

SOME ASPECTS OF RESISTANCE IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER

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ABSTRACT

Therapists who treat patients with Multiple Personality Disorder (MPD) commonly experience discomfort and frustration. This paper contends that the most significant cause of therapist discomfort is the particular resistances encountered in the treatment of MPD. In MPD, etiologic childhood traumatic experiences are defensively repressed and dissociated. In addition, the normal ability to engage in trusting interpersonal relationships is disrupted. Thus, a psychotherapy which requires the retrieval of past traumas in the context of an interpersonal therapeutic relationship is tremendously threatening to the patient with MPD. In the normal course of the psychotherapy of MPD, intense resistances are encountered at every stage. This paper outlines the nature of resistance in the treatment of patients with MPD, presents a number of clinical examples, and discusses the importance of understanding and working with resistance as an intrinsic part of the treatment.

INTRODUCTION

Over the past several years the importance of trauma has been increasingly acknowledged as an etiologic factor in psychiatric illness. Through a body of clinical and research data, it is now clear that many of the victims of childhood abuse develop major dissociative disorders, including multiple personality disorder (MPD) (Putnam, Guroff, Silberman, Barban & Post, 1986). As an increasing number of patients with dissociative disorders are recognized and treated, therapists have experienced certain similar and notable reactions (Kluft, 1984). It appears to be a commonly shared experience among therapists that the treatment of dissociative disorders, particularly MPD, is often arduous and emotionally wrenching. Therapists frequently find themselves feeling isolated, overwhelmed, helpless, frustrated, angry, and intruded upon. Some of these feelings may simply be due to hearing about the extremely traumatic experiences of the patient. Other difficult feelings may be due to the intensely dependent and ambivalent therapeutic relationship that often evolves with these patients. However, the greatest degree of therapist discomfort is best understood as due to the profound resistances encountered in the treatment of MPD.

Although they are a part of every psychotherapy, resistances in the treatment of MPD are particularly difficult. This is due to the very nature of MPD. An important aspect of the primary psychopathology is "forgetting" (repression and dissociation). The treatment process involves "remembering" (de-repression, abreaction, and working through), and is met with great resistance. This paper sets forth a conceptual framework for understanding resistance in MPD. Such an understanding is essential for the rational treatment of MPD, and for maintaining the therapeutic capacities of the therapist. I have included a number of clinical examples of resistance throughout the course of treatment; these are followed by a brief discussion and conclusions.

RESISTANCE IN MPD

Freud (1895) first defined resistance as any force which opposed the treatment process. It was most evident when the analyst attempted to elicit information from his patients. Although the concept of resistance classically was associated with psychoanalytic treatment, it has been observed in other clinical situations including various forms of therapy (Sandler, Dare & Holder, 1973), and might now be defined as any attitude, behavior, pattern of communication or defense which impedes or opposes progress towards the objectives of treatment. Freud (1926) defined various forms of resistance; of these the ones that appear most important in the treatment of MPD are resistances to the emergence of repressed memories and affects as they begin to become conscious. These resistances arise in two major situations: the exploration of repressed traumatic experiences (repression-resistance), and in the transference to the therapist (transference-resistance). Both of these kinds of resistances are present in most clinical situations in the treatment of MPD.

RESISTANCE TO THE EXPLORATION OF REPPRESSED TRAUMA

The traumatic etiology of MPD predisposes the patient to have striking manifestations of resistance. In treating patients with MPD, it is essential to recall the etiologic forces behind the disorder, and the primary defenses of repression and dissociation. The use of repression and dissociation to create separate personalities has at least four important functions. It permits escape from harsh and unbearable realities, coexistence of irreconcilable conflicts, isolation of affect, and encapsulation of traumatic experiences. In nearly all the cases of MPD that have been studied, these defenses have been used as survival mechanisms for coping with severe child abuse, usually beginning at a very young age (Putnam et al., 1986); i.e., the unbearable realities were physical, emotional, and sexual abuse. Irreconcilable

conflicts are manifested in contradictory behaviors and communications by those with power and authority over the child. A child may be told that brutal punishment is "caring" or "teaching." The child may be nurtured at times and abused at other times. These conflicts are dealt with through dissociation: some personalities know the caring while others accept the abuse. Isolation of affect occurs as a result of denial of the child's affective states, bodily needs, or physical distress by abusers; the resultant isolated affects may be split off into separate personalities. The child who is repeatedly told that anger is sinful, and is severely punished for angry outbursts, may become compliant and obedient, and dissociate anger into a rageful personality. Extremely traumatic events may be encapsulated into one or more personalities, leaving others with little or no memory of these events.

The treatment process threatens these four functions of repression and dissociation. Through therapy, unbearable realities must be faced and worked through. Conflicts manifested through different personalities must be resolved. Unacceptable affective states must be modified, accepted, and made part of the whole. Extremely traumatic events must be remembered by all of the personalities. Hence it is not surprising that resistance opposes these main objectives of the treatment. In a patient with MPD, the alter personalities have a function to protect the self from conflicts and painful affects and awarenesses. These alter personalities are analogous to members of a highly conflicted and disrupted family, and exist in a state of fragile homeostasis or unstable truce. The family functions in a delicate balance, but if stresses (such as psychotherapy) are brought to bear, the truce breaks down and the family begins to feud or self-destruct. The family scrambles desperately to reestablish the former level of homeostasis, even at the cost of progress towards health. Both in dysfunctional families and in MPD patients, resistance thus takes the form of attempts at repression, further dissociation and flight. If these attempts fail, gross disorganization or destructive behavior may ensue.

RESISTANCE IN THE TRANSFERENCE TO THE THERAPIST

Resistance to acknowledging, working through, and resolving transference phenomena in treatment is heightened due to the painful early interpersonal experiences of MPD patients. Rather than being able to rely upon comfort, love, and support from caretakers, patients with MPD encountered abuse, betrayal, and neglect during their childhoods. A number of investigators have hypothesized that an essential factor in the development of MPD is a family constellation in which both parents either participate or passively collude in the abuse. The family presents a united front to the community and denies that any abuse has occurred (Braun & Braun, 1979). If the abused child confides in a friend, teacher, health professional, clergyman, relative or neighbor, the usual response is disbelief (Goodwin, 1985). The message of, "There is no protection or rescue," is a powerful force in the child's development (Braun & Braun, 1979). This leads to an abandonment of hope and trust in others, and a turning inward in the quest for internal solutions.

Patients with MPD have learned to mistrust others as a result of their early experiences. They are convinced that other people will not hear, understand or believe them, and they persist in a maladaptive self-reliance. These attitudes become major resistances in psychotherapy. Transferences must be acknowledged

and worked through. The patient with MPD is apprehensive, and will try to conceal ambivalence or negative feelings towards the therapist. Once they are revealed, the MPD patient may then be unable to work toward their resolution. These patients must learn to look to others, including their therapists, for help, protection, and support. Trust must be established and maintained. This therapeutic task seems impossible to the patient, who perceives it to be an invitation to participate in self-destruction. It is not surprising that when the therapeutic relationship feels too threatening, major resistances arise, and the patient may flee back to reassuringly familiar, but dysfunctional and painful solutions.

CLINICAL EXAMPLES OF RESISTANCE IN MPD

RESISTANCE TO THE DIAGNOSIS OF MPD

Resistance begins at the outset when the patient presents for diagnosis and treatment. The patient's background experiences of abuse, punishment, betrayal, lies, and contradictions represent formidable challenges to the clinician attempting to make a diagnosis. The fear, mistrust and despair of the abused child are recapitulated in the therapeutic situation. Information needed to make the diagnosis of MPD is consciously and unconsciously withheld. It is paradoxical that when these patients present for treatment they have enormous difficulty in communicating the basis of their distress, as in the following example.

Betsy, aged 32, presented for her twenty-third psychiatric hospitalization with complaints of suicidal ideation and "not feeling like myself." Her history of psychiatric treatment included six years of individual psychotherapy with Dr. T. and frequent inpatient hospitalizations, including a prolonged stay of more than one year. When not hospitalized, she functioned competently as a psychiatric nurse. Her diagnosis was borderline personality disorder, although Dr. T. wondered if she was schizophrenic on the basis of 1) her delusional beliefs that she was being controlled, and 2) her auditory hallucinations. Upon closer investigation by another clinician, it was found that Betsy had a history of dissociative episodes during which friends and family found her to be "out of contact" with them. She admitted to auditory hallucinations including voices commanding her to kill herself. In response to specific questions, she admitted to having "lost" time, and that she had been unable to account for periods of up to several hours or even days at a time. She acknowledged that she had items of clothing in her closet that she had not bought, and that she was often told that she had done or said something for which she had no recollection. As a child she was often called a liar, and her mother commented on how different she seemed at times. The hospital therapist expressed an interest in helping her understand what had happened when she lost time. Betsy appeared quite frightened by this suggestion, and stated, "Nothing happens. I just lose time, that's all," and terminated the session. On subsequent occasions when the therapist suggested that there might be other parts of herself of which she was unaware, Betsy would react either by terminating the interview or by ridiculing the therapist's ideas and devaluing the therapist. However, over the next several weeks several personalities did emerge to talk with the therapist. In addition to Betsy, the core personality, these included Elizabeth, a depressed and suicidal young woman; Liz, a carefree teenager; Beth Ann who believed walls could move

and who was afraid of closed spaces; and Betty, a six-year-old child personality who was fearful of being punished. When asked why she never mentioned the periods of amnesia to Dr. T. in over six years of therapy, Betsy replied, "I never thought to mention it. I didn't think it was important and I didn't think he wanted to hear about it." Elizabeth and Liz also claimed to have met Dr. T., they said they had pretended to be Betsy because they were fearful that he wouldn't believe in them. This example illustrates resistance to avoid repressed and dissociated experiences as well as mistrust of the therapist, with both conscious withholding and unconscious dissociation.

RESISTANCE TO ENGAGING IN TREATMENT

Patients with MPD have profound ambivalence about their treatment and particularly about their therapist. Despite a desperate wish to feel connected to another person and to feel understood, these patients' past histories predict abuse and abandonment. Basic mistrust is universal with patients with MPD. Although they enter the therapy with hope, they ultimately expect and usually bring about the recapitulation of the conflicts and disappointments of previous primary relationships. It is essential to recognize that even if there appears to be an excellent therapeutic alliance and powerful motivation for treatment, profound ambivalence, doubt, and mistrust still exist. Negative affects such as anger, fear, and suicidal or homicidal feelings are withheld or dissociated into other personalities. Since these affects are present but unexpressed, they can easily lead to flight, destructive behaviors or other dysfunctional modes of acting out, as in the example below.

A 28 year-old patient with MPD began in treatment and appeared to be highly motivated. The presenting personality, an adult, related a long history of misdiagnosis and questionable treatment. She indicated that she trusted the therapist and felt that she had found someone who would be able to help her solve her problems. She intensely devalued former therapists and attributed much of her lack of progress to their lack of knowledge about the treatment of MPD. This personality stated that she was willing to do whatever she needed to do, for as long as it took to get well. A young child alter personality similarly expressed her appreciation for the therapist's help. Her only reservation was that the therapist was male, but felt reassured in that he was "like a lady." She charmingly stated that she would be in therapy "for ever and ever and ever" if necessary. The therapist felt quite gratified by the open display of confidence, but had some unexpressed misgivings as well. He did not explore the ambivalence about the therapy. Later that same day, the child alter personality was repeatedly cut with a razor by a hostile and punitive alter personality in order to "teach" her not to trust anyone. The hostile personality stated, "I told you not to tell anything to doctors. They fuck you over and will put you in the insane asylum if you tell them anything." In this way, the fears and ambivalence about the therapy were expressed.

RESISTANCE TO THE BREAKDOWN OF REPRESSION

As the treatment process continues and traumatic experiences begin to become conscious, the patient with MPD is threatened by further loss of homeostasis. Repression and dissociation had allowed the patient to survive the intolerable, and the breakdown of repression liberates unbearable affects and unwelcome awarenesses, resulting in terror and fierce resistance. The patient may cling to secrets or flee from treatment

with desperate energy. If so, there is a return to dysfunctional patterns of behavior, as illustrated below.

A young woman patient with MPD began in therapy and gradually revealed various personalities. As treatment progressed, she spontaneously began to recall and relive an event having to do with a murder she had witnessed at age four. She had been playing in a woodshed when two men entered. They quarrelled and one man struck the other viciously with an ax. She screamed and was discovered by the murderer. She was then forced to participate in the dismembering of the body and its disposal. Several personalities evolved from this incident, including a young girl who did not age, and remained "not knowing" and innocent, and two "psychotic" personalities who constantly saw themselves covered with blood. When introduced to the therapist, these "psychotic" personalities became highly agitated to the extent of having severe anxiety attacks, headaches, and suicidal impulses. There was a loss of control of switching. The patient began to miss appointments with the therapist, and withheld much information. Some of the adult personalities joined an evangelical church group which only permitted the adult personalities to participate in services, branding the child and "psychotic" personalities as manifestations of Satan. In this way, partial control was reestablished. The young woman intimated that what she needed was regular religious contact, and not so much psychotherapy.

RESISTANCE TO INTEGRATION

Not only does the patient with MPD regard the therapist and the therapy with ambivalence, but many of the personalities regard one another with ambivalence or even outright hostility. Any attempt in the therapy to promote more harmonious relations among the personalities or to facilitate integration is met with resistance, stemming from the need to keep irreconcilable conflicts separated into dissociated fragments, and to extrude unacceptable affects, behaviors, and events from consciousness.

Maryann, a young patient with MPD, had approximately 18 personalities. Maryann, the core personality, had been predominantly "asleep" (i.e., inactive) since the patient's high school years, a time during which she had become so confused and agitated that she was no longer able to function. As the therapy progressed, she was called on to emerge. Efforts were made to begin to sort out the events of her life and to help her to remember. She was amnesic for much of her early life. She loved and respected her father, not knowing that he was responsible for much of the abuse. She did have vague memories of traumatic events which she understood to have happened to the "other girls." She was timid and fearful. She was particularly frightened of men, and of knives, even butter knives, which she feared could "jump down your throat." She refused to sit in chairs or to eat, saying that she was not allowed to. During the periods in which she was allowed to emerge, the therapist urged various alter personalities to help her and to join with her in her difficulties. However, she experienced this as having intrusive feelings and hearing a cacophony of voices inside her head. She became increasingly fearful and agitated, fearing that she would be put in the "lunatic asylum." Unbeknownst to the therapist, several of the alter personalities were becoming quite upset at having to deal with Maryann, and were alarmed that she was learning "secrets." They undermined the work by screaming at Maryann when she was "awake." Moreover, they were envious of the time that the therapist spent with her. Talking amongst

themselves, they agreed to make Maryann kill herself. After all, they reasoned, it was her fault that they were multiple; if she had not needed protection, they would not have been needed. It would be better, they thought, if she were dead, and they could go find their rightful bodies. Maryann, they felt, was useless and hopeless, and so psychotic that she was an embarrassment to all the other personalities. These personalities went to the edge of a cliff in the woods, and forced Maryann to emerge, and encouraged her to jump. The attempt was only thwarted because Maryann became so frightened that she became frozen and catatonic. Following this event, the therapist became acutely aware of the need to address the difficulties inherent in bringing together the various personalities.

THERAPEUTIC IMPASSE DUE TO RESISTANCE

Resistances must be recognized and addressed as the therapy proceeds. If appropriate therapeutic interventions are not made the therapy reaches an impasse. Often the result is that the patient and the therapist both become increasingly frustrated and angry, openly or secretly blaming each other. The patient, unable to tolerate the sense of increasing rage, may become disorganized, paranoid, suicidal, or homicidal as a result. This kind of crisis, due to the failure to acknowledge and resolve resistances, leaves the therapist in a high state of confusion, helplessness and frustration, often leading to the therapist's withdrawal, as in the following example.

A female patient with MPD who had been in treatment for over a year began to deepen her relationship to her therapist. She relived several frightening early experiences which caused her much anxiety. Fearful that she could not tolerate continuing to relive such experiences, she began to resist coming to psychotherapy, often showing up late for sessions. She insisted on bringing her infant child, feeling afraid to leave the baby with babysitters due to her own history of being abused by babysitters. She most often presented in the therapy as young child personalities who were "too scared" to endure therapeutic reliving, and insisted that the personalities who needed to have therapy were too angry and psychotic to appear around her baby. When confronted about this avoidant behavior, a deaf/mute personality began coming to therapy, making any further work impossible. The therapist, feeling angry and frustrated, did not acknowledge this patient's resistance and her intense fears about the work. The angry and psychotic personalities became more out of control, and began to call the therapist at home, making threats of suicide. They devalued the therapist and began to talk of wishes to blow up the hospital where the therapist worked. The therapist, highly frustrated and angry, began to think that the patient was unworkable and had fantasies of terminating therapy.

RESPECTING RESISTANCE

Resistance does need to be respected at times. If the work is seen by the patient as too overwhelming, regression can and does occur. Therapists need to be respectful of the patient's fragile defenses, and to remain mindful that the work of therapy needs to be approached in a stepwise fashion, and in increments which are tolerable. If the resistance is confronted and overridden too aggressively, a crisis may result, as in this example.

A newborn baby personality of an adult patient with MPD progressed rapidly in treatment, learning to talk and communi-

cate. Over the course of several months, she attained a functional level of four years of age. The therapist, encouraged by his success, insisted that the child continue her growth and take on more adult functions and responsibilities. He disregarded the child personality's statements that this was impossible. Massive resistance was met, and the child personality began to become increasingly depressed and suicidal. Eventually, the child personality retreated to the background, and a new baby personality emerged. It was much later ascertained that an extremely traumatic event involving torture, murder and mutilation had occurred on the patient's fifth birthday, and that the child alter personalities could not grow past age four until the incident was relived and worked through.

DISCUSSION

This paper does not contend that resistance can be eliminated. Rather, it is an inevitable part of the treatment of MPD. In fact, massive resistances and crises have to occur, perhaps as the only way the patient with MPD can communicate about his or her difficulties and intrapsychic structure. It is as if only through replicating his or her fragmentation in the therapy, recreating the anxiety and anguish of the past, and even threatening the therapeutic relationship and his or her own wellbeing, can the patient express what is wrong. In this way, the patient brings his or her difficulties and limitations into the psychotherapy.

Paradoxically, the resistance and the resulting crises of the patient in treatment are the substrate for the therapeutic process itself. As the resistances to progress are noted and understood, the inherent difficulties of the patient's life and barriers to health are revealed. Patients with MPD impact on the therapist through their resistances, recreating their anxiety, helplessness and frustration in the therapeutic relationship. In view of the inherent fragmentation of these patients, this can be an extremely demanding and emotionally exhausting task. Therapists may find themselves retreating to an intellectualized position, essentially abandoning their patients. Conversely, overidentification leads to exhaustion on the part of the therapist, and to loss of clinical perspective.

A rational approach to the psychotherapy of MPD requires the understanding that resistance, and the many crisis situations that come up because of it, are integral parts of the treatment. It is as if patients with MPD express the crux of their difficulties by thrusting the resistances and crises into the therapeutic arena. Thus, resistances cannot be avoided in a successful therapy, nor are the crises merely difficulties to endure. They represent major opportunities for further understanding of the patient, as the patient and therapist together experience the vicissitudes of the patient's life. Productive therapeutic intervention demands that the patient and therapist together grapple with the resistances and repetitions of the past until they are finally understood and resolved. The active involvement of the therapist with the patient in struggles around resistances allows the treatment to occur in an interpersonal arena. And, it is precisely the interpersonal relationship which eventually allows the patient to bear and ultimately resolve past traumatic experiences.

The conceptual understanding of resistance does not directly impact on the patient. Rather, it enables the therapist to avoid his own disorganization and soften his or her often strong

negative countertransference responses. As the trauma of the patient's past is recapitulated in the therapy, the potential always exists for the therapist to feel traumatized, and, in reaction, to inflict further trauma on the patient. Rarely, in the treatment of other disorders, is the therapist called on to contend with so much. The therapist must be able to endure the horrors of reliving traumatic experiences with the patient, intense dependency combined with enormous mistrust, repeated and expectable crises involving acting out, psychosis, suicidal and homicidal behavior, as well as conscious and unconscious avoidance and flight. The therapeutic tasks can be overwhelming: encouraging and supporting functional behavior in confused and often withdrawn personalities; reassuring and nurturing terrified child personalities; calming enraged, suicidal, or homicidal personalities; preventing harm to the patient or others; containing all forms of acting out; helping psychotic personalities achieve a sense of reality; contending with longstanding phobias, myths, and delusions; dealing with emptiness and despair; coaxing frightened or hostile personalities to become actively and productively involved; fostering self-esteem; helping to form alliances between enemy personalities; contending with sexual identity confusion, and more. All these tasks must be accomplished with only one patient, and sometimes many of these tasks must be addressed within the same hour.

An understanding of resistance can help the therapist "keep his head" and to provide containment during the therapeutic process. A holding environment which provides containment, but allows growth, is achieved through a therapist who, through personal resources and understanding of the patient, remains patient, calm, warm, firm, but accepting and validating, skillfully utilizing flexible treatment approaches. Adequate supports such as therapist availability both in and out of sessions, as well as such external supports as friends, family, an adequate living situation or the structure of a hospital setting, are essential. An adequate holding environment is essential or the patient will not be able to take the risks involved in the therapy without suitable support.

Therapists need to recognize that, at times, patients may have somewhat different agendas; maintaining the status quo may be their wish rather than progress towards recovery. It is

very easy to be seduced by "reasonable" explanations as to why the therapeutic work of uncovering and reliving cannot continue. Acknowledgement of the resistance must be made, and gentle confrontation about the use of dysfunctional defenses needs to be exercised. Therapists also need to remain sensitive about the difficulty of the therapeutic work, and must be respectful when resistances that the patient, for the moment, cannot tolerate resolving, legitimately limit the pace of the therapy. Patients need to move forward with the therapy, to extend themselves and to take risks, but must not be expected to achieve the overwhelming tasks of the therapy without hesitation and misgivings.

CONCLUSIONS

In summary, resistance is an inherent part of the treatment of MPD, due to the very nature of the disorder. Since the primary defenses of repression and dissociation serve to protect the patient from the conscious awareness of past abuse, any efforts at breaking down these defenses will be met with massive resistance. Resistance can take many forms, but basically therapists need to realize that the therapeutic process, involving the breakdown of repression, and the therapeutic relationship itself, is disruptive to the patient's internal homeostasis and is enormously stressful in and of itself. Therapists must assume that there is frequently underlying mistrust and ambivalence about the therapeutic process and that there is usually internal strife, particularly early in the therapy. Finally, resistance, and the crises that result from resistance, must be viewed as an integral part of the treatment. Rather than being a phenomenon to be avoided, resistance must be viewed as a communication about the difficulties and limitations that the patient experiences. Despite the fact that resistance can engage the therapist in emotionally stressful situations, resistance also offers an opportunity to engage with the patient in an interpersonal arena that has the potential for therapeutic understanding and resolution. It is only through understanding and dealing with resistance that therapists can avoid feeling overwhelmed, and can communicate with MPD patients in a way that is potentially curative, rather than a repetition of the abuses of the past.

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