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ABSTRACT

Determining the prognosis of a multiple personality disorder (MPD) patient has received little systematic attention in the literature. Drawing on clinical experience, the author offers sixteen questions that he finds useful in gauging whether or not an MPD patient is likely to have a good or poor prognosis for a relatively straightforward psychotherapy and constructive outcome. In the author's experience, patients who have less favorable prognoses in terms of these questions generally will have difficult and prolonged therapies, and are more likely to interrupt treatment, reach a stalemate in treatment, or fare poorly.

The literature on the treatment of multiple personality disorder (MPD) is still quite young. Although the determination of the prognosis of a given MPD patient is a rather critical step, and is most useful for the therapist who is attempting to plan and carry out the therapy of a given MPD patient, the topic of prognosis has not received systematic and scientific attention.

In the course of his 1984 article on the treatment of MPD, Kluft noted, in passing, some characteristics that distinguished patients who declined treatment, interrupted treatment, and who failed treatment from those who achieved and held integration. He observed that the most common issues raised by treatment refusers were: "(1) fearful of the pain of opening up and dealing with their pasts, (2) finding their multiplicity desirable or being unable to conceive of living other than as a system or family of selves, and (3) a major personality's opposing the therapy (p. 17)." Some refused to cease substance abuse as an aspect of their treatment. He found that those who interrupted treatment felt guilty about being unable to pay for treatment, felt that uncovering their pasts would have intolerable consequences, left in response to therapist errors, or had serious narcissistic issues. Patients whose treatments failed had not succeeded in establishing a viable therapeutic alliance despite years of effort, and had some or all of the following features: they had severe ego weaknesses, were enmeshed with traumatizers, demonstrated prolonged outright warfare among their personalities, abused substances, and often were sociopathic. Some lived primarily in their inner fantasy worlds, which were more compelling than the common reality. Some were discharged from therapy for repeated assaultive behaviors or for doing damage to the therapist's office. A literature review uncovered little additional information.

The purpose of this article is to share the insights with regard to prognosis that have emerged from the author's years of experience in work with MPD patients. These insights are shared with a full appreciation of their preliminary nature and their incompleteness, but with an awareness as well that the observations of experienced clinicians, although they do not constitute the most valid form of data, often provide the only landmarks in a field in which clinical practice is proceeding without an available body of hard research to guide it, and without the prospects for access to that type of data for the foreseeable future.

Experience suggests that there are a number of issues that should be looked at quite carefully in the treatment of any MPD patient. These issues often are difficult to appreciate early in the course of therapy. One must establish rapport with the patient and permit the course of therapy to develop its particular unique pattern before they can be assessed with some degree of accuracy. However, it is useful and important to take an inventory of those features that are relevant to prognosis as soon as possible. The therapist is helped by knowing whatever he or she can about the nature of the difficulties with which the treatment may be forced to contend. If nothing else, such knowledge may reduce the countertransferential pressures upon the therapist, who might otherwise begin to have severe concerns about the patient and the management of the case, and about his or her own competence, uncorrected by information that might have offered some guidance as to the nature of the problems the therapy is likely to encounter.

The following is a list of questions that need to be considered in attempting to determine the prognosis of an MPD patient. This list is by no means complete, but it provides a loosely structured format for assisting the therapist in his or her deliberations.

1. DOES THE PATIENT ACCEPT THE DIAGNOSIS OF MPD?

The patient's acceptance of the diagnosis is necessary in order for treatment to proceed in a planful manner, and for the establishment of a strong therapeutic alliance. There is considerable variation in the amount of time that it takes MPD patients to accept the diagnosis. In my series of sixty-nine cases, this has ranged from acceptance on the first visit to non-acceptance after two or more years of therapy. Acceptance refers only to the emotional insight and understanding of the concept of MPD as opposed to the patient's mere intellectual agreement that such a condition not only exists, but applies to him or herself. Difficulty in accepting the diagnosis points toward a prolonged and/or rocky course of treatment.
2. UPTO NOW ARE YOU THE FIRST THERAPIST TO TREAT  
THE PATIENT FOR MPD?  
This refers strictly to the number of therapists who have 
treated the patient for the known diagnosis of MPD. Cases are  
now emerging with histories of having had consecutively and 
for long periods of time two or more different therapists who 
were knowledgeable about MPD. This does not usually include 
patients who had found it necessary to make personal geo-
graphic changes, but rather refers to patients who had had a 
difficult time in therapy with each successive capable therapist. 
Such a history is less than favorable.  

3. IF SO, WHEN WAS THE DIAGNOSIS FIRST MADE  
AND HOW LONG HAS THE PATIENT BEEN  
UNDER TREATMENT?  
The duration of therapy from the time the diagnosis is made 
until progress is noted may be a significant factor. Frequently 
there is a prolonged lack of progress, and an extended duration of  
discovery, in disproportion to the apparent therapeutic impact 
of the treatment. This is not to say that the course of an  
ultimately successful therapy may not be exceedingly long as 
well as difficult, but a prolonged lack of progress should alert 
the therapist to consider the possibility of a change in approaches, 
and explore further for factors that may be impeding progress. 
Patients' failure to show improvement for long periods indi-
cates a less favorable prognosis for rapid recovery.  

4. IF NOT, HOW MANY PREVIOUS THERAPISTS (FOR MPD)  
HAS THE PATIENT HAD AND HOW LONG HAS THE  
CONDITION BEEN KNOWN?  
In general, the greater the number of therapists and the 
longer the duration of the therapy since discovery of the MPD, 
the more difficult the therapy is likely to be.  

5. WHAT IS THE MAXIMUM NUMBER OF ALTER PERSONA-
LITIES INVOLVED AND HOW LONG HAVE THEY BEEN  
PRESENT UP TO THIS POINT IN YOUR THERAPY?  
An unusual case was that of a patient who, at the the begin-
ing of therapy reportedly had over 500 personalities. After a 
total of more than seven years of therapy, she still recorded the  
presence of over 200 personalities. At least three highly skilled 
and experienced therapists had become involved in her case at 
different points. Such complexity, and tenacity in maintaining 
it, argue for a long and problematic therapy.  

6. ARE THERE EXTREME AND VERY HIGHLY SPECIAL-
IZED FUNCTIONS AMONG ALTER PERSONALITIES?  
An example is that of a patient who had one fragment whose 
only function was to wash dishes. It would be extremely bad 
news if after prolonged therapy there remained also another 
fragment that only dried dishes! A patient who clings to these 
highly individualized personalities and is quite reluctant to give 
them up, even though that patient intellectually accepts the 
notion that he or she should be able to wash and dry their own 
dishes, is extremely dedicated to MPD as a way of life, and less 
than likely to pursue either unification or a stable arrangement 
of personalities. Of course, this is but one of hundreds of 
examples that could be recounted.  

7. THROUGHOUT THE THERAPY DOES THE PATIENT  
TEND TO BE PREOCCUPIED WITH FOCUSING ON THE  
SEPARATENESS OF THE ALTER PERSONALITIES?  
When faced with stressful therapeutic issues, many patients 
will retreat to the position of dealing with the alter personalities 
as totally separate entities. Patients who cling to this notion for 
protracted periods of time, even after having given lip service to 
understanding that they are really apart of one entity and that 
they are all mutually involved, are making a powerful statement 
that they are unready to move toward resolution.  

8. THROUGHOUT THE THERAPY IS THE PATIENT PRE-
OCCUPIED WITH USING THE ALTER PERSONALITIES  
AS THE EXCLUSIVE MEANS OF PROBLEM SOLVING?  
A distressing issue is that of the continued presence of num-
nerous child personalities, who are commonly used by adult 
alters for the purpose of experiencing pain and other traumata. 
As a matter of fact, it probably should be pointed out to the 
patient that this might even constitute an extension of the child 
abuse that caused his/her problems in the first place. Patients 
are often reluctant to translate the intellectual language of 
insight into changing practical daily activities. This type of 
behavior suggests that the patient is not prepared to develop 
non-dissociative styles of coping.  

9. DOES THE PATIENT COMMONLY ATTEMPT TO DOMI-
NATE AND DETERMINE THE NATURE, EXTENT, AND  
COURSE OF THERAPY?  
It is not unusual for patients to attempt to insist on control-
ing such things as the therapeutic milieu, the subject matter to 
be discussed in the session, the duration of the interview and 
the focus on the work to be done, regardless of the intent of the 
therapist. This is often the case when these matters have not 
been worked out early in therapy. However, the persistence of 
such behaviors after therapy is well underway betokens a pro-
longed course.  

10. DO YOU FIND YOURSELF FEELING EXTREMELY  
CONTROLLED BY THE PATIENT?  
Many therapists have reported feeling as though they were 
not in charge of the constellation of their life events when 
treating an MPD patient. It becomes quickly apparent that the 
expectation of the patient far exceeds the therapist's capacity to 
deliver and the therapist may start to feel that, his life is not his 
own. The multiple may intrude into the therapist's life and 
usurp not only the waking hours, but a good portion of the 
sleeping hours. When MPD patients succeed in bringing about 
such circumstances, the prognosis is guarded.  

11. IS IT DIFFICULT TO MAKE CONTRACTS WITH THE  
PATIENT?  
If the therapist is not firm in insisting that contracts be kept, 
the patient will learn very quickly that they can be broken 
without bearing much, if any, of the consequences. This may 
become a major deterrent to therapeutic progress. If the pa-
tient is uncooperative and/or unreliable about making and/or 
keeping contracts, the therapy is in difficulty.  

12. WHAT IS THE DEGREE AND PERVERSIVENESS OF  
CONFABULATED HISTORY?  
All MPD patients confabulate. It goes with the pathology. 
The therapist should expect a certain amount of it and deal 
with it. However, the constant use of confabulation involving
extensive and complicated stories that usually are discovered to
be inconsistent with the actual history is a clear warning sign.
Such patients learn to use such confabulations to sidetrack the
therapy rather than working diligently toward therapeutic
resolution.

13. HAS THERE BEEN A PROLONGED PRESENCE OF
VIOLENCE OR A VIOLENT ATTITUDE?
The attitudes of the MPD patient with regard to violence
should be monitored carefully and repeatedly, if present at all.
Overt violence should not be tolerated by the therapist and
rather stringent contracts should be made. In general, it is a bad
prognostic sign if no impact at all can be made on the violence
issue.

14. IS THERE ANY EMOTIONAL COMMITMENT
TO CHANGE?
Attention should be paid to the amount of meaningful ap­
proach that the patient makes toward therapeutic goals. Usu­
ally patients who are serious about their recovery will exhibit
some degree of change, and there will be affective progress
noted by the therapist. In other words, do they know the music as
well as the words? If not, a prolonged stalemate is likely.

15. DOES THE THERAPY TEND TO FOCUS ON DISCOV­
ERY MUCH MORE THAN THERAPEUTIC ATTITUDES
AIMED AT RESOLUTION?
Very often the MPD patient will become extremely preoccu­
pied with uncovering more and more information as sessions
progress. Therapists may realize that after a long period of time
there always tends to be new material uncovered, and the pa­
tient demonstrates a preoccupation with that new material rather
than with working toward resolution. Unfortunately, many
MPD patients have complex and tragic pasts, and require ex­
tensive efforts to achieve its discovery. Here I refer to patients
who will work toward discovery, but will not work toward resolu­
tion of their MPD and/or life problems.

16. HAS THERE BEEN A PROLONGED EFFORT ON THE
PART OF THE MPD PATIENT TO PRESERVE AND
PROTECT INTERNAL FUNCTIONAL GROUPINGS
TO THE EXCLUSION OF OTHERS?
Some MPD patients will cling fiercely to alter personalities
who seem to have banded together for the purpose of dominat­
ing all other alters. Very often their spoken intent is to prevent
other personalities from getting any attention whatsoever from
the therapist. This often is a sign that a form of resolution is
taking place that would not be consistent with the usual thera­
peutic goals for most MPD patients.

As lengthy as the above list of questions may appear, there
are many more that could and should be asked. The list is
merely an example of the types of considerations that should go
into a therapist’s attempts to anticipate the likely nature of his
or her patient’s course of therapy.

Most of the author’s insights come from his personal expe­
rience as a therapist, his discussions with other therapists treat­
ing MPD patients, and his consultations to colleagues. He rec­
ognizes that there are and will be exceptions to any of the gen­
eralizations that he has reached, but concludes that such gener­
alizations as have become available are worth sharing, both to
assist others to the degree that they can, and to put on record
impressions that are amenable to and may inspire some re­
search investigations of their reliability and validity. Therapists
need some structure and some points of reference with which
to guide their expectations about the therapy of MPD patients.
The questions above and the considerations that they raise may
prove useful against the time that more stringent and reliable
measures become available.

REFERENCE