clinics of North America,* 14, 721-740.

Loewenstein, R. J. (1993). Posttraumatic and dissociative aspects of transference and countertransference in the treatment of multiple personality disorder. In R. P. Kluft & C. G. Fine (Eds.), *Clinical perspectives on multiple personality disorders* (pp. 51-85). Washington, DC: American Psychiatric Press.

Loewenstein, R. J., & Ross, D. R. (1992). Multiple personality and psychoanalysis: An introduction. *Psychoanalytic Inquiry,* 12, 3-48.

Marmer, S. S. (1980). Psychoanalysis of multiple personality disorder. *International Journal of Psychoanalysis,* 61, 439-451.

Marmer, S. S. (1984). The dream in dissociative states. In J. M. Natterson (Ed.), *The dream in clinical practice* (pp. 163-175). New York: Jason Aronson.

Marmer, S. S. (1991). Multiple personality disorder: A psychoanalytic perspective. *Psychiatric Clinics of North America*, 14, 677-694.

Nathanson, D. L. (1989). Understanding what is hidden: Shame in sexual abuse. *Psychiatric Clinics of North America,* 12, 381-388.

Nathanson, D. L. (1992). *Shame and pride.* New York: Norton.

Noll, R. (1989). Multiple personality, dissociation, and C. G. Jung's complex theory. *Journal of Analytic Psychology,* 34, 353-370.

Ogden, T. H. (1992). Consultation is often needed when treating multiple personality disorder. *Psychodynamic Letter,* 1 (10), 1-4.

Putnam, F. W. (1989). *Diagnosis and treatment of multiple personality disorder.* New York: Guilford Press.

Putnam, F. W., Guroff, J., Silberman, E. K., Barban, L., & Post, R. (1986). The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. *Journal of Clinical Psychiatry,* 47, 285-293.

Putnam, F. W., & Loewenstein, R. J. (1993). Treatment of multiple personality disorder. *American Journal of Psychiatry,* 150, 1048-1052.

Ross, C. A. (1989). *Multiple personality disorder: Diagnosis, clinical features, treatment.* New York: Wiley.

Satinover, J. (1993, October). *Archetypal structures and the neural basis of dissociability: An integrative model.* Paper presented at the 10th International Conference on Multiple Personality/Dissociation, Chicago.

Schreiber, F. R. (1973). *Sybil.* Chicago: Regnery.

Schultz, R., Braun, B. G., & Kluft, R. P. (1989). Multiple personality disorder: Phenomenology of selected variables in comparison to major depression. *Dissociation,* 2, 45-51.

Smith, B. L. (1989). Of many minds: A contribution on the dynamics of multiple personality. In M. G. Froman & B. L. Smith (Eds.), *The facilitating environment* (pp. 424-458). New York: International Universities Press.

Spiegel, D. (1986). Dissociating damage. *American Journal of Clinical Hypnosis,* 29, 123-131.

Spiegel, D. (1991). Dissociation and trauma. In A. Tasman & S. M. Goldfinger (Eds.), *American Psychiatric Press Annual Review of Psychiatry* (Vol. 10, pp. 261-275). Washington, DC: American Psychiatric Press.

Spiegel, D. (1993, October). *Dissociation, trauma, and DSM-IV.* Paper presented at the 10th International Conference on Multiple Personality/Dissociation, Chicago.

Steinberg, M. (1993). *Structured clinical interview for DSM-III-R dissociative disorders (SCID-D).* Washington, DC: American Psychiatric Press.

Stem, C. R. (1984). The etiology of multiple personalities. *Psychiatric Clinics of North America,* 7, 149-160.

Stolorow, R. D., & Atwood, G. E. (1982). Psychoanalytic phenomenology of the dream. *Annual Psychoanalysis,* 10, 205-220.

Ulman, R. B., & Brothers, D. (1988). *The shattered self.* Hillsdale, NJ: Analytic Press.

Watkins, J. G., & Watkins, H. H. (1984). Hazards to the therapist in the treatment of multiple personalities. *Psychiatric Clinics of North America,* 7, 111-121.

Wilbur, C. B. (1984). Treatment of multiple personality disorder. *Psychiatric Annals,* 14, 27-31.