EDITORIAL:

RUMINATIONS ON METAMORPHOSES

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I often find myself puzzling over a curious phenomenon in my daily clinical work, in my teaching, and my research. I have been struggling with the same problem for over twenty years. Although I often have believed for a moment that the solution was within my grasp, or thought I caught a brief glimpse of an explanation through the mists of my confusion and uncertainty, on each occasion I have found my conclusions disconfirmed by clinical facts or have come to appreciate that my apparent answer was in fact an invitation to raise yet another cleverly-disguised question. I have shared my perplexity with a large number of colleagues, and have been impressed that many of them did not believe that I had identified a genuine problem, and that others were quite secure with answers that I had found lacking or had abandoned years before.

Let me frame the dilemma, which I alluded to in passing in my paper, "The Natural History of Multiple Personality Disorder" (Kluft, 1985a). Although it has only been in recent years that others' experience and research has confirmed my own impressions, I have long been struck with how simple so many cases of childhood dissociative disorders are in terms of the number of alters, how frequently the children's allegations of abuse can be documented, and how rapid the response to treatment can be when the child can be made to feel completely safe from further harm. However, it is clear that dissociative disorders in adults often are not simple in structure, that allegations of abuse frequently cannot be documented, and the treatment typically can be long and arduous. I also have seen relatively little "character pathology" in my childhood cases, while it is not at all infrequent in adult cases.

To summarize many observations in a number of articles and presentations, I suggested that during adolescence some MPD cases appeared to consolidate at their childhood degree of complexity but in others the MPD adaptation could take on a life of its own, achieving a secondary autonomy, with the formation of alters becoming a major coping style, called into play in all manner of circumstances. I also observed that when alter formation continued to occur, it was not uncommon for the MPD patient to develop a complex inner world and personal myths, in which the alters' relationships with one another and their interactions achieved a compelling reality to the patient (Kluft, 1988). Furthermore, there seemed to be some sort of relationship between (1) the proclivity to develop an elaborate inner world and other indices of complexity and (2) the propensity to respond to exogenous social pressures and influences by forming additional alters and according them a believed-in history.

Thus, I indicated that many but not all MPD patients undergo a metamorphosis in which, as in many species of insects, the adult form differs in many ways from the original structure and presentation manifest in childhood. This metamorphosis is a dilemma, a riddle, a puzzle, a conundrum that deserves our most careful attention. It remains arguable that the difference is due to other factors, such as iatrogenic pressures, and that the complex adult forms are not naturalistic phenomena. However, the frequency with which I have been able to gain documentation from family members and concerned others of the presence of dissociative psychopathology in the childhoods of my complex adult cases convinces me that most of them, if not all of them, have grown up dissociative, and that their dissociative psychopathology may have undergone significant transformation over time, a process I have described elsewhere (Kluft, 1985a).

The reader may not be aware that although Frankel (1992) has disputed the traumatic etiology of MPD by noting that alleged abuses are rarely documented in the MPD literature, this argument was made without considering the literature on childhood MPD and dissociative disorders. Had Frankel addressed this literature, it would have been rather difficult to maintain his stance. Articles by Kluft (1984, 1985b), Fagan and McMahon (1984), Bowman, Blix, and Coons (1985), Hornstein and Putnam (1992), and several others have indicated abuse was documented in most of their cases. Recently Coons (1994) was able to confirm child abuse in eight of nine cases of childhood and adolescent MPD and all twelve cases of dissociative disorder not specified in this age range. In this issue, Klein, Mann, and Goodwin report several cases in which documentation was demonstrated, and Wickramasekera offers highly suggestive evidence that a somatic memory has a historical foundation, offering a physiological expression of Bessel van der Kolk's axiom that "the body keeps the score."

Unfortunately, no such confirmatory evidence exists for the allegations of most adult cases. Also, the accounts of many complex adult MPD patients are so suffused with allegations the credibility of which is suspect that the believability of their more mundane allegations is discounted in the current socio-political climate.

Clearly, something is happening that we very much need to understand. From genuinely hurt children with whom it is easy to empathize and sympathize, a metamorphosis occurs such that adults emerge who tell stories about them-

selves that are complicated, confusing, and often strain the belief of the listener. They become adults with whom many have no sympathy and empathy, and the reality of whose hurt is all too often challenged if not peremptorily discounted.

To cite illustrative cases from my clinical experience, let me contrast two situations I assessed recently. The first is of a sixteen-year-old girl I diagnosed with dissociative disorder not otherwise specified; the second regards a woman in her forties. In the first instance, the patient's mother looked me in the face and said, "I suppose it wouldn't do any good to deny I abused her?" I said, "Sometimes things happen that we regret when we look back on them." Thereupon she gave a full account of her mistreatment of her daughter. I later received additional documentation from an agency that once had removed the girl from her mother's home.

The second patient, a poised professional woman, eyed me warily. She had wanted to "interview" me and learn my diagnostic opinion before applying to the dissociative disorders program I head. She opened with: "I am the victim of transgenerational Satanic abuse. Do you believe me and do you know how to deprogram me?" This unfortunate woman alleged herself to have several thousand personalities, and believed her mind had been manipulated by virtually every major agency and component of the military-industrial complex. Her DES (Bernstein & Putnam, 1986) score was 47, and a SCID-D interview showed severe symptomatology in all areas assessed (Score=20/20). Her elementary school records documented severe dissociative symptoms in childhood. She certainly suffered MPD, but whether her given history is accurate and whether her thousands of alters developed in response to historical trauma remains uncertain at best.

How can we understand the second case? It is over-simplistic to make the glib assumption that her complexity and her accounts are iatrogenic artifacts, because she had made the same presentation to her first therapist. Did she respond to social pressures of some sort? Certainly it would be naive to assume that a person can live in a society without being influenced by what is happening in that society, but her particular presentation cannot be explained by social pressures alone. Millions were exposed to similar social pressures and did not suffer this type of outcome. Could she have wanted to be especially fascinating to me, to evoke my interest? Perhaps, but her presentation was the same to all who had examined her, and I was not then or subsequently asked to become involved any further than to do a diagnostic assessment and discuss my program with her.

I think that a series of intrapsychic processes that I do not pretend to understand is at work in such cases. I do not exclude the possibility of all sorts of influences from therapy, the media, and society playing crucial roles in generating such complex presentations, but they are partial explanations at best, and insufficient to account for the full picture. If they were sufficient, this nation of soap opera and talk show viewers would be producing such patients by the hundreds of thousands rather than by the hundreds or thousands. Instead, it is my impression that something happened in the second patient so that her mind wove the intricate tapestry of pathology with which I was presented. Fantasy, imaginative involvement, hypnotizability, fantasy-proneness, and psychodynamics have been recruited in this process. In my opinion, creativity gone wild seems to be a factor. The inner worlds of many MPD patients bear striking resemblances to the imaginary worlds depicted in fantasy epics and the science fiction literature. These patients' interpretations of the here-and-now world in terms of their inner worlds are reminiscent of the efforts of students in English at a seminar on allegory in literature, trying earnestly to understand everything in terms of the principles of interpretation that are under study. I have come to thing that the efforts of the mental health disciplines alone may be insufficient to apprehend all aspects of the metamorphosis under discussion.

Although I have no illusion that it will be easy to grasp the essence of this metamorphosis, or that ready solutions will come our way in the immediate future, I think it is essential to begin its exploration in two ways. First, it will be useful to build bridges toward this phenomenon from areas of knowledge already at our disposal. Such efforts are useful, but often vulnerable to confirmatory bias and to a tendency to reduce the new area under study to the status of an example of something already known. Its uniqueness and possible differences from previously studied subjects are easy to overlook or negate. Second, it will be useful to study the phenomenology of these metamorphoses and try to discern their message to us. This type of effort runs the risk of becoming lost in itself, and neglecting what is already known. Taken together, hopefully both sorts of exploration can exert corrective influences upon one another.

In the current atmosphere of polarized debate that surrounds allegations of childhood mistreatment, the often difficult-to-accept accounts of adult patients with MPD are frequently a prime target of those who are skeptical of patients' accounts of the traumata they have suffered. The consequences for the credibility of our patients and our field are problematic. The understanding of this metamorphosis will be to the benefit of all parties. The failure to understand it is a guarantee of further acrimony and confusion. I consider it urgent to begin the systematic study of this process of transformation and its consequences. ■

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REFERENCES

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

Bowman, E.S., Blix, S., & Coons, P.M. (1985). Multiple personality in adolescence: Relationship to incestual experience. *Journal of the Academy of Child Psychiatry*, 24, 109-114.

Coons, P.M. (1994). Confirmation of childhood abuse in child and adolescent cases of multiple personality disorder and dissociative disorder not otherwise specified. *Journal of Nervous and Mental Disease*, 182, 461-464.

Fagan, J., & McMahon, P.P. (1984). Incipient multiple personality in children. *Journal of Nervous and Mental Disease,* 172, 26-36.

Frankel, F.H. (1992). Adult reconstruction of childhood events in the multiple personality disorder literature. *American Journal of Psychiatry,* 150, 954-958.

Hornstein, N., & Putnam, F.W. (1992). Clinical phenomenology of child and adolescent dissociative disorders. *Journal of the American Academy of Child and Adolescent Psychiatry,* 31, 1077-1085.

Klein, H., Mann, D.R., & Goodwin, J.M. (1994). Obstacles to the recognition of sexual abuse and dissociative disorders in child and adolescent males. *DISSOCIATION,* 7, 138-144.

Kluft, R.P. (1984). Multiple personality in childhood. *Psychiatric Clinics of North America,* 7, 121-134.

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

Kluft, R.P. (1985b). Childhood multiple personality disorder: Predictors, clinical findings, and treatment results. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality disorder* (pp. 167-196). Washington, DC: American Psychiatric Press.

Kluft, R.P. (1988). The phenomenology and treatment of extremely complex multiple personality disorder. *DISSOCIATION,* 1 (4), 47-58.

Kluft, R.P. (in press). Reflections on current controversies surrounding dissociative identity disorder. In L.M. Cohen, M.R. Elin, & J.N. Berzoli (Eds.). *Multiple personality disorder: Diagnosis and therapy* (title tentative). New York: Aronson.

Steinberg, M. (1993). *The structured clinical interview for DSM-IV dissociative disorders (SCID-D).* Washington, DC: American Psychiatric Press.

Wickramasekera, I. (1994). Somatic to psychological symptoms and information transfer from implicit to explicit memory: A controlled case study with predictions from the high risk model of threat perception. *DISSOCIATION,* 7, 153-166.