DYNAMIC THERAPIES FOR PSYCHIATRIC DISORDERS

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

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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.

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