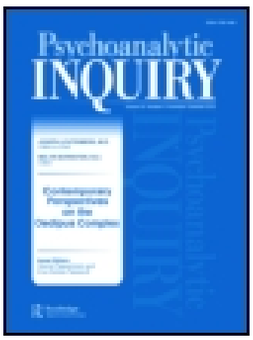

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Multiple Personality Disorder and One Analyst's Paradigm Shift

RICHARD M. WAUGAMAN, M.D.

LAMENTABLY, RECENT DISCUSSIONS of multiple personality disorder (MPD) reflect sharp polarizations between those who accept the existence of this disorder as a genuine clinical entity (e.g., Putnam, 1989; Kluft, 1996) and those who believe it is either rare or iatrogenic, the joint creation of gullible therapists and suggestible patients (e.g., Merskey, 1992; Simpson, 1995). Until several years ago, I shared the opinion of the latter group. But more recently, my own clinical experience led me to change my mind (see also Waugaman, 1998, 1999, and Imperio, 1999). In this article, I will discuss this shift in my thinking about MPD. In my title, I borrow the concept of a paradigm shift with respect to MPD from the excellent article by Loewenstein and Ross (1992), who, in turn, borrowed the term from Thomas Kuhn (1970). I have found their discussion of the paradigm change involved in current theories of dissociative disorders to be a very useful way of understanding not only the evolution of my own thinking about MPD, but also the reaction of colleagues to these phenomena. In my own experience, some analytically trained colleagues can be especially self-assured in their insistence that MPD does not exist or is iatrogenic or is an incorrect diagnosis for some patients who actually have border-

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line personality or some other disorder. Kluft (1992) notes that "few mental disorders have remained as remote from the mainstream of contemporary psychoanalytic inquiry as MPD" (p. 139). I want to clarify that the paradigm shift I am referring to is my recognition of the existence of MPD and of technical modifications in its treatment, not some abandonment of the psychoanalytic model. I share Richards's (1996) preference for Rangell's "total composite theory" of psychoanalysis, which contends that analytic theory grows by accretion, rather than by completely replacing old theories with new ones.

There are several possible reasons for some analysts' skepticism about MPD. Naturally, it is possible that they are correct. Putnam (1989) and others have introduced a second possible explanation, by tracing the current controversy over MPD back to the intellectual rivalry between Sigmund Freud and the nineteenth-century French psychiatrist Pierre Janet. Freud's victory in this rivalry has led, especially for psychoanalysts, to a greater emphasis on intrapsychic etiological factors and repressive defenses, as opposed to traumatic etiologies and dissociative defenses. Many debates about MPD involve a false dichotomy between a focus on intrapsychic conflict or a focus on external trauma. As Rangell (1995) has recently argued, both of these etiological factors play a role in every patient's psychopathology:

> When Freud . . . moved from seduction to fantasy, from the concrete to the psychological as an explanatory concept, a split was allowed to develop on the basis of a fallacy, which, to this day, seems never to have been corrected. It is difficult to say which group represents the larger number today: those who believe seduction has been betrayed . . . or those who hold that external experiences are false, unimportant, or diversionary. . . . The fact is that Freud discovered two streams of aetiology sequentially; the fused outcome can only be explained by both together [p. 15].

Oversimplification seems to be a widespread cognitive error. All of us are prone to treat complex matters of diagnosis, etiology, and treatment as though we are in a voting booth and are forced to pick only one candidate from a list of choices. This oversimplification is highly maladaptive, though I suppose it is so ingrained partly because it harkens back to a time when our forebears might encounter

a saber-toothed tiger. Our gene pool was enriched by those who made rapid fight-or-flight decisions and gradually depleted of those whose temperament favored a more leisurely assessment of the many complex questions posed by such an encounter. (An MPD patient offered one of the best metaphors I have encountered for all-or-none thinking when she quipped, "I wasn't wired with dimmer switches.")

Another possible reason for psychoanalysts' resistance to the dissociative paradigm is that psychoanalytic theory is our most complete explanation of human psychology. The very intensity, thoroughness, and length of analytic training may leave analysts with the false confidence that they understand the essentials of the mind and how it functions. MPD challenges some of these basic assumptions. In other respects, it brings new meaning to many previously abstract analytic concepts.

DSM-IV has renamed MPD as dissociative identity disorder, or DID. David Spiegel, who was responsible for this change, has explained (personal communication, 1994) that the term MPD may reify as objectively valid some patients' subjective sense of being a collection of different people. In working with MPD, we are always walking a fine line between validating the subjective reality of the patient's inner multiplicity—in keeping with Evelyn Schwaber's (e.g., 1992) emphasis on intrapsychic reality—while also not forgetting that the patient is, in fact, a single person. This is easier said than done. For example, in dealing with alters (or alternate personalities) that are based on childhood abusers, I have repeatedly discovered that I had lapsed into a sort of countertransference psychosis, and I was feeling toward these alters what I would have felt toward the abusers on whom they were based.

Since 1984, I have worked intensively with several MPD patients and consulted on many others. I often felt that the result of my efforts to convince skeptical colleagues of the existence of MPD was either to enhance the credibility of MPD as a diagnosis or—especially early on—to damage my own credibility in the eyes of those colleagues.

My interest in MPD goes back to 1967. When I was in college, I had a summer job typing the manuscript of a book (Sottong, 1969) that included an extensive case report of a patient who had MPD. At that time, most psychiatrists believed MPD was extremely rare. A powerful and lasting aspect of this experience was an injunction made by the psychiatrist for whom I worked that I never, under any circumstances, discuss this patient with anyone. He added that, if I did so, someone

would be killed. I had inadvertently learned the identity of the patient he was writing about, and this was one reason for his warning. (In the meantime, he has rescinded his prohibition against my discussing his patient.)

For the first several years of my own clinical work with MPD, it never occurred to me to connect my recent interest in this disorder with my earlier experience with the book manuscript. When I did finally ponder this blind spot in my thinking, I concluded that I must have made a considerable unconscious effort to keep these experiences separate—in effect, I had dissociated them from each other. And I assume that my doing this reflected the ongoing effectiveness of the psychiatrist's injunction never to talk about his patient. If you do not allow yourself to think about something, there is less danger that you will ever talk about it. I thus had a small taste of an experience that is common in patients with MPD—these patients are abused in unspeakable ways, and then their abusers typically forbid them ever to disclose the abuse to anyone, often under the threat of death (Lister, 1982).

For example, the man who regularly molested one of my patients during her early childhood threatened her with a gun and warned that he would kill her if she ever told anyone what he did to her. She once told me these threats constituted the worst aspect of his abuse because they prevented her from talking about it until her work with me. Not being able to tell anyone about his abuse was one of the factors that led her to use massive dissociation as an extreme defense against psychic annihilation (cf. Shengold, 1989; Loewenstein, 1996). So when the psychiatrist for whom I typed the manuscript warned me that someone would be killed if I ever talked about his patient, I would speculate that he was motivated in part by an unconscious enactment with me of some feature of his own patient's history, which intensified his countertransference identification with her actual abuser as well as his identification with her abuser introject, or alter.

I had to overcome considerable inner resistance in order to present my work with an MPD patient for the first time at the annual Chestnut Lodge Symposium in 1990. That patient had told me I would be killed if I ever told anyone about her abuse. Like the psychiatrist for whom I typed the book manuscript, I was powerfully gripped by the force of this threat, until further knowledge of her and her disorder helped me put her threat in perspective. When I presented that patient, I had begun, but I had by no means completed the paradigm shift to which I referred in my title.

It was in preparing that presentation that I began to read the current literature on MPD. Previously, I was probably like many analysts who inadvertently find themselves working with an MPD patient. The diagnosis of MPD had crossed my mind from the earliest weeks of my work with that patient. But I tried to dismiss it, telling myself it was highly unlikely, since it was such a rare disorder. Furthermore, I believed it was largely the iatrogenic product of a therapist's excessive interest in the fascinating symptoms of a hysterical patient, so I did my best to betray no interest in my patient's dissociative symptoms, while likewise betraying no interest in the solid literature on MPD that—I now realize—was then available. And last but not least, I was worried that if my patient did have MPD, it meant I had overlooked the correct diagnosis for years, and there was a lot I needed to learn in order to treat her more effectively. Analysts can avoid such an experience of cognitive dissonance by convincing themselves that MPD is rare or iatrogenic.

To my further embarrassment, all the while I was preparing that earlier paper and beginning to read the MPD literature, I was working intensively with a second patient who had a severely traumatic history and who, in retrospect, showed rather glaring dissociative symptoms, without my once considering the possibility that she too suffered from MPD. My paradigm shift with that second patient occurred only several years into our work. I had not been paying much attention to her reports of episodes of amnesia. Once more, I thought this patient was hysterical and unusually moody ("La donna è mobile"!—the aria from Verdi's opera *Rigoletto*) and that it would be a mistake to encourage her by getting too interested in such a symptom. But when I finally asked her how often these episodes occurred—"Every month or so?"—she replied with surprise, "No, it happens every day!" After that turning point, I explored her dissociative symptoms, and she eventually showed obvious evidence of MPD. (Ann-Louise Silver, M.D., has suggested that my question, "Every month or so?" revealed my unconscious countertransference minimization of her symptoms as comparable to menstruation.)

I may not need to emphasize how disconcerting I found it to acknowledge to myself that I had overlooked this second patient's correct diagnosis for several years, not even suspecting it, as I had with my first MPD patient. One painful aspect of making the paradigm shift to the dissociative model for experienced analysts is having to admit that one has been wrong in overlooking the diagnosis of MPD in

some of one's current and previous patients. Rather than admit one has been wrong, it is easier to deny that the disorder exists.

After these confessions, I want to mention one advantage of my slowness to recognize MPD in these patients and to acquaint myself with the recent literature. One of the charges leveled by the MPD skeptics is that these patients' symptoms fit such typical patterns, not because of any genuine illness, but merely because the patients have been manipulated by their treatment to invent these symptoms. But my first two MPD patients were protected against this possibility for years by my ignorance of the MPD literature.

My third MPD patient had been keeping journals for several years before I began treating her. Like my second patient, it was her symptoms of amnesia—"losing time"—that alerted me to the possibility that she had MPD. She had never mentioned this symptom to her previous analyst, whom she saw five times per week for 2 years. Nor did she ever tell him that there was a full year in high school of which she had absolutely no memory. She readily told me about these symptoms in one of our first sessions, but only after I had directly asked her about gaps in her memory. As we began exploring the possibility that she had MPD, she was extremely skeptical. However, she eventually found herself rereading her old journals. One of the first things she noticed was the sudden shifts in her journal entries, with abrupt changes of topic, emotional state, and even handwriting. Despite this, she stubbornly denied the possibility she could have MPD. Finally, a few months later, she admitted, "I've known for as long as I can remember that there are different sides of me. But I made a deal with them a long time ago that I'd keep them secret if they'd let me be in charge." Despite the skeptics' allegations about patients feigning symptoms of MPD for secondary gain, none of my three patients has welcomed this diagnosis. In fact, my patients could outdo your average professional skeptic in their creativity at rationalizing away all evidence of their multiplicity. For example, "It's just something we're imitating because it's on television all the time"; "some people do have MPD, but we only seem to have it"; or perhaps most mind-bending of all, one alter will deny having MPD, while admitting that the other alters seem to have it.

One of the things I found so convincing about reading the MPD literature was how closely the clinical descriptions I read conformed to the material that I had previously encountered in my patients. The MPD paradigm illuminated symptoms and behavior I had found par-

ticularly baffling. It also helped me deal far more effectively with some of these symptoms. I will give some examples. My first MPD patient would occasionally enter what I considered at the time to be transference psychosis regressions in her hours with me, when she would misidentify me as her childhood molester. I found it nearly impossible to contain her at those times. When she sometimes tried to injure herself in my office—cutting her hands and wrists, smashing her hand against the sharp edge of the handle on my filing cabinet, breaking the glass that covered one of my certificates with her fist—I felt compelled to physically restrain her, which only frightened her further.

With the help of the literature I was reading (e.g., Putnam, 1989), I came to the belated realization that, in these states, the patient was switching to a specific protector alter, who exhibited the violence that would be appropriate in dealing with the abuser she perceived me to be. Like most of us, my instinctive reaction when dealing with such an alter was to want to get rid of it. Putnam's description of the constructive, protective role these alters play and his suggestions for handling them helped re-orient me with my patient. Eventually, I would ask to speak to this protector alter when I anticipated she might be about to arrive on the scene. Or I would ask this alter to stay especially close by if I was about to speak with a second alter about a topic I expected the latter would find threatening. I also learned to clarify for the patient who I was and what the current year was when I sensed that frightened child alters were experiencing me in a "flashback transference" (Loewenstein, 1993). With such modifications of my approach, the patient's behavior changed dramatically. Her violent behavior in my office stopped altogether, and her chronic self-cutting outside sessions subsided and eventually ceased. Furthermore, for the first time she was able to remember some of her childhood traumas. Previously, every time I brought them up or they emerged spontaneously, they would lead to marked regressions in which she relived these events, misidentifying me as an abuser.

Similarly, a second patient had an alter who contained many of her traumatic memories, but this alter could only relive those events and could not remember them. After this alter fused, the patient described with amazement how she could now voluntarily recall traumatic events. She said that, hitherto, she either believed they had not occurred or she got swept away by the floodwaters of flashbacks, in which she experienced her childhood traumas as actual contemporary

events. Like so much of the clinical phenomenology of MPD, this dramatically illustrates aspects of psychoanalytic theory (e.g., Freud's [1914] paper, "Remembering, Repeating, and Working Through").

A third patient, whom I will call Ellen, also illustrates the value of the dissociative paradigm in managing self-destructive impulses. Ellen had had 17 previous hospitalizations before I began treating her. She had made numerous suicide attempts, some of them nearly fatal. The session before she was leaving on a trip to take care of some business out of town, she told me she was afraid she would once again cut herself while she was away. She admitted that not all parts of her mind would agree to keep herself safe on the trip. "I won't hurt myself, but I'm concerned I might dissociate." I understood this to mean that she knew another alter might hurt her. She promptly fell into a silent trance for a minute and then spoke in a different, angry voice about the trip. Assuming she had just switched to a different alter, I asked, "Are you angry at Ellen about the trip?" She admitted she was, and she said she planned to cut Ellen on the trip. She was angry because the patient would be traveling to a city where she had previously been hospitalized and severely mistreated. This session, 1 year into treatment, marked the first occasion when one of her alters had addressed me so directly. It illustrates a point that Harold Searles (personal communication, 1985) has made about suicidality in borderline patients: that the suicidal impulse may constitute the effort by one introject to murder another part of the patient's mind. His formulation is a good example of a psychoanalytic construct that vividly comes to life in working with MPD.

Getting back to Ellen, I told the angry alter who planned to cut Ellen that she and Ellen were in it together and needed to learn to communicate with each other better. I speculated that she had not tried to speak with Ellen directly, but just threatened her with cutting. Rather than reply, this alter switched back to Ellen. She had no memory of the previous 15 minutes, during which I had spoken with the alter. But when I summarized those 15 minutes, Ellen got angry and said of the alter, "She's the one who got me hospitalized in the first place!" I pointed out how much they blamed and misunderstood each other, and I told her it was essential for her safety that they communicate better internally. Ellen went on to have a successful trip and did not cut herself.

Naturally, these changes in my approach with my MPD patients did not always go smoothly. Several years ago, after I had read some

recent articles on MPD, I became more active in trying to facilitate contact among some of the alters of my first MPD patient. She noticed the change in me, and she complained, "You're not talking like yourself." On the other hand, perhaps identifying with the more direct approach I was taking with her, she now sought and received external confirmation of her abuse for the first time.

As I mentioned earlier, I borrowed part of my title from Loewenstein and Ross's (1992) article on MPD. They persuasively apply Thomas Kuhn's concept of paradigm shifts in the history of science to the newer conceptualizations of dissociative disorders. The clinical phenomenology of MPD has been described by the traditional psychoanalytic conceptualizations of hysteria or by the newer diagnosis of borderline personality. I believe that Loewenstein and Ross were correct in drawing attention to the collection of forces that may impede us in objectively considering alternate conceptualizations of dissociative pathology.

Many of those who have written about posttraumatic and dissociative disorders have cited the nineteenth-century work of the French psychiatrist, Pierre Janet. Despite the historical antagonism between Freud and Janet and the residual false dichotomy between a focus on intrapsychic conflict and a focus on external trauma, clinicians are likely to find that working with dissociative patients makes excellent use of their analytic or psychodynamic training. Psychoanalytic conceptualizations, that otherwise seem esoteric and abstract, take on new meaning in working with this patient population. You've never really seen identification with the aggressor until you've encountered an alter that is based on this mechanism. Much of object relations theory, for example, seems tailormade for the understanding of MPD. In fact, Fairbairn's (e.g., 1931) contributions to object relations theory, in all likelihood, owed a great deal to his work with patients who had MPD and other posttraumatic disorders (Jill Scharff, personal communication, 1994). Ferenczi's (1933) paper "Confusion of Tongues Between Adults and the Child" is extraordinarily prescient in anticipating much of the current thinking about the etiology, transferences, and countertransferences involved in the treatment of posttraumatic psychopathology.

I would now like to discuss some further connections between the MPD paradigm and our familiar analytic paradigm. Familiarity with the central role of intrapsychic conflict helps the analytically trained therapist avoid lapsing into an oversimplifying etiological and thera-

peutic model that places exclusive emphasis on the traumatic impact of outside events and people. Analytic training helps us appreciate the complex interaction between multiple intrapsychic and external factors in producing and perpetuating psychopathology.

Analysis is also relevant to the treatment of MPD from the point of view of the psychology of the therapist. Therapeutic work with posttraumatic patients is inevitably traumatizing to some degree for the therapist (so-called secondary or vicarious traumatization), and personal therapy or analysis is especially important in helping us minimize these effects of treatment while working with MPD patients, whose traumas have been so extreme.

I am convinced that one hazard of failing to recognize dissociative pathology in a patient is an increased risk of boundary violations by the analyst. Putnam (1989) believes that MPD patients become sexually involved with their therapists much more often than do other patients (p. 192). There is considerable evidence that patients who have been sexually abused in childhood are at increased risk for sexual involvement with their therapists. A number of features of MPD make such a risk seem even greater than with other previously abused patients. I suspect this risk is greater still when the therapist is unaware that the patient has MPD. For example, one patient became sexually involved with both of her previous therapists. Neither of them had realized she has MPD. She told me that, when she became convinced they intended to seduce her (perhaps because of some innocent expression of warmth on their part), she switched to the alter who had been created to be present when she was sexually abused as a child, and she then turned passive to active and initiated sexual involvement with her therapists. If an analyst is unfamiliar with MPD or unaware that a patient has it, he or she is then less aware of the special risks of boundary violations with such patients. Specific countertransference reactions elicited by MPD patients (Loewenstein, 1993) contribute to these risks. These reactions include the secondary traumatization I mentioned earlier; confusion in the face of switching between alters or, more commonly, covert influence of alters on one another; identification with the defensive use of dissociation; and an erotized countertransference reaction to an alter that, as in the case I just mentioned, turns passive to active and seeks to seduce in order to avoid feeling sexually abused.

Gabbard (1992) has described the hazard of a countertransference identification with the patient's childhood deprivations and the

resulting wish vicariously to repair related deprivations in the therapist's own childhood by offering the patient inappropriate gratifications. The frustration of being unable to understand or help these patients with their dramatic and dangerous symptoms may contribute to what Searles (1979) has characterized as the wish to cure the patient through physically expressed love. Similarly, Kluft (1996) has written, "Often one feels deskilled with these patients. Some [therapists] become angry at the patient or themselves; some may make frantic efforts to do something, anything, that works. Many boundary violations find their origin in such efforts" (p. 1625). I hope I do not need to add that these remarks are in no way intended to blame the patient when boundary violations do occur.

The assumption that there is a single correct treatment approach to patients with MPD may interfere with therapists continuing to search for more effective methods of treatment, which are specifically suited to each patient–therapist dyad. Some specialists in the field of dissociative disorders have speculated that the patient who wrote *I Never Promised You a Rose Garden* had MPD (Loewenstein and Ross, 1992). She had an excellent outcome, but no one has claimed that Frieda Fromm-Reichmann was following some now prevalent treatment protocol for MPD. It is conceivable that some of these patients could even do better with a therapist who does not believe MPD exists—such a therapist could more effectively use a suppressive approach, albeit unwittingly. Most patients who have MPD spend longer or shorter periods of their life with their multiplicity latent (Kluft, 1996). The overtness of their MPD depends on the balance of stressful and supportive forces in their lives. A supportive treatment approach by a therapist who does not recognize the underlying MPD may help some of the patient's symptoms, although it cannot resolve the underlying propensity to resort to MPD in the face of future life stresses.

As Kluft (1996) has written, "In clinical practice, the clinician working with DID patients will find that no particular model of treatment provides an ideal guide for all the situations and circumstances he or she is likely to face" (p. 1606). Kluft acknowledges that some treatments that do not aim to integrate the patient's alters can still be useful (p. 1607). Having said all this, I do contend that the MPD paradigm vastly enriches the treatment of these patients. If a therapist has patients with traumatic histories who are not responding well to treatment, I would strongly suggest that MPD be considered in

the differential diagnosis. When encountering a treatment-resistant patient with any medical or psychiatric disorder, it is prudent to reconsider the initial diagnosis.

Formal hypnotherapy is often a central aspect of the treatment of MPD. This may deter analysts who have not been trained in hypnosis from undertaking the treatment of these patients. I have been able to do a sort of experiment in nature on the treatment of MPD without using formal hypnosis, since I have not been trained in its use. One of my MPD patients has been gradually fusing. This process has now assimilated more than half of her previous alters. This has convinced me that such an outcome does not require formal hypnosis. Nevertheless, it is clear that self-hypnosis plays a central role in dissociative disorders, and helping patients control that process more effectively, such as in their switches, is a vital goal of therapy.

I would like to turn to the question of differential diagnosis—specifically, between MPD and schizophrenia. Citing a paper by Milton Rosenbaum (1980), Putnam points out that, from 1914–1926, there were more case reports of multiple personality than of schizophrenia or dementia praecox in the medical literature, but afterward, thanks to Bleuler's influence, the proportion of these diagnoses was reversed. Putnam has raised the possibility that this may have led to misdiagnosing many dissociative patients as schizophrenics. In a survey Putnam conducted, half of the patients with MPD had received a diagnosis of schizophrenia at some point in their prior treatment.

My 8 years of work with one severely psychotic patient has convinced me that, at the very least, the posttraumatic, dissociative model of psychopathology has heuristic value in making contact with certain psychotic patients. George, as I will call him, had shown no significant evidence of psychiatric disturbance until college, when he dated for the first time. According to his friends, the woman he then fell in love with was a prostitute, and when he refused to leave her front yard one day, her pimp had him gang-raped by a group of men. He immediately became floridly psychotic, and has remained so for the intervening 20 years. During my first months of work with him, I was struck by his habit of referring to himself in the third person as George. I discovered that Bleuler described this symptom as occurring in schizophrenics, but it was years before I saw the similarity with the way in which dissociative patients refer to themselves when speaking as an alter. I then administered the Dissociative

Experiences Scale (DES) to the patient. The DES is a self-test containing 28 questions. George scored a 55, which is well above the mean score for schizophrenia and in the range found in MPD. For example, he reported that 80 percent of the time, he was told he did not recognize friends or family members, and 100 percent of the time, he felt that his body did not belong to him.

Several years into our work, I became more active in directing our sessions to the topic of his rape. I was encouraged in doing so because he showed great interest when I brought this up and became far more verbal than he usually was. I explained to him that his answers on the DES raised the possibility that his reaction to the rape was having ongoing effects on how his mind functioned, and we began exploring these effects. George asked, "Does this treatment involve an outpouring of emotions?" During the earlier years of our work, he was unable to tolerate any discussion of his rape. Or more accurately, I could not tolerate it, after he came close to assaulting me because he misperceived me as the man who set up the rape, and he shouted at me threateningly, "You caused a man to be raped!" Now, there was a striking increase in his capacity to talk about the rape, albeit sometimes in a highly thought disordered way. He asked during one of these sessions, "Do you know anything yet about 3, 2, 1? Urination, defecation, castration. I think the only way to get home from the hospital would be to be led to a bathroom." Because of his reference to castration, I told him that men feel emasculated by being raped, but they are still men. On another occasion, he revealed the gender confusion that had resulted from his rape by saying, "It happened through a left cheek approach, up the fallopian tube." I asked what the worst thing about the rape was, and he replied, "being unprepared." At other times, he would resort to massive denial, claiming not only that he was never raped, but that no one has ever been raped. I thought he was conveying something of the psychological annihilation that the rape represented to him when he asked, "Doctor, did you ever study Hiroshima and Nagasaki in connection with the rape?"

After lapsing back into silence during most of his sessions, George again became much more verbal when I used dissociative language, and I joined George in referring to him in the third person. I had just suggested that we might go off the hospital grounds together, something we had often done in the past. George protested, "No, that wouldn't be a good idea." When I asked why, he said it was because

of "sterile precautions." He elaborated on this idea, stating that it would be dangerous, and possibly even fatal, for George to acquire some illness caused by our not observing sterile precautions. As I then joined him in referring to him as George, he seemed to become "a different person"—talkative, interactive, thoughtful, showing good recall of some of our past sessions over the years, smiling and laughing, and so on. He explained, "Strict silence is the best way of keeping sterile precautions. But we've already passed that point, and no harm seems to have come from it. You've asked to talk with different parts of my mind." This was something I had indeed asked in the past, but not in this hour or in the previous few months.

One session, he began telling me about a man who supposedly came to his room every night and had been doing so since about the time he was raped. When I asked him to tell me more about this man, he responded, "That wouldn't be possible without digressing." I thought this "man" might represent an alter, so I encouraged George to "digress," and this seemed to facilitate something akin to a switching process. When I asked for the name of this man, George replied, "An ergotamine medical allergy of gangrenous proportions with a contact frailty neurological malady transfer complaint, which my wife and I were made subject to for an indefinite period of time." (I had been hoping for a name that would be easier to remember!) But this ostensible gibberish seemed to contain an etiological theory, or perhaps metaphor, which George was proposing for his illness. I have frequently been surprised by the extent of George's medical knowledge. Ergot is produced by a fungus that grows on rye. In the Middle Ages, there were epidemics of ergot poisoning from contaminated rye bread. It caused agonizing burning sensations in the extremities, which developed gangrene and sometimes fell off. (Recall George's comment about castration during one of the times we had talked about his rape.) Ergot poisoning can also cause psychotic symptoms—LSD is related to ergot. The "wife" he referred to now appears to be an alter that was created at the time he was raped, to help him deal with the gender confusion a man would feel in being raped. Kluft (1991) proposed the category of "posttraumatic MPD" to refer to patients whose MPD was "clandestine" until some adult trauma, such as rape, leads the MPD to become overt. His formulation may be relevant to George's case. Putnam (personal communication, 1994) has suggested that George may exemplify a group of patients who appear to have both schizophrenia and MPD; I find this suggestion plausible in

George's case. Ross (1989) reported that he has encountered one patient who had both MPD and severe schizophrenia; he also speculates that "there may be a dissociative subtype of schizophrenia, however" (p. 160).

I would now like to describe some further observations from my work with MPD patients. Many forces in the patient oppose the work of integration. Cognitively, seeing themselves as a single person may be as bizarre and illogical to MPD patients as their sense of multiplicity is to us. When I talked with one patient about the possibility of bringing her alters together into a unified self, she said that struck her as being equivalent to walking to a classroom and asking all the children there to become one person. She later said that she was afraid integration would mean she would permanently lose her ability "to be different people" and would then be helpless to cope with any future trauma. A child alter of another patient felt less secure after three other alters fused. She implied that she found "strength in numbers" and also said she worried there were now fewer alters to switch to when the alter who was out wanted to leave. I consulted on a patient who had years earlier given up a child for adoption and who seemed to keep her alters separate from one another, partly as a sort of talion punishment for separating from her child. A final factor may also play an important role in the perpetuation of child alters. This is the deeply cherished wish to compensate for never having had anything approaching a "normal" childhood by preserving and protecting the patient's child alters, in a way that the patient herself was not protected in childhood.

I find it helpful to ask MPD patients if there is a difference between changing their mind and switching. I find this question intriguing, and by raising it with patients, I hope to draw attention to the function that dissociation plays for them. I do consider switching to be a particular way of changing one's mind, which is based on the patient's intolerance for acknowledging that the same mind contains a range of opinions, thoughts, and feelings. As a patient fuses previously separate alters, changing one's mind does become more of a viable alternative to switching.

Extended sessions may offer significant benefits in the treatment of MPD patients (Putnam, 1989). I had treated one patient for 10 years, three to five times per week, in 45-minute sessions. She had remained guarded about her system of alters throughout that time. When a change in her schedule allowed her to see me only twice

weekly, I suggested that one of those sessions be a 90-minute session. She agreed. With these extended sessions there was a striking change in the quality of her relatedness to me. A much greater number of alters began participating in sessions, with many more opportunities to increase their awareness of one another, communicate among themselves, and work cooperatively. In retrospect, I realized that the 45-minute sessions had created an atmosphere where their primary interaction with one another was to vie for time "out," that is, to have the floor and be able to speak with me. Each alter would ask directly if she were my favorite.

With the extended sessions, the alters seemed to sense that now there was enough time to go around, which facilitated constructive changes in their relationships with one another, as well as with me. One example of these changes was that she began telling me the names of her alters for the first time. Previously, she had claimed they did not have proper names, and she had referred to them only by descriptions (e.g., "the one who breaks everything" to refer to a protector alter). She had said, "I don't take them that seriously—that's why I won't let them have names." She had also explained that, if I knew the names of her alters, "then you could control them even more than you already do, which is more than I feel I can ever do." The resistance against disclosing names was centered in a specific alter, who played the role of denying her MPD and her traumatic history, claiming "they make it all up to get attention."

With their fluid ego boundaries, these patients are prone to experience the therapist as being equivalent to one of their own alters, and their transferences may be illuminated by keeping this in mind. Projective identification into the therapist is a prominent feature of the treatment of these patients (Peebles-Kleiger, 1989; Loewenstein, 1993). These patients may experience their own alters as being completely separate people. The patient may fail to differentiate between their abuser alters and the actual abusers these alters are based on. So it is not surprising that they would be prone to experience the analyst as an alter. Alternatively, the patient may view the analyst as also having MPD. Before I realized one patient had MPD, I asked, attempting to elucidate her current transference to me, "Who am I?" She later revealed that my question had profoundly shaken her—she momentarily thought I no longer knew who I was, as though I had just switched to a disoriented alter. Another patient routinely asked

just before leaving her sessions, "Will you be here tomorrow?" It was years before I heard this question as "Will *you* be here tomorrow?" as though she worried a less trustworthy alter of mine might be present instead at the next session. Harold Searles (personal communication, 1985) had a patient who conveyed her belief that he was under the delusion that he was one person, whereas she thought she would introduce him to people inside him whom he did not know about.

This assumption that the analyst has MPD may be a way of rationalizing the contradictory perceptions of the analyst among the patient's various alters—it may serve as an alternative to accepting the fact that the patient herself has MPD, as well as constituting a projection onto the therapist of the patient's inner world. Likewise, the patient whose own MPD was etiologically related to growing up with a parent who had MPD may project onto the analyst the patient's childhood adaptation to parental switching by resorting to dissociative defenses herself.

The patient's transference to the therapist as having alters leads to further projections related to the switching process. A patient who herself feels she has little or no control over switching may then attribute something similar to the therapist. After she had become relatively comfortable exploring her childhood abuse by her neighbor, a patient was still markedly resistant to taking seriously the allegations on the part of two of her alters that her father had also abused her. Initially, she alternated between a flashback transference to me as her father, in which she refused to give any details of his abuse ("You know already") and her more frequent position of denying that he abused her. However, she occasionally switched to child alters who acknowledged his abuse, and she then expressed her disappointment in her mother's failure to protect her. ("He used to come in my bedroom at night, in both senses of the word.". . . "I hate [her mother]—she doesn't help anything. She doesn't stop him!") One of the alters who struggled against implicating her father pleaded with me not to become her father: "I don't want you to become my father—I'm afraid you won't be able to go back to being just a psychiatrist. Please don't try to become him!" As threatening as this possibility clearly was to her, it was apparently more acceptable than facing her memories of her father's abuse, as well as realizing that she had a hitherto unrecognized alter based on her father. She asked

me to read John Fowles's book, *The Magus,* in which the protagonist comes to doubt his sanity because of a number of implausible events, including a woman who changes suddenly and drastically. After reading it, I suggested that this book captured something of her experience of feeling that I was turning into different people. She felt I had more control over my own alters and was better able to control my own switches than she was able to control her switches. This may have offered her an opportunity to use this projected view of me as a role model for better controlling her own switches.

Patients with MPD can have idiosyncratic transferences to their illness. For example, one patient felt she and I were playing some sort of game in "pretending" she had MPD. This was related to her transference to me as her childhood molester, who regularly played sadistic "games" with her as part of his pattern of abusing her. He would order her to pretend to be unafraid or pretend to be frightened of him. Thus, one meaning her MPD took on for her in treatment was another "game" she was playing with a coercive abuser. Another patient had an alter who contained the memories and feelings of being locked in a closet as a child by her mother. This alter complained that she was only allowed to be "out" during our sessions and that she felt her other alters kept her locked in a closet the rest of the time.

Alters internalize many aspects of the traumatic past. Alters may not only be based on specific childhood abusers, but when an abusive parent also had MPD, the patient may have several alters that are based on identifications with radically different maternal or paternal alters. In addition, the relationships among the patient's various alters internalize widely divergent childhood experiences. Some alters may have the function of protecting specific child alters. In other respects, alters may interact with one another based on power, threats, and efforts to dominate, as the patient had experienced in her relationships with childhood abusers. For example, one patient has an alter who exploits the worst fears of specific other alters to keep them under control.

Ernest Hartmann (1991) has made a distinction between people with "thin" and "thick" boundaries. He has noted that people with thin boundaries characteristically have difficulty distinguishing between their dreams and reality for several minutes after awakening in the morning. Patients with MPD frequently exhibit this symptom.

One patient reported that she often got into arguments with her husband after awakening from dreams in which he had done something that displeased her. Such a dream is like a flashback, which blurs distinctions between past and present, sleeping and being awake.

In summary, I have presented a personal account of the evolution of my own thinking about MPD. I have done so because I believe many psychotherapists and analysts have encountered or will encounter similar quandaries when they are faced with such patients. The bitter controversies that often engulf both professional and lay discussions of MPD and childhood abuse often obscure the full complexity of these problems, reducing them to either/or choices between oversimplified alternatives of traumas or fantasy, truth or fiction. If all of your patients are responding well to treatment, it is difficult to argue with success. But for analysts who work with challenging patients who are not responding well to treatment, you may find that you (and your patients) will be richly rewarded if you become better acquainted with the MPD paradigm.

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