THE INITIAL STAGES OF PSYCHOTHERAPY IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER PATIENTS

Richard P. Kluft, M.D.

Richard P. Kluft, M.D., is Director of the Dissociative Disorders Program at The Institute of Pennsylvania Hospital, and Clinical Professor of Psychiatry at Temple University School of Medicine, both in Philadelphia, PA.

ABSTRACT

The psychotherapeutic treatment of multiple personality disorder (MPD) places many burdens and demands upon a patient who is already beleaguered if not overwhelmed. Therefore it is useful if not essential to prepare the patient to manage the stresses that treatment may impose before beginning to deal with difficult material. The role of the first stages of the psychotherapy is to prepare a firm foundation for the more intense and draining work that will follow. The initial stages of establishing the psychotherapy and making preliminary interventions provide optimal opportunities to establish the therapeutic alliance, introduce the patient to techniques that will be essential components of the more difficult stages, clarify basic transferential patterns before they have become problematic, address anticipated problems regarding shame and secrecy, foresee likely causes of potential stalemates, and define and resolve problems in therapist-patient collaboration.

INTRODUCTION

This paper will describe an approach to the treatment of dissociative disorder patients that prioritizes the protection and safety of the patient, the patient's significant others, the psychotherapy, and the psychotherapist. It is designed to safeguard as well the best possible future options and most beneficial potential life trajectories available to the patient. This therapeutic stance relies heavily on my clinical experience in rendering direct treatment and serving as a consultant to colleagues. This experience has taught me that attempts to move rapidly toward work with difficult material may result in crises and decompensations that substantially lengthen the duration of treatment; e.g., often slower proves to be faster.

The present communication expresses the current state of my still-evolving efforts to make the psychotherapy of those who suffer dissociative disorders as humane and gentle as is possible, given the nature and origins of their problems, the imperfect state of our knowledge, and the inevitable limitations of even the most skilled and best-intentioned clinician. In this paper my choice to implicitly distinguish psychotherapy from treatment in several contexts reflects my observation that psychotherapy often is only one of the modalities of treatment necessary for the care of a dissociative disorder patient.

Looking back over the development of my ideas, in retrospect I appreciate that I experienced a curious sequence of preoccupations as I treated increasing numbers of patients with multiple personality disorder (MPD) and allied dissociative states classified under dissociative disorder not otherwise specified (DDNOS). (In the interests of simplicity, hereafter all such conditions will be referred to as MPD.) I gradually developed a comprehensive approach to their treatment. Initially, my concerns were focused upon those aspects of MPD and its treatment that were relatively unique, strange, and unfamiliar. The alters and their inner worlds, the traumata that my patients revealed, the drama of intense abreactions, and the complex and difficult to explain process of integration—these arrested my attention and became my initial areas of study and concern.

Within a few months, however, I found myself struggling with crises, regressions, inappropriate behaviors, suicidality, and the vicissitudes of managing MPD within a hospital setting. My patients' minds, bodies, and lives all too often had become veritable battlefields, devastated by the reliving of painful events and the destabilizing impact of the treatment process. I rapidly came to see that my original concentration, however comprehensible, was misdirected. My unwitting focus on the MPD phenomena and their resolution had, in effect, given precedence to the disorder rather than to the patient who suffered it. Such a treatment approach was in danger of actualizing the old medical jest, "the operation was successful, but the patient died."

Therefore, from the early 1970s to the present, my efforts have been dedicated to learning to conduct the treatment of MPD in order to safeguard the patient against such consequences. I have referred to my attempts to dedramatize the therapy and to minimize the time spent on decompensations and crises as the process of "boring the patient into health." This begins with the treatment's first interventions and continues throughout its course. Although my efforts are rarely if ever completely successful, I have been gratified to observe their increasing effectiveness.

145

In 1986 I reported my treatment of twelve high functioning MPD patients who had lost an average of three days from school or work over the course of their psychotherapies, from diagnosis to termination. In 1990 I observed that psychiatry residents and psychology graduate students with dissociative disorders usually were able to complete their training without major disruptions, and that practicing psychotherapists with dissociative disorders almost always were able to continue or return to practice (Kluft, 1989, 1990a, 1990b). My current figures (Kluft, 1991) indicate that approximately 85% of the MPD patients whose treatment I can begin slowly and gradually never require hospital care or become disabled. However, of the MPD patients I treat who already have been in treatment for MPD and come in a troubled or decompensated state, 85% are likely to require hospital care and/or become disabled within six months. My current research on treatment trajectories in MPD (1993) demonstrate that those patients who accept and endorse the approaches that are designed to slow and pace the treatment make more rapid progress and have many fewer crises than those who do not; i.e., "the slower you go, the faster you get there."

My personal odyssey has been paralleled by the experiences of many individual clinicians and treatment teams throughout North America, and in Europe. It has been repeated in the collective experiences of the members of study groups. Therapists new to work with MPD often develop a preoccupation with MPD phenomena and may undertake treatments that fail to take into account the strengths and weaknesses of those who suffer the condition. As a result, many MPD patients appear to decompensate or worsen in treatment, leading to therapeutic nihilism and/or the impression that it is unwise to treat MPD lest such efforts worsen the patient.

This sequence has been observed so widely that it has motivated many workshop directors to emphasize the need to go slowly and cautiously in treatment, and to accord new respect to the initial stages of treatment. In workshop settings I try to emphasize the importance of the initial stages of therapy by citing what I call Belafonte's Law: "House built on a weak foundation, it will fall. Oh, yes! Oh, yes! Oh, yes!" The security of the recovery process will be profoundly influenced by the manner in which treatment is begun. Once an MPD patient comes to believe that the therapy is not a sufficiently safe place in which his or her pain can be contained and addressed, even the most skillful therapist is hard-pressed to help the overwhelmed patient restabilize and avoid significant regression, hospitalization, or both.

My own style reflects my cautiousness. I delay even gathering comprehensive histories across the alters until I have reason to think that the patient and I are prepared to manage the discomforts, clashes of personalities, flashbacks, and spontaneous abreactions that may accompany the process of gathering a detailed history.

THE STAGES OF TREATMENT FOR MPD: A LITERATURE REVIEW

The treatment of MPD is a subset of the overall problem of treating the traumatized. As Herman (1992) has argued, the treatment of the traumatized has three stages: "Recovery unfolds in three stages. The central task of the first stage is the establishment of safety. The central task of the second stage is remembrance and mourning. The central task of the third stage is reconnection with ordinary life. Like any abstract concept, these stages of recovery are a convenient fiction, not to be taken too literally"(p. 155). Herman illustrates her point by charting the presence of these three stages in many models of trauma treatment, including Putnam's (1989) outline of stages in the treatment of MPD.

Herman's stages can be found in those schemes of MPD treatment that address the whole person rather than MPD alone. Table 1 illustrates the outlines offered by Braun (1986), Putnam (1989) and myself (1991). Similar plans by Sakheim, Hess, and Chivas (1986) and by Turkus (1991) are not as complete; those by Bliss (1986), Ross (1989), and Fine (1991) are not easily amenable to being outlined in this form. A conceptualization by Allison (1974) is somewhat different in focus and is difficult to reconcile with the current discussion; its focus is on the extrusion of negative personalities and the integration of the remainder. Fine (1991) speaks of preunification phases of suppression and dilution, in which the stage is set for the control and stepwise management of difficult material in a planful way with minimal disruption. Sachs (personal communication, November,1990) advises an early phase of strengthening the most adaptive alters prior to any uncovering work.

All of these conceptualizations share a mutual awareness of the vulnerability and crisis-proneness of the MPD patient (Kluft, 1984a); they are sensitive to the stress that the treatment will impose upon the treatment of the patient as a whole, and upon the alter system. However, they devote relatively little time to the early stages of therapy per se, except to note the techniques by which alters may be accessed and communications and contracts arranged.

In this communication, I will restrict my focus to the first two stages of Kluft's 1991 model, which overlap with Braun's (1986) stages 1.-4. and 6., and with Putnam's (1989) stages 1.-5. All of these stages, phases, or steps would fall under Herman's (1992) first stage: the establishment of safety. The Kluft 1991 model is based on the assumption that the more the MPD patient is able to approximate the ego strengths of the patient without MPD, the more amenable he or she will be to psychotherapy.

Rationale for the Model Proposed

The MPD patient is all too often highly unstable, and the condition implies several inherent vulnerabilities.

> The very presence of alters precludes the possibility of an ongoing unified and available observing ego and disrupts autonomous ego activities such as memory and skills. Therapeutic activity with one

TABLE 1
Outlines of phases, steps, and issues in the treatment of MPD

Braun, 1986	Putnam, 1989	Kluft, 1991c
1. Developing trust	1. Making the Dx	1. Establishing the Rx
2. Making and sharing Dx	2. Initial interventions	2. Preliminary intervention
3. Communicating with each personality	3. Initial stabilizations	3. Hx gathering and mapping
4. Acceptance of Dx	4. Metabolism of trauma	4. Contracting
5. Gathering Hx	5. Development of communication and cooperation	5. Moving toward integration/resolution
6. Working with each personality state's problems	6. Metabolism of the trauma	6. Integration/resolution
7. Special procedures	7. Resolution and integration	7. Learning new coping skills
8. Developing interpersonality communication	8. Development of post-resolution coping skills	8. Solidification of gains and working through
9. Achieving resolution/integration		9. Follow-up
10. Developing new behaviors and coping skills		
11. Networking and using social support systems		
12. Solidifying gains		
13. Follow-up		

personality may not impact upon others. The patient may not impact on others. The patient may be unable to address pressing concerns when some personalities maintain they are not involved, others have knowledge which would be helpful but are inaccessible, and still others regard the misfortunes of other alters to be to their advantage.

A therapeutic split between the observing and experiencing ego, so crucial to insight therapy, may not be possible. Cut off from full memory and pensive self-observation, alters remain prone to react in their specialized patterns. Since activity is followed by switching, they find it difficult to learn from experience. Change via insight may be a late development, following a substantial erosion of dissociative defenses. (Kluft, 1984a, p. 52)

Furthermore, the MPD patient tends to live in several parallel but incompletely overlapping constructions of the world and of life experience. The different personality structures embody different adaptational patterns, attitudes, and perceptions. Their memories do not contain congruent and mutually compatible contents or data bases. Their cognitive processes are distorted by numerous errors of thought (Fine, 1988) and they reflect the pernicious influence of trauma upon the development of cognitive skills, models, and processes (Fine, 1990). Consequently, the various alters, working from different assumptions, drawing upon different data bases, and thinking with different cognitive schemes and patterns, live in different subjective realities. The MPD patient suffers "multiple reality disorder." Some of these subjectively endorsed realities are actually psychotic with respect to conventional perceptions and understandings.

In the treatment of MPD, it becomes important to devel-

147

op a sufficient number of mutually endorsed and shared premises in order to ensure reasonable communication among the alters and the therapist. Before entering the more difficult and demanding areas of the treatment, the therapist must come to appreciate the assumptive worlds of the alters, and they must acknowledge that of the therapist. There need not be initial agreement, but there must be some mutual understanding of the points of view that will impact upon the therapy.

In the typical non-MPD patient, the unknown or unconscious aspects of mental function will be inferred from their impact upon and intrusions into the known and conscious realms. Unconscious obstacles or resistances to the work of treatment may be interpreted. However, in the MPD patient, although the typical unconscious is at play and its impact may be interpreted, the majority of the work of bringing what is outside of awareness to awareness consists of creating the possibility of sharing what is in one conscious system with another conscious system with which it has little or no connection. One is dealing with parallel distributed processors (Spiegel, 1990 [after Rumelhart & McClelland, 1986]). The problem might be said to be one of accessing not the unconscious and unknown, but the *elsewhere thought known*.

The first phases of the therapy, then, are designed to bring the MPD patient to a position in which many of his or her vulnerablities or deficits in ego functioning are either improved, repaired, compensated for, or supplemented by a prosthesis provided by the structure, consistency, and culture of the therapy. For example, although it is not possible to bring about a unified observing ego rapidly in such patients, it may be possible to create a situation in which all parts of the mind pay attention when the therapist requests that "everyone listen."

Such interventions allow the MPD patient to be treated more as a unity simultaneously with being treated as an aggregation of separate parts. From the first, it initiates powerful pressures toward integration and responsibility, and against irresponsible autonomy. It also emphasizes that the treatment is that of a person, not of a series of pseudo-people. Within this framework the treatment of MPD becomes less strange and forbidding, to patient and therapist alike.

STAGE I: ESTABLISHING THE THERAPY

"*Establishing the psychotherapy*" involves the creation of an atmosphere of safety in which the diagnosis can be made, the security of the treatment frame can be assured, the patient begins to understand the concept of the treatment alliance in a preliminary way, the nature of the treatment is introduced to the patient, and sufficient hope and confidence is established so that the patient feels prepared to begin what may be a long and difficult process. (Kluft, 1991, p. 178)

Mutual Voluntary Participation

When I take a new patient into treatment, the patient and I are beginning a relationship that may last many years. We are both eager to get off to a good start; the beginning of our work may set the tone for what will follow. I try to emphasize the mutually voluntary and cooperative nature

of our work, and underline that the therapeutic process is subject to ongoing review and reassessment by both the patient and by myself. I want the patient to know he or she has the right to discontinue the therapy if for some reason we cannot work well together, and that I reserve the right to withdraw. I appreciate that this may be misunderstood or misused by the rejection-sensitive and resistant, but I do not want any patients to believe that my agreement to work with them obligates me to remain engaged with them despite intractable resistance, disruptive behavior, and/ or regressive dependency in the service of the infinite deferment of their dealing with pressing life circumstances. I also want the patient to have a face-saving forum within which to tell me that despite our initial decision to work together, I am not the right therapist. *Example:* A massive and muscular female MPD with a history of extreme violence began therapy with a petite woman resident under my supervision. She was told that any violence would create a situation in which treatment could not continue. After a period of good behavior long enough for the resident to decide to go forward, the patient menaced several persons physically and endangered them by nearly causing a conflagration. Treatment was terminated. I was asked to see the patient, who had made a moving plea to have treatment reinstated, and threatened to sue for abandonment. We had a constructive interview in which the patient appreciated that she had known the circumstances of her acceptance, and had made her choice. Although she tried to argue that the personality that had been problematic did not understand her circumstances and believed she was in danger, she came to see that by living in "multiple reality disorder" she had bought short term relief at the cost of her long-term well-being.

It is important to realize that many patients come to treatment consciously or unconsciously doubting that they can recover, and accord a higher priority to acquiring a need-fulfilling relationship of indefinite duration than a psychotherapy designed to effect substantial change within a reasonable amount of time. Although psychotherapy may offer a safe haven in a difficult and scary world, such sanctuary is not meant to be an end in itself; it is provided to facilitate other goals.

Pragmatic Arrangements

I try to establish a firm understanding about financial matters, and make it clear that therapy cannot continue if such obligations are not sustained. Although in practice I will try to continue treatment through time-limited difficulties in the life of a reliable patient, and err toward the side of leniency, it is neither practical nor therapeutic to do so indefinitely.

I also try to ascertain whether the patient is going to be able to attend sessions with a reasonable amount of continuity and frequency. If this cannot be assured, therapy must remain supportive or quite modest in its pace, and this should be discussed with the patient. *Example:* In the course of his work with me, a man's company promoted him to a position that involved increasing amounts of travel. Therapy has been interrupted so extensively that his progress has been slowed at the expense of maintaining function and facili-

tating day-to-day coping.

Trust

Although Braun (1986) and Ross (1989) speak of establishing trust early in the therapy, it is my experience that this is not a realistic goal. Trust is best understood as an early developmental achievement accomplished in the context of good or good enough mothering. The role of difficulties in the dyadic or early mother-child relationship in the development of MPD has not been explored sufficiently. Suffice it to say, most MPD patients do not appear to have developed secure basic trust as described by Erickson (1963). Many of their early experiences involve harm, betrayal, and failures to protect and nurture. The early appearance of trust in MPD is usually a leap of faith, a wish, an enactment of a fantasy, an expression of hope, or telling a potential aggressor, the therapist, what the patient thinks he or she wants to hear. Ross' (1989) text and personal conversation with Braun (November, 1990) indicate that they appreciate these concerns, but choose to use the word trust regardless. Genuine trust rarely develops early in the therapy. A more operational definition of what appears to be early trust is enough hope, curiosity, or desperation to return for the next session.

I concur with Putnam (1989) and Ross (1989) in regard to dealing with the patient's suspicions about me and my intentions. Rather than confront, explain, or reassure in response to the patient's mistrust, I encourage my patients to value mistrust as an important warning sign. I indicate that since the patient has been hurt quite deeply, the development of apprehension, suspicion, and misgiving are natural and essential protections against further traumatization. Often the entire treatment of MPD is an ongoing test of the therapist in the face of the patient's conviction that the therapist, too, will prove corruptible and abusive. Putting mistrust to rest rapidly is usually a wishful fantasy. I will talk to the patient about the negative consequences of leaving mistrust unexplored, and advise the patient to study his or her misgivings over time. Usually as time goes on, the distrust is felt by a diminishing number of alters, and more and more alters endorse me. This building of trust is superceded by the emergence of more and more negative transferences, which echo the earlier expectations, but which hopefully are explored with a more sophisticated patient who has been helped to anticipate such developments.

Aspects of Safety

I try to create an atmosphere of safety by the way I conduct myself rather than by reassurances and promises. I invite all parts of the mind to express and explore their concerns, and indicate that the treatment is for all aspects of the person before me. I have found that unless I do this, the alters may assume that I favor those who spoke first, or that I implicitly endorse the values and stances of those I first encountered.

I try to be honest, and answer early questions either candidly, or by indicating that it would not be appropriate to answer, or that I do not choose to answer. Many MPD patients are quite intrusive, and many are fearful that what they do

not know about their therapist may correspond with their worst fears. Others feel that the somewhat tilted power relationship in therapy must be undone or it will be used against them. It is a rare abuse victim who feels that strength may be benign or exercised in his or her best interests. I try, in a gentle way, to educate the patient about the benefits of my remaining relatively anonymous.

Not infrequently the MPD patient will pressure the therapist to make promises that the patient believes are necessary for the patient to feel safe, but which would compromise the therapist's efficacy. It is unwise to make such promises with the hope that the patient will become more reasonable thereafter. Common requests are that the therapist will never pursue involuntary commitment, hospitalization, the use of medications, or the dismissal of the patient from treatment. Although it is true that all of these interventions may be perceived as similar, if not identical, to childhood or later abandonments or traumatizations, and that they may have been unpleasant (or even misused) in prior treatments, they are all legitimate aspects of psychotherapeutic treatment which one should not forfeit.

Another increasingly common request (or demand) is that whatever the patient says will be validated without further question. "How can I feel safe with a therapist who doesn't believe me?" is a common plaint. This is an extremely problematic request, not only given the vicissitudes of memory, but because it establishes the dangerous precedent that the patient may control what can and cannot be explored for its genetics and determinants. The latter gives license to the keeping of secrets in the therapy, which is a virtual guarantee of impasse. Also, it has been my experience that many MPD patients knowingly misrepresent significant issues and facts for a variety of reasons, and the exploration of these misrepresentations is crucial for their recovery (Kluft, in press).

At times patients will ask for a special favor as an indication that the office is a safe place; e.g., being allowed to bring and/or leave a stuffed animal or some other possession there. My policy is to allow such requests if they are neither inconvenient, disruptive to other patients, nor complicated by issues of specialness. However, I make it clear that anything left in my office may attract the attention of others, and that I cannot guarantee that others will not use their special things. Consequently, little is left in my office.

I usually ask the patient to share any concerns or anxieties that have been raised about me and treatment with me, and to discuss any worries about safety. I not only demonstrate a willingness to hear and address all relevant concerns. I also pursue the issue by asking "What else?" after each has been addressed. I never assume that all can be shared from the first, and invite the exploration of other concerns as they emerge. Many patients are concerned about my safety as well, fearing that they, their material, or their abusers may be hurtful to me. I try to address each concern in a matter of fact manner. I tell my patients that our initial task is no more than to learn how to feel safe while we sit in the same room together, and I am prepared to spend from minutes to months exploring my patients' apprehensions.

On occasion, I will openly voice my own apprehensions

about safety. Some MPD patients have clear histories of violent behavior (Kluft, in press), others threaten violence or voice a fear of loss of control, a few have histories of carrying weapons, and a small number are so imposing in stature or so expert in unarmed combat skills that I have reason to fear being injured if they misperceive me as a dangerous person or (more commonly) if I attempt to interrupt their attempts to harm themselves. Of the two people in the room, it is preferable that the patient is the more anxious. My approach is to state that I cannot function effectively if I am concerned about my safety. I will insist on meaningful reassurances, and, if they are not forthcoming, I will decline to treat.

In the matter of seeking reassurances, if I am told about some "horrible" or "evil" alter that is violent and will attack me if I make some error or am seen as causing the patient pain, I immediately ask such alters to listen, and explain that treatment is often painful and upsetting, and that I am imperfect. I insist on reassurances, and will use hypnotic methods to gain access if I cannot simply "talk over" (Kluft, 1982) the alter that is currently in executive function. I insist on the patient's valuing and cooperating with efforts to protect my personal safety, and that the patient go nowhere near my home or family. Although I accept that harsh language and statements of hostile intent toward myself are part of the business of doing therapy, I tell those few patients who seem inclined to make threats that any threat toward my family will be grounds for the instant discontinuation of the therapy and the filing of legal charges. Almost invariably I can get reassurance in one or two sessions. Of over 300 MPD patients that I have considered taking into treatment, only three would or could not provide this. They were not treated. With regard to matters of my safety, it is, in the words of Richard Loewenstein (personal communication, November, 1988), "my way or the highway." In over twenty years, I have only discharged one patient for violence against me, and one for making a threat to a family member.

Neophyte therapists are often reluctant to insist upon their own safety, and pursue risky and heroic ventures on behalf of poorly controlled MPD patients. I have known several who have suffered assaults and injuries, and continued to treat their patients/assailants lest they feel rejected and become suicidal. For many years I continued to work with patients who violated the rules noted above. However, a review of my records from 1970 to the present disclosed that not a single patient who had made a serious attack (involving physical aggression) or threat upon me (such as brandishing a knife or aiming a gun) had ever recovered in treatment with me. Once genuine danger, harm, or intimidation enters the therapist-patient dyad, effective therapy is over. It is time to transfer the patient, who hopefully can learn from the experience and behave more appropriately with a subsequent therapist.

The Treatment Frame

The concept of the frame or treatment frame is "a metaphor for the implicit and explicit ground rules of psychotherapy and psychoanalysis" (Langs, 1980, p. 526). I try to help the patient understand the boundaries of confidentiality, and indicate under what circumstances it will be breached. In the United States, considerable differences exist in state laws regarding doctor-patient privileged communication, but in general either suicidality or imminent threat to others constitute such grounds. Also, we are mandated reporters of certain situations, such as child abuse.

The patient and I also discuss anticipated intrusions upon the therapy, and how they may be managed best. I insist that we review the handling of telephone calls from concerned others, requests for information from insurers, review organizations, and other relevant parties to the situation. I ask patients to instruct me in the handling of inquiries and communications of a non-urgent variety. I ask with whom their circumstances can be discussed, and to what extent. I tell patients that if I receive a call about them, I will not even acknowledge that they are my patients without their permission. I explain that their family and concerned others may find me abrupt or rude if they insist on asking about things I will not discuss. I tell my patients that I will share with them any call or communication I receive that concerns them, even if the caller wishes that this not be done.

We discuss with whom the patient will share information, and to what extent. I discourage my patients from sharing any more than is necessary, and educate them about the risks of bringing others into this aspect of their personal lives. The MPD patient often wants to have others to support them, who will interact with alters and provide a reparenting or a corrective emotional experience. I try to help the patient appreciate that friendship does not consist of having one's dependency needs met, or of entertaining or being exploited by those who are fascinated with one's pathology. I point out that the most likely consequences of such interactions are exploitation and rejection, and encourage my patients' keeping the overt display of their illness confined to the therapy setting.

I discourage my patients from entering support groups, a fashionable fad with undemonstrated efficacy. It has been my ironic experience that MPD patients rapidly become so engulfed in the concerns and reactions of their group members that they find themselves using their individual treatment to help them cope with the group from which they had hoped to draw support. If involvement in other simultaneous treatments is necessary or desirable for some reason (and it is inevitable if the patient requires medication, and is in therapy with a non-medical professional), we go over how communication between and among the therapists will occur. We review how my notes on their confidential matters will be dealt with, and we talk over how much information will be shared with those who cover for me in my absence, and develop a protocol for their work with such persons to maximize the effectiveness of the coverage without encouraging splitting. *Example:* An MPD patient's child personalities liked a covering doctor but feared me. They decided they would not work with me, but would do their work with my colleague while I was away. The colleague and I agreed that the child alters could have no more than five minutes of each session with her, and would do work in ther-

apy with me, as did all the others. The patient protested vigorously, but, after seeing that the colleague held firm, worked with me and integrated in short order.

We discuss my availability between sessions, and the nature of available support systems. I try to communicate that while I am on call for genuine emergencies, I am not available for general companionship, ongoing reassurance, or as a moment-by moment consultant, confidant, or guide. I emphasize that an emergency is an unforseen situation that calls for immediate action, not a period of discomfort during which the patient feels badly. I work with the patient to establish a hierarchy of things to do at such times, the last of which is to call me. It is essential to build mastery and to avoid the pull of regressive dependency. I make it clear that any misuse or abuse of my availability must be addressed and resolved if treatment is to continue. In my experience, only a small minority of MPD patients will be inappropriate if these conditions are set forth, but a majority will make such demands on the therapist if they are not. The essential communication is that the therapist is on call, but not on tap.

Therapeutic Alliance

The therapeutic alliance is the most crucial aspect of the treatment of MPD. I discuss it in depth with the patient, and define therapy as a type of work that we endeavor to achieve for the patient's benefit. I distinguish the therapeutic alliance (roughly equivalent terms are treatment alliance, working alliance, and helping alliance) from transference and the real relationship using the definitions of Ralph Greenson (1967). As we talk, I take pains to emphasize the importance of the patient's taking an active role in the treatment, and convey repeatedly that therapy is something that is done collaboratively with me, and not done by me to the patient. Many patients promptly make it clear that they have no genuine hope of recovery, but believe if I am available to take care of them, that in some magical way I will make it possible for them to be relatively safe or comfortable. Others convey that their relationship to me will be the primary focus from the start.

I make sure that I give my patients many assignments both within and between sessions, and help them understand by my manner that I am extremely attentive to their producing what has been requested. From the first I challenge any apparent learned helplessness (Seligman, 1975), and work for the establishment of an internal locus of control. Constructive work on traumatic material will not be possible with a patient who looks to the therapist to do all of the work. I praise and reinforce any indication of the patient's active participation in therapy. When I become aware of reluctance (i.e., conscious resistance) I not only note the problem, but I also indicate what active efforts on the part of the patient might lead to a more productive outcome. When the patient makes such efforts, I offer encouragement.

I explore the patient's previous psychotherapy experiences, which are a valuable indicator of what I will have to contend with. I try to learn what worked, and what did not. I assess the transferences, resistances, acting out, responses to various techniques and approaches, and how their dissociative difficulties were addressed. I try to learn about any boundary violations and exploitations by any prior health care provider or other persons in ostensibly safe relationships with the patient. If there are such experiences, I discuss their likely impact on the therapy, and make it clear that their ongoing effects will be studied between us (Kluft, 1989). Using a recently published outline (Kluft, 1992), I study all the available information to ascertain whether any of the conditions that may encourage therapeutic impasse are operative, and try to anticipate how these may be addressed.

Having studied the vicissitudes of prior therapies and the potential for impasse, I attempt to socialize the patient to psychotherapy in a manner influenced by the early research of Orne (Orne & Wender, 1968). Few patients appear to understand what psychotherapy entails, or appreciate how they must conduct themselves in order to obtain its potential benefits. This is particularly true of mental health professionals who suffer dissociative disorders.

Many MPD patients are widely read and sound quite sophisticated, but they come to treatment with expectations that are decontextualized. They fail to comprehend that the treatment of MPD is a subset of psychotherapy in general, and that verbatim knowledge of the MPD literature is not a firm foundation for understanding psychotherapy per se. A major aspect of my socialization is anticipating for the patient the emergence of negative and traumatic transferences, recurrent bouts of misgiving and mistrust, incessant testing of the therapist, doubting of the diagnosis and the veracity of recollected material, apprehensions of dire consequences for making revelations within the treatment, etc. I express my confidence that we can negotiate such distressing occurrences if we appreciated them as part of the process of the treatment, and encourage the patient to welcome them as indicators of issues that require our joint attention, rather than as signs that invariably indicate something is seriously amiss.

I discuss the importance of transference phenomena, and make it clear that they are valuable topics for discussion, but poor guides to action. For the sophisticated patient, or any patient who worries about my reactions, I will explain that my countertransference experiences are also valuable information for the therapy. I explain that at times the feelings I experience may represent my growing awareness of the patient's inner state and the many ways it can be communicated (e.g., projective identification). Relatively naive patients often are unduly frightened by a candid discussion of countertransference, especially if transference itself is a novel idea to them. For them, I usually defer such discussion until a graceful opportunity occurs to discuss a relatively bland and readily apparent example.

In addition, I try to explain my specific ground rules, some of which have been alluded to above. I prefer to do this in a gradual and naturalistic manner as relevant subjects emerge, because a stark recital can be very offensive and threatening, especially to a patient who is afraid of rejection in some alters, and inclined to provoke it in others. One such patient recently said, "You have just told the bad ones how to destroy the treatment." Other patients appreciate

knowing exactly where they stand.

I try to help the patient appreciate that under some circumstances it is not advisable for us to continue. If we fail to establish a therapeutic alliance or find ourselves disliking one another as people, treatment is unlikely to prosper. If the patient and I disagree about how the treatment must be conducted or if the patient incessantly struggles to control the therapy, a good outcome is not likely to be within reach. If the patient violates the boundaries of treatment, interferes with other patients' treatments, or becomes intrusive into my personal life, the patient will be confronted and told that further such episodes will lead to the end of treatment. If the patient fails to attend sessions, does not do the work of therapy, declines to honor or is unable to meet financial obligations, or encounters logistical difficulties that make therapy problematic, it is best to discontinue. If the patient is more assaultive with words or actions than I choose to tolerate, and does not conform his or her behavior within the range I can manage within the constraints of psychotherapy, I see no reason to continue. It is countertherapeutic to allow one's self to be abused by a patient. Not only does it build up understandable resentment in the therapist, but it sets before the patient a masochistic role model in the guise of a more healthy individual with whom the patient will identify, and whose characteristics will be internalized. Therefore, it is in the patient's best interests for the therapist to insist upon the right to interrupt dysfunctional verbal assaultiveness. A threat to a member of my family or any intrusion into my personal life are grounds for ending treatment. In marginal cases I will consider an enforced period of time away from treatment with me, with resumption contingent upon our mutual agreement after a series of interviews at a later agreed-upon time.

My psychoeducational efforts in support of the therapeutic alliance encompass most of the topics of this article. I explain the importance of speaking freely, and the roles of interpretation and insight. I indicate that as painful as the past may have been, It is only by learning from it that the safety of the patient's future may be assured. I briefly describe abreaction, and discuss the roles of medication, hypnosis, and any other discrete techniques that may be employed (e.g., journaling). I may use vignettes from other therapies (emphasizing that I have permission to do so) to illustrate how various interventions have helped other patients. I explain that we may or may not use the exact techniques that we have reviewed, but that it is important to appreciate that there are many approaches available to make the treatment tolerable and manageable.

As noted above, I anticipate that patient's feelings toward me and the treatment may change, and observe that as they come to see me in terms of those who have hurt them, at times they may have difficulty distinguishing me from these persons. I point out that their high hypnotizability combined with their past experiences may make me appear to be other than I am; in fact, their perceptions of me may appear to confirm their worst fears (e.g., Loewenstein, 1993). I explain that all such distortions and their exploration have a role in advancing the therapy, but that at times they may be so intense

that I may have to challenge rather than explore their perceptions in order to preserve the therapy.

I explain to my patients that even though we will focus to a great extent upon their inner worlds and pasts, their day to day function, their future aspirations, and their contemporary personal comfort is of great concern to me. I emphasize that I want to maximize their strengths and will do my best to ensure that the treatment will cause no distress other than that which is necessitated by the subject and dictates of our therapeutic work. I discourage masochistic (and courageous) pressures to push ahead regardless of the pain. Instead, I urge my patients to accept the need to pace the therapy meticulously, and to respect the axiom, "the slower you go, the faster you get there." That is, the fewer crises and messes encountered as a result of impatience or haste, the more goal-directed and efficient the therapy can be. I make it clear that we will obey the "rule of thirds" (Kluft, 1991) and take pains to avoid their being overwhelmed or decompensated, notwithstanding their concerns over what may seem to be an indolent rate of progress.

I try to offer anticipatory socialization to the possible impact of traumatic material and painful revelations. We plan for contingencies, such as conserving some personal and vacation time for use if difficult work is planned or if the patient is briefly overwhelmed. I also give my patients a mini-lecture on the problems associated with the recovery of unconfirmed apparent memories, and urge them against taking action precipitously upon the materials recovered in the course of treatment. This is an exquisitely difficult issue to address, and some MPD patients have pronounced difficulties with impulse control in this connection.

Many MPD patients enter treatment demoralized and despondent. Sufficient hope and confidence to motivate such a patient to continue may come from his or her courage, desperation, religious faith, the support or encouragement of concerned others, dreams for the future, etc. Usually the patient is able to draw upon the experience of initial empathic connectedness with the therapist and the therapist's demonstration of expertise vis-a-vis their early interactions as a basis for continuing the treatment. It is my experience that the early stages of working with MPD are facilitated by frequent use of a self-psychological perspective that stresses interventions focused on empathy and mirroring. Such efforts usually address the patient's need to feel understood, and convey that the patient has found a therapist who can articulate and give expression to the inner experiences that have so long made the patient feel weird, different, and incomprehensible, and therefore, beyond hope.

The importance of a demonstration of expertise to inculcate hope, first emphasized to me by Bennett G. Braun, M.D., in a series of conversations in 1979-81, cannot be overemphasized. It is best if the demonstrations do not narcissistically aggrandize the therapist or prove beyond the patient's comprehension, but instead convey to the patient that he or she may have reason for hope, even optimism. *Example:* A patient I was admitting to the hospital began to have a flashback and showed signs of disorganizing terror, presaging rapid decompensation. I quickly used a hypnotic tech-

nique to stop it. The patient was amazed and began to express profuse admiration and gratitude to me. I interrupted this adulation, which threatened to place me in the role of a magical wizard upon whom the patient would have to depend, and persuaded the patient to learn to bring the flashback back, and then to interdict it herself. She was amazed, and said, "You actually taught me to do that . I did that! My God! I think I'll be able to get well and get out of this therapy rat-race." I responded, "Why not?" The patient made very rapid progress, and rapidly mastered the use of techniques used in session to comfort and control herself in my absence.

Accepting the Diagnosis

Although the mutual acceptance of the diagnosis is a crucial aspect of the therapeutic alliance in MPD, it constitutes a significant subject in and of itself. Denial of the MPD diagnosis is a commonplace event. In my experience, behavioral acknowledgement of the diagnosis is more crucial than the verbal acknowledgement. If the patient participates productively in a treatment that, by its very nature, indicates MPD is present, I am not inclined to argue over words. Denial, suppression, or derealization of the diagnosis may continue throughout the therapy, or may make recurrent appearances. There is little to be gained by demanding that the reluctant patient accept the diagnosis, often complaining, "We don't have multiple personality!" The MPD patient suffers multiple reality disorder, and has no trouble endorsing mutually contradictory percepts. Often the denial will persist until integration, or even survive it.

It interests me that I rarely encountered denial in the 1970s, before the connection between MPD and child abuse was common knowledge. My experience has led me to think that often the underlying issue is that with the acceptance of the diagnosis comes the implicit acceptance that one has suffered child abuse and that one's close relations with significant others may require reconsideration. My work with MPD patients has convinced me that the reality of the abuse may be denied with more vigor and endurance that the diagnosis itself: "But I am one of those MPD patients who did not suffer child abuse."

Typically a patient will endorse the diagnosis because it allows him or her to make sense of the many events in the past that have proven baffling, and explains distressing symptoms and events in the here and now. This is followed by a questioning and rejection of the diagnosis, often accompanied by a challenge to the clinician's judgement and competence. Usually, this is because the implications of the diagnosis have struck the patient, and must be disavowed. Consultation often is sought.

Many patients attempt to bargain— "Maybe I am dissociative, but I don't have MPD." "I admit that I have dissociative features, but I don't think I could have MPD. Maybe I have DDNOS." "I have parts, but we, I mean I, don't have personalities." I usually explore the patient's fantasies and fears about what the MPD diagnosis means, and address the specific apprehensions as best I can. At times I will educate the patient about the natural history of MPD, observing that most people with MPD spend most of their lives in a DDNOS state (Kluft, 1985). With others, I may suggest that we can study the diagnostic issue together over time. I try to communicate gently and compassionately that the diagnostic niceties that upset them so are meaningless to me and do not have significant implications for the treatment process. When a patient is determined to deny the diagnosis, but is cooperating with all other aspects of treatment, I let the matter rest. If the patient is deeply invested in denying the diagnosis, and this is delaying all progress, it is clear that unless the diagnosis is wrong, the patient is preemptively declaring that he or she is not ready for treatment, or not willing to work with the current therapist. Often consultation helps. Several such patients have opted to work with the consultant, and, years later, told me that they were so angry at me for having made the diagnosis that they could not bring themselves to work with me; in effect, they had "killed the messenger who brought the bad news."

STAGE 2: PRELIMINARY INTERVENTIONS

Preliminary interventions involve gaining access to the more readily reached personalities; establishing agreements or contracts with the alters against terminating treatment abruptly, self-harm, suicide, and as many other dysfunctional behaviors as the patient is able to agree to curtail; fostering communication and cooperation among the alters (a process that is at the core of the treatment from here on); expanding the therapeutic alliance by achieving the patient's acceptance of the diagnosis across increasing numbers of the personalities (some will deny it to the end); and offering what symptomatic relief is possible. Hypnosis may play an invaluable role in facilitating these measures. (Kluft, 1991, p. 176)

The goals of this stage are to strengthen the patient as a whole and across the alters in order to preserve or enhance the current level of function, establish the coping skills necessary to begin the difficult phases of treatment to follow, and work out any problems in the collaboration between therapist and patient.

I have always likened this stage to the preparations I would make for the safety of a day's cruise with guests on a sailboat. Before leaving the dock and before leaving the shelter of the harbor for open water, I not only want to make sure that the boat itself is safe and well-equipped, I want to have adequate reassurances that those about to embark are in adequate condition for the voyage. I want to know who can swim and who cannot. I must have approved flotation devices (life preservers) for all, and be sure that everyone can put his or hers on rapidly. I require that the non-swimmers wear life preservers at all times. I must learn who can help me sail, and how to communicate with them. Some may know nautical language, but some may not. I want to be sure that someone else can operate the emergency devices and the radio in case I become incapacitated. Then, as we leave

153

the dock and are still in the harbor, I will make sure to call upon my potential helpers to see if they truly can and will do what I ask. I want to work out my contingency plans before I encounter a difficult situation. In a similar manner, the wise therapist tests and improves the collaboration with the patient long before therapist and patient venture into the treacherous tides, winds, currents, and navigational hazards of strong and difficult material.

The tasks of this stage are in the service of mobilizing a reasonable facsimile of normal ego function (i.e., a "crew" that can work together and with me). It will fall apart and require reassembly time and time again, but its resilience depends on a strong foundation. Virtually all interventions in this stage address the problem of communication across and throughout the alter system.

Alleviating Punitive Superego Attitudes

The equivalent of loosening the punitive superego in the first stages of the psychoanalytic psychotherapy is a series of efforts to understand the alter system's rules of function, and to alleviate the more problematic patterns of behavior. For example, the alter system may have developed methods of enforcing secrecy by punishing alters that make revelations. I try to understand such patterns before attempting to elicit materials that may mobilize such responses, and try to establish agreements that allow a free flow of information. For example, I often try to get contracts to the effect that no alter or the body is punished for making revelations. One helpful alternative approach is to decline to accept information from any alter that is at risk for reprisal, and to instead initiate a dialog with the alter that enforces the prohibitions. This usually leads not to the information, but to the loosening of the protective system, a more appropriate early goal. Once I have engaged the protectors of the secrets in long dialogs, they usually become more reasonable, or at least agree to warn me if they are about to feel compelled to be punitive. This allows me to prevent many episodes of self-harm. Optimally, later in therapy I can work with these potentially dangerous alters on the issues of their own origins and pains, so by the time I get to the material they were trying to keep hidden, they are allies, or at least will abstain from obstructionistic or self-destructive practices.

With regard to guilt, I seize upon trivial incidents of irrational self-blame in order to educate the patient about the nature of responsibility, and to explore the alters' sense of morality. In a similar context I assess the patient's masochism and sadism both within the alters and across the total human being. It is much easier to address this first in minor issues than in connection with attributions of blame for abuse events.

Shame Management

I am impressed with Nathanson's (1992) "Compass of Shame," and use it to classify the alters' likely response to embarrassment and humiliation. From the perspective of the patient, the entire therapy process may be experienced as an extended mortification. As Nathanson describes, shame may sever the interpersonal bridge between the shamed

individual and his or her peers. Shame can make one want to disappear, die, or destroy those who have caused or witnessed one's humiliation. MPD patients' dissociative defenses can accomplish this in their inner psychological worlds. If the patient in different alters is likely to attack the self, attack others, withdraw, or avoid acknowledging matters (the four points of Nathanson's "compass of shame") in the face of shame, I want to know the characteristic response patterns. Intolerable shame is one reason that alters may make themselves inaccessible for long periods of time. Alters that cause shame to the others may be suppressed. I want to help my patients talk about shame and how we can solve the problems it may pose long before we come to difficult work with potentially humiliating materials. I routinely advise those I supervise to read about shame, because its management is crucial to work with the traumatized.

Determining Core Conflictual Relationship Themes

Luborsky and his colleagues (Luborsky, 1984) have demonstrated that the analysis of verbatim transcripts of patients' remarks in psychotherapy reveals that they repeatedly concern themselves with a limited number of core conflictual relationship themes (CCRTs). I make verbatim notes of several sessions involving major and/or troublesome alters. This allows me to identify and articulate their CCRTs very early in the treatment, and knowing their CCRTs allows me to anticipate the likelihood of crises as therapy themes unfold and life goes on. To the extent that I can help my patients foresee and protect themselves from situations by which they had been surprised and in which they hitherto had experienced themselves as helpless victims, I can better safeguard both them and their therapies. Once they appreciate that therapy is helping them in such a manner, their motivation and optimism is enhanced.

Communicative Fields

I find it useful to assess the patient's and the predominant alter's communicative behavior, and employ Langs' (1980) description of types of bipersonal or communicative fields in this endeavor. All too often the therapist working with an MPD patient has the uncanny experience that what appears to be an open and revealing conversation has left him or her confused, that their words and their patient's have passed like ships in the night. Also, many MPD patients insist that their therapists, although engaged and interactive, have failed to understand them.

Langs (1980) has described three forms of communicative or bipersonal fields. The Type A field and communicative mode is one in which symbolism and illusion play a central role. It is characterized by the development of an ambience in which transference can develop and be interpreted as such. It "is essentially symbolic, transitional, illusory, and geared toward insight" (p. 547). The Type B field and mode is "characterized by major efforts at projective identification and action-discharge. The mode is not essentially designed for insight but instead facilitates the riddance of accretions of disturbing inner stimuli. It can, despite the interactional pressures it generates, be used in a manner open to inter-

pretation" (p. 547). The Type C field and mode is one "in which the essential links between patient and therapist are broken and ruptured, and in which verbalization and apparent efforts at communication are actually designed to destroy meaning, generate falsifications, and to create impenetrable barriers to underlying catastrophic truths. The Type C communicative mode is designed for falsification, the destruction of links between subject and object, and for the erection of barriers designed to seal off inner and interactional chaos" (p. 547).

Clearly, Type C phenomena are inherent in many shame responses, and in the structure of many MPD systems and inner worlds. An unknowing encounter with such a field is likely to engender a sense of exasperation and futility in the therapist, and often in the patient as well. Type B fields often are powerful contributants to some of the angry exchanges that can occur between MPD patients and their therapists.

I find it useful to discover the types of communicative fields that are characteristic with particular alters and/or subjects of discourse. This prepares me to anticipate difficulties and plan accordingly. It also alerts me to prepare my patients to hear interpretations of projective identification and the defensive obscuring of meanings. It is difficult to interpret such phenomena later in therapy, when affects are intense, the transference powerful, and the material disturbing without having undertaken extensive preparatory efforts under less demanding circumstances.

Gaining Access to Alters

I rarely let a session go by without accessing several alters, if only to make ideomotor inquiries, facilitate brief contacts, or to ask how they are doing. I want the alters to begin to listen in on one another in therapy unless there is some specific contraindication. For example, a series of alters originating during a prolonged intolerable trauma were created because forming one new alter was insufficient to encapsulate the trauma, so more and more were created. Early accessing was designed to shield each from the revelations of the other, lest the patient be overwhelmed, as she was whenever these shielding efforts failed under the original traumatic circumstances.

I will assign pairs or groups of alters the task of talking together about decisions to be made or issues of concern, but most commonly at this stage I want them to do no more than spend time together and hold casual conversations. I want communication channels to be established early on, and for there to be feeling of fellowship among the alters before I address their areas of discord. I will ask alters to comment on what is occurring in therapy, and invite their participation. I lose no opportunity to reinforce that the treatment is for all parts of the mind, the total human being, and that all are welcome. I preach the 'golden rule" vociferously, and frequently remark that "No one can win over the others. Either all of you win or all of you lose. You are all in this together." I try to avoid establishing a pattern that appears to favor or focus on certain groups to the exclusion of others. I am not particular about whether there is full emergence, inner talk in which the alter that is "out" pass-

es along the words of the others (which are heard or thought inwardly), or ideomotor signals must be used. Some alters may be unable or unwilling to speak, but can write or draw.

It is important to challenge the notion that some alters are beyond communication, but to do so in a manner that conveys that one is invested in solving problems carefully rather than proving one's potency. If an alter is represented as pre-verbal, non-human, only able to speak in another language, or otherwise incapacitated, I will find an alter that can communicate with it and be its translator. Some alters are constructed without a voice or mouth in order to be unable to make revelations and/or to preclude oral traumata. Usually waking or hypnotic suggestion makes it possible for other alters to lend their voices, or to suggest the development of a voice or a mouth.

I avoid attempting a formal or obvious mapping at this stage, because this could trigger difficult material to emerge unexpectedly, and before the patient is ready to manage it. Instead, by requesting inner speech or signalling, I try to see if there is any alter that knows the inner system, or at least a major part of it, and can serve as a resource or guide through the world of the personalities. I also ask if there are any alters that oppose or have apprehensions about the treatment or me, and invite them to join in the discussion. I usually state that their apprehensions are reasonable under the circumstances. Not uncommonly, we become allies in short order.

I ask if there are any alters who want to die, commit suicide, or inflict injury to the body or others in the system. I immediately try to get them into a dialog with me, and to either contract for safety or to suspend their activity, perhaps by going to sleep between appointments. I have observed that neophytes usually begin by working with the more cooperative and pleasant or distressed alters, and encounter the oppositional alters later. Conversely, I am more likely to start by working with the most negative alters fairly promptly, attempting to bring them into an alliance before the oft-encountered oppositional scenario is enacted, and takes on a life of its own. This is one of the reasons I rarely encounter the problems with angry and hostile alters that so commonly preoccupy those who work with MPD. When negative alters refuse to be accessible, or the patient prevents their emergence, I talk over (Kluft, 1982) the alter that is out to address them, and they usually emerge spontaneously in short order. If they threaten or menace me, I suggest that they communicate with me through another alter. They usually find this so frustrating that they come out and control their behavior.

Contracts

Braun's 1986 discussion of this topic remains a classic reference in work with MPD, and makes an extended discussion here unnecessary. It is my style to try to get time-limited verbal agreements, and to rarely resort to legalistic written ones. I explain that all alters should listen in and contribute to such discussions, because all will be bound by the promises that are made. If the amnestic barriers across the alters are dense, I may induce trance and make the suggestion that "everybody listen" (Kluft, 1982). It is essential to record and

155

renew all contracts. I enter the renewal dates in the chart, in my date-book, and in an electronic reminder function on my wrist-watch. Allowing a contract to lapse is interpreted by the patient as uncaring, rejecting, and as an implicit suggestion to enact the previously forbidden behavior. Most therapists work to get contracts for abstaining from inappropriate behaviors. A therapy in which contracts address only prohibiting behaviors inadvertently creates an atmosphere in which it appears that only the patient's self-restraint and shortcomings are discussed. I make it a point to contract as well for constructive behaviors, so I never lack the opportunity to offer the patient encouragement and reinforcement. This stance is especially important for the so-called bad or hostile alters, because it will be necessary to question and restructure their negative identities repeatedly. This is much more easily achieved in a process that involves such alters in constructive activities and behaviors that they themselves will perceive are antithetical to their self-perceived negative identities. For example, one alter maintained that another was a wimp, and should be punished for its shortcomings. In the interest of "being objective," I assigned the critical alter the task of recording every wimp-like behavior of the week. This alter returned with very little on its list, and concluded the other had done fine. This opened the door for a productive dialog. In another instance this technique resulted in a long list. It was possible for the alters involved to discuss this together in conference, using Frazer's (1991) dissociative table technique, and agree that some were behaving poorly. In a series of dissociative table talks, they resolved the problems. The critical alter received much positive feedback in this process, even from those it had criticized, and from the alters that had previously been completely protective toward those that were criticized.

It is important to bear in mind that the consciences of most MPD patients have lacunae, escape clauses, and exceptions to accommodate their deepest fears and maintain phobic avoidance of situations and issues that a more uncompromising sense of right and wrong would force them to address. They may defend and rationalize their stances with the vigor of the most zealous advocate or attorney. It may take months for the therapist to succeed in conveying the importance of consistency, and for the patient to accept such constraints. This is time well-spent, because without it, the therapy will go from crisis to crisis as the MPD patient betrays apparent agreements. It is unusual to achieve 100% accord on such matters, even after years of treatment, but near-complete accord, punctuated by occasional backsliding, is attainable, and is an essential ingredient to a successful therapy.

Confrontation of the MPD patient over broken agreements often leads to such regression and/or self-punitive behavior and/or angry attacks that many therapists back away from a firm stance. In my experience, most of these reactions can be averted by careful advance planning, and by using the late David Caul's "compassionate confrontation" style, recently the subject of an article by Chu (1992), who rescued Caul's work from obscurity. I do not back down (unless I realize that my initial request was either premature or overly demanding), and am willing to become very firm

on these matters. Once the patient finds that a demonstration of distress will make the therapist retreat, it is difficult to maintain a rational and functional therapeutic alliance. The therapy becomes a parallel to the MPD patient's intrinsic defense system—in the face of discomfort, a switch occurs that rescues the pained personalities from distress.

Fostering Communication and Cooperation and Expanding the Therapeutic Alliance

I periodically ask questions of all alters, running down the list of known names and designations, and asking for their thoughts. If emergence on request is not possible, or is unduly time-consuming, I will use hypnosis to either access the alters or to set up an ideomotor mechanism for questioning them in a rapid manner. I accustom the alters to sharing opinions, impressions, and awarenesses with me and with one another with regard to their interactions, the course of therapy and the problems under discussion, current problems, and historical events of low emotional intensity. If alters refuse to share, I repeat my requests. If this fails, I express my regrets and anticipate good future communications. If alters obstruct one another, I explain the therapeutic alliance aspects involved and insist on a "golden rule" perspective. I ask the alters that are obstructing if they were the ones being obstructed, would they wish to be cut off from expression in this manner? I also make it clear that if they were being blocked, I would be trying to access them to offer them the chance to be heard. Over weeks or months, usually such arguments are successful.

I assign alters problems to resolve and issues to discuss, with the intention of increasing mutual empathy, identification, and understanding. Usually I suggest topics related to possible opportunities to cooperate, and recommend 15-30 minutes per day be spent in this manner. When coconsciousness is difficult and cannot be taught or suggested easily, I may request that the dialog occur in a journal, and for each to write an entry when he or she is out. Few patients appreciate how effectively such techniques render dissociative defenses more porous, bringing about enhanced togetherness before work on painful materials has the potential to drive the alters further apart.

I also may suggest that alters learn how to combine their strengths by copresence, coming forward at the same time (unlike the temporary fusion or blending described by Fine [1991]). Not infrequently, I will have two relatively similar alters come out together to do something that usually exhausts either alter working alone.

I also try to recruit other alters to the therapy by asking if any other parts of the mind that I have not yet met would like to contribute their thoughts or share any concerns or opinions. If there is no response, I may say, "Since there is no answer, may I assume that those of you I have not met are in agreement?" This often leads to inner speech or emergence by other alters, or discomfort that can be explored.

The recheck protocol (Kluft, 1985) is introduced to the patient early in treatment. In this approach, all known alters are contacted periodically to make sure that none feel neglected or overlooked. Alters unknown to the therapist and known

alters are invited to join. This is a useful early warning system about problems that otherwise would emerge as apparently abrupt crises. It is often done with ideomotor signals in a manner that allows large numbers of alters to be screened in a few moments. In my experience it usually saves me a lot of effort, and spares my patients a great deal of pain. Although this technique was published as early as 1985, it is infrequently taught and rarely used.

Offering Symptomatic Relief

In classical psychoanalytic work, the patient has reasonably high ego strength, and anxiety is considered essential to motivate cooperation with the treatment. With insufficient anxiety, it is difficult for the patient to make such a deep investment in the analytic process. Conversely, in work with MPD, the patient is all too often flooded and overwhelmed by anxiety. The reduction of this disruptive anxiety is essential to make it possible for the patient to undertake the risk of facing the additional anxiety attendant upon the treatment itself and to confront the difficulties of the past. Here, reduction of anxiety usually motivates cooperation and deepens the patient's investment in the therapy.

The use of medications in the treatment of MPD is the subject of an excellent recent review by Loewenstein (1991), and will not be discussed at length. Unless unique considerations and contraindications apply, there is no reason not to attempt to alleviate all symptoms that are legitimate targets for psychopharmacologic intervention. Several considerations in the psychopharmacologic approach to MPD are reviewed in Kluft (1984) and Barkin, Braun, and Kluft (1986). One crucial point should be appreciated: unless the target symptom is present in all or nearly all of the alters, it may be much more responsive to hypnosis than to medications.

It is useful to advise the patient to simplify his or her life while oppressed by inner pain and turmoil. Less pressure, fewer symptomatic episodes. This maxim, first enunciated by Janet (van der Hart & Friedman, 1989), is mentioned for the sake of completeness. It is rare for an MPD patient to accept this advice in a constructive manner. As a group, they try are inclined to make what they perceive as reparative efforts that further complicate their lives. Thereafter some feel they must withdraw from others, and do so to a dysfunctional degree. There is a risk that some will misperceive such advice as permission to abandon those aspects of their lives they find stressful, but which are serving a vital stabilizing function. It must be made clear that any simplifications must be undertaken only after discussion with the therapist, and not announced by the patient without warning. One patient actually quit her job without reflecting that without it she no longer could afford her treatment. For those few who follow a rational course of simplification, they find that it is most helpful.

A new technique of peremptory symptom challenge (Kluft, 1992b) is useful to that subgroup of MPD patients who are so disrupted by specific symptoms that their lives or treatments are compromised. It consists of using hypnosis to make an aggressive search for the origins of the symptoms, and to effect a rapid resolution while bypassing the genetics until later in the treatment, or effecting a very circumscribed abreaction. Because this technique is associated with a certain risk of precipitating severe discomfort, for the most part I restrict its use to work with hospitalized inpatients. When successful, its results can be quite gratifying.

Many MPD patients suffer frequently from spontaneous abreactions or disruptive flashbacks. The patient who can be assured that these symptoms can be alleviated or controlled, even in part, is much more able to participate wholeheartedly in the treatment. Behavioral techniques of thought-stopping, cognitive methods, autohypnotic procedures, helpful post-hypnotic suggestions, and skillful distractions all can be useful. Some methods will be alluded to below.

Virtually all MPD patients suffer from many cognitive distortions (Fine, 1988) that predispose them to revictimization (Kluft, 1990). To the extent that the therapist can help the patient learn to reality-test his or her perceptions and adopt an experimental attitude in the place of rapid avoidance-driven response patterns, the patient's day to day anxieties will be diminished. A cognitive challenge of an MPD patient's irrational perceptions is well worth the effort (see Fine, 1991, 1993).

Hypnosis, with an Emphasis on Temporizing Techniques

Although the majority of the literature discussing hypnosis with MPD addresses work with the recovery of dissociated memories, the abreaction of traumata, and the integration of the personalities, hypnosis is very useful at the stage of preliminary interventions. Braun (1984) described the use of autohypnosis in alleviating anxiety in MPD patients. Margaretta Bowers many years ago (personal communications, prior to 1980), and Cory Hammond, in a number of recent workshops, have recommended the use of extremely deep trance to provide relief from severe autonomic arousal. Kluft (1982, 1983, 1985, 1988, 1989b) has contributed numerous useful techniques in a series of papers. Hammond (1990) has compiled a collection of useful techniques from many experts. Kluft (1992c, 1992d) has contributed two reviews of the roles of hypnosis with MPD patients.

However, the most useful techniques in the stage of preliminary interventions are derived from those first described by Kluft (1988, 1989b; see this author's entries in Hammond, 1990). These were originally developed to stabilize fragile MPD patients at later stages of treatment, and then, when their potential wider application was appreciated, were applied earlier in the therapy to MPD patients with all levels of ego strength (e.g., Fine, 1991, 1993). They are described as temporizing techniques, because they interrupt processes that would or could prove overwhelming, and "buy time" for the patient and the treatment. Their purpose is to offer psychological respite and asylum in the context of achieving mastery. They allow the treatment to titrate the amount of discomfort the MPD patient must endure against his or her resources and capacity to achieve mastery and self-efficacy. By involving MPD patients' active participation, they may offer them their first opportunities to experience themselves "as effective rather than impotent before the course of events" (Kluft, 1989, p. 93).

157

In my use of these techniques, I endeavor to apply them at first to material and situations that are relatively circumscribed and non-threatening. Once the patient is accustomed to their predictable efficacy, and anticipates their success, they can be applied to the more difficult material and devastating affect storms encountered in the later stages of the therapy. If they are used for the first time under conditions of great discomfort and urgency, their routine success is less likely.

The temporizing techniques consist of 1) alter substitution, 2) the provision of sanctuary, 3) distancing maneuvers, 4) bypassing time, 5) bypassing affect, 6) the attenuation of affect, and 7) reconfiguration.

1) Alter substitution is employed in conjunction with other interventions. Often alters that carry major responsibility for major life events are exploited to the point of exhaustion and are overwhelmed and a switch occurs. Although they may welcome being relieved, they experience a sense of shame, defeat, demoralization, and incompetence. It is often possible to arrange for another alter to take over for a period of time while the depleted alter is "put to sleep", sent on a fantasy excursion, or brought out only in therapy sessions for ego strengthening and supportive measures. Without such arrangements, overwhelmed alters may absent themselves and/or be thought to be dead by the others. Such incidents often terrify the alter system, and can prolong treatment considerably. They feed into alters' fear that the hard work of therapy will destroy them.

2) The provision of sanctuary involves the use of procedures described in the hypnosis literature with terms like "secret place" or "safe room" techniques. They can be taught for autohypnotic use several times daily as a means to prevent exhaustion or longstanding severe anxiety that might prove overwhelming. They are very useful in treatment when an alter needs respite from intense work or when the therapy requires work on difficult material with one alter while protecting the others from its impact. *Example:* A courageous but fragile patient's reaction to a television program led me to infer that a devastating gang rape may have been followed by a pregnancy and abortion known only to one alter. I sent the others to their safe places and interviewed that alter, who confirmed my inference. We agreed that it was premature to share this information, which was kept sequestered as that alter and I processed it over several weeks. There are two unique features to the use of these techniques in MPD. First, many alters must know how to initiate their use in autohypnosis lest a single alter with this knowledge become overwhelmed or unavailable. Second, each alter must be allowed to create a safe place that is meaningful and valid within its own unique patterns of perception.

3) Distancing maneuvers "reduce the intensity of distressing materials by taking charge of the patient's tendency to disavow the material or the ownership of the material and thereby utilize the anticipated dyscontrol to enhance mastery" (Kluft, 1989, p. 94). A more adaptive dissociative technique is substituted, in the interests of enhancing mastery. These techniques involve suggesting permissive amnesia, the library technique, and all manner of screen techniques. I recently have used a "backwards telescope" technique effectively: the patient is instructed to envision the distressing materials through the wrong end of a telescope so they become progressively smaller and the feelings more remote and distant, and finally cannot be discerned or perceived at all.

4) Bypassing time "involves reducing the patient's subjective experience of those elements of his or her therapy that are perceived as an ordeal" (Kluft, 1989, p. 95). Time distortion, pseudo-orientation in time, and therapeutic sleep are useful variations. To illustrate time distortion, it is possible to suggest that a patient will have the subjective experience of a difficult trauma over a period of a few minutes. This allows speeded abreaction and the devotion of more time to helping the patient restabilize. Many patients who initially recoil from abreactive work are willing to face their traumata when they appreciate that it will "be over" in a brief period of time.

Pseudo-orientation has many potential uses. For example, a patient who was sure she would injure herself on her birthday was age-progressed to believe the birthday had already occurred. Later she was age-regressed back to the time of the pseudo-orientation and then rapidly age-progressed back to the current time.

Therapeutic sleep is one of the most effective and clinically effective temporizing techniques. It is most useful to prevent the patient from being overwhelmed, or walking about in a chaotic state, impinged upon by the feelings of several anguished alters. I typically will put overwhelmed alters or those holding memories or affects intolerable to the alters handling day-to-day functioning to sleep in between sessions, or even longer. This type of approach allows the avoidance of many hospital admissions, regressions, and impulsive self-injuries. It also is helpful in assisting the overwhelmed MPD patient to manage separations and the therapist's vacations.

5) Bypassing affect "involves techniques that diminish the patient's exposure to intense and potentially disruptive dysphoric affects" (Kluft, 1989, p. 95). These techniques appear to be enhanced by deepening. A typical example is the time locked vault. In a deepened trance the patient is asked to visualize strong bank vault door, sealed with an enormous combination lock and a time lock. The patient is

asked to place the difficult affect and the associated memories in the vault, to close the door, set the combination lock, and then, finally, to set the time lock so it will open a few minutes after the next session begins, but only in the office and in the presence of the therapist. It is useful to teach the patient to reinforce these suggestions autohypnotically between sessions, because a significant minority of MPD patients will report that "the vault has begun to leak" between sessions.

6) The attenuation of affect techniques were developed for the treatment of older adults with MPD (Kluft, 1988), and form an essential component of unique treatment strategies that exploit their particular strengths (Fine, 1991). In brief, they encourage slow and gradual rather than intense and explosive abreactive work. MPD patients who regress, decompensate, or become overwhelmed in traditional abreactive work often are able to process their traumatic experiences quite effectively with these techniques. "The fractionated abreaction technique (Kluft, 1988) involves deliberately interrupting abreactive events after a small amount of affect has been expressed and processing what has been recovered at great length"(Kluft, 1989, p. 96). It is discussed at length in Fine (1991). "The 'slow leak' technique (Kluft, 1988) involves the use of suggestions to the effect that the emotions in question will be experienced and dissipated slowly over time" (Kluft, 1988, pp. 95-96).

7) Reconfigurations effect rearrangements among the alters. In "bartering" alters are convinced to refrain from acting upon dysfunctional impulses in exchange for more time in treatment or in control. It is often useful when destructive alters are prominent in the therapy. "Shuffling the deck" refers to complex reconfigurations undertaken when many alters are deeply distressed and/or disorganized. It usually involves using several of the techniques above in order to restore equilibrium and function. Usually several alters will be put in safe places and/or to sleep, protectors will be mobilized to guard the apprehensive, and destructive alters may be helped to agree to foreswear action in exchange for time in control or other help or relief.

It is important to appreciate that virtually all of these techniques will be more effective if they are first used in the management of relatively non-demanding tasks, and only later used to handle more strenuous ones. For example, in bypassing affect, I might first suggest placing in a vault some mild displeasure about some relatively trivial contemporary event, progress to containing the last residua of a minor problem under discussion, and finally, after a dozen or so successes, use it to deal with stronger material or an interrupted spontaneous abreaction or flashback. Again, when I

teach age regression, I first use it to "turn back the clock" by requesting that an alter that left at a moment of conflict return and resume our discussion. I might then use it to recall the subject matter of the last session that the patient had hoped to return to, but has forgotten (unless it were clear that the dynamics of the "forgetting" were very crucial and deserved study in and of themselves). Next, I might go back to recover neutral and positive experiences. Only then would I use the technique to access difficult or painful issues. The reader should note that the first uses of the technique, which will be to recover material observed and known to the therapist, will offer some indication of the degree of confabulation and pseudomemory formation characteristic of the patient.

Although it is not a technique in itself, trance ratification can play a powerful role in strengthening the patient's confidence in the genuineness and efficacy of hypnotic interventions and techniques. In my experience, relatively few contemporary therapists working with MPD patients use traditional longer inductions and elicit hypnotic phenomena in order to teach them about hypnosis. This deprives them of a powerful tool to convince the patient of the potency of the hypnotic methods. Because so much of the hypnotic response is determined by the subject's expectations (Orne, 1959), interventions that buttress the expectation of a powerful impact are useful to apply, and ought not be squandered. A patient to whom I have demonstrated analgesia, catalepsy, or some similar phenomenon will be much more prepared to accept my suggestions that pain from past traumata can be softened and relieved, or that a problematic alter can be allowed to emerge and control only the head in order to engage in a therapeutic dialog while the body remains catatonic, immobile, and without the capacity to enact an undesirable behavior.

A final intervention I have found useful in recent years is a crude screen for baseline levels of confabulation. I make no claim for its accuracy in a scientific sense, but it offers me clinical information that I think can be helpful. As noted above, I often take verbatim notes early in therapy. At a later date, should a patient ask for help in recalling the content of a session on which I have made such notes, I may age regress them back to the session and record verbatim what they report. This allows me to study my patients' tendencies to confabulate, and to see whether the pattern of confabulation suggests a particular psychodynamic or thematic trend. The patient's confidence in the accuracy of his or her recall can be appreciated in the context of an objective test of accuracy. If a patient demonstrates profound, pervasive, or fantastic elements of confabulation, I am alerted to the possibility that such phenomena may infiltrate their given and retrieved accounts of their past. The absence of such elements do not indicate an absence of the potential for confabulation, however.

DISCUSSION

The initial stages of the psychotherapy of MPD offer unique opportunities to strengthen both the patient and the ther-

159

apeutic alliance. They allow the establishment of a firm foundation for the remainder of the treatment. The energetic use of approaches that offer the patient the sense of mastery and active collaboration reduce the patient's sense of helplessness and demoralization. With an enhanced sense of self-efficacy (Bandura, 1977), the MPD patient is less likely to have recurrent crises or to develop regressive dependency as the treatment progresses into its more demanding stages.

It is crucial to appreciate that the techniques and procedures discussed above do not constitute competent therapy in and of themselves. They are designed to facilitate and enhance competent therapy. Their purpose is to help the therapist help the MPD patient become more capable of finding his or her way through the difficult process of healing. ∎

REFERENCES

Allison, R.B. (1974). A new treatment approach for multiple personalities. *American Journal of Clinical Hypnosis*, 17, 15-32.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84, 191-215.

Barkin, R., Braun, B.G., & Kluft, R.P. (1986). The dilemma of drug therapy for multiple personality disorder. In B.G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 107-132. Washington, DC: American Psychiatric Press.

Bliss, E. (1986). *Multiple personality, allied disorders, and hypnosis.* New York: Oxford.

Braun, B.G. (1984). Uses of hypnosis with multiple personality. *Psychiatric Annals*, 14, 34-40.

Chu, J.A. (1992). Empathic confrontation in the treatment of childhood abuse survivors, including a tribute to the legacy of Dr. David Caul. *DISSOCIATION*, 5(2), 98-103.

Erickson, E. (1963). *Childhood and society* (2nd edition). New York: Norton.

Fine, C.G. (1988). Thoughts on the cognitivie perceptual substrates of multiple personality disorder. *DISSOCIATION*, 1(4), 5-10.

Fine, C.G. (1990). The cognitive sequelae of incest. In R.P. Kluft (Ed.), *Incest-related syndromes of adult psychopathology* (pp. 161-182). Washington, DC: American Psychiatric Press.

Fine C.G. (1991). Treatment stabilization and crisis prevention: Pacing the therapy of the multiple personality disorder patient. *Psychiatric Clinics of North America*, 14, 661-676.

Fine, C.G. (1993). A tactical integrationalist perspective on the treatment of multiple personality disorder (pp. 135-154). In R.P. Kluft & C.G. Fine (Eds.), *Clinical perspectives on multiple personality disorder.* Washington, DC: American Psychiatric Press.

Frazer, G.A. (1991). The dissociative table technique: A strategy for working with ego states in dissociative disorders and ego-state therapy. *DISSOCIATION*, 4(3), 205-213.

Greenson, R. (1967). *The technique and practice of psychoanalysis* (vol. 1). New York: International Universities Press.

Hammond, D.C. (1990). *Handbook of hypnotic suggestions and metaphors.* New York: Norton.

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

Kluft, R.P. (1982). Varieties of hypnotic interventions in the treatment of multiple personality. *American Journal of Clinical Hypnosis*, 24, 230-240.

Kluft, R.P. (1983) Hypnotherapeutic crisis intervention in multiple personality disorder. *American Journal of Clinical Hypnosis*, 26, 76-83.

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

Kluft, R.P. (1985). Using hypnotic inquiry protocols to monitor treatment progress and stability in multiple personality disorder. *American Journal of Clinical Hypnosis*, 28, 63-75.

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

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

Kluft, R.P. (1989a). Treatment of the patient who has been exploited by a previous therapist. *Psychiatric Clinics of North America*, 12, 483-500.

Kluft, R.P. (1989b). Playing for time: Temporizing techniques in the treatment of multiple personality disorder. *American Journal of Clinical Hypnosis*, 32, 90-98.

Kluft, R.P. (1990). Dissociation and revictimization: A preliminary study. *DISSOCIATION*, 3(2), 167-173.

Kluft, R.P. (1991). Multiple personality disorder. In A. Tasman & S. Goldfinger (Eds.), *The American psychiatric press annual review of psychiatry*, vol. 10 (pp.161-188). Washington, DC: American Psychiatric Press.

Kluft, R.P. (1992a). Paradigm exhaustion and paradigm shift — Thinking through the therapeutic impasse. *Psychiatric Annals*, 22, 502-508.

Kluft, R.P. (1992b, March). *Peremptory symptom challenge.* Paper presented at the Annual Scientific Meeting of the American Society of Clinical Hypnosis, Las Vegas.

Kluft, R.P. (1992d). The use of hypnosis with dissociative disorders. *Psychiatric Medicine*, 10, 31-46.

Kluft, R.P. (in press a). Treatment trajectories in the psychotherapy of multiple personality disorder. *DISSOCIATION*.

Kluft, R.P. (in press b). Misrepresentations by multiple personality disorder patients. *DISSOCIATION*.

Langs, R. (1980). *Interactions.* New York: Aronson.

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

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy.* New York: Basic Books.

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

Orne, M.T. (1959). The nature of hypnosis: Artifact and essence. *Journal of Abnormal Psychology*, 58, 277-299.

Orne, M.T., & Wender, P.H. (1968). Anticipatory socialization for psychotherapy: Method and rationale. *American Journal of Psychiatry*, 124, 1202-1212.

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

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

Rumelhart, D.E., & McClelland, J.L. (Eds.). (1986). *Parallel distributed processing: Explorations in the microstructure of cognition*, vol. 1, Foundations. Cambridge, MA: MIT Press.

Sackheim, D.K., Hess, E.P., & Chivas, A. (1986) General principles of short-term inpatient work with multiple personality disorder. *Psychiatry*, 25, 117-124.

Seligman, M. 1(1975). *Helplessness. On depression, development, and death.* San Francisco: W.H. Freeman.

Spiegel, D. (1990). Hypnosis, dissociation and trauma: Hidden and overt observers. In J.L. Singer (Ed.), *Repression and dissociation* (pp. 121-142). Chicago: University of Chicago Press.

Turkus, J.A. (1991). Psychotherapy and case management for multiple personality disorder: Synthesis for continuity of care. *Psychiatric Clinics of North America*, 14, 649-660.

van der Hart, O., & Friedman, B. (1989). A reader's guide to Pierre Janet on dissociation: A neglected heritage. *DISSOCIATION*, 2(1), 3-16.