DETERMINING PROGNOSIS IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER

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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 forseeable 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 countertransference 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 inellectual 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. UP TO 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 geographic 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 indicates 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 PERSONALITIES 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 beginning 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 SPECIALIZED 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 part 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 PREOCCUPIED WITH USING THE ALTER PERSONALITIES AS THE EXCLUSIVE MEANS OF PROBLEM SOLVING?

A distressing issue is that of the continued presence of numerous 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 DOMINATE AND DETERMINE THE NATURE, EXTENT, AND COURSE OF THERAPY?

It is not unusual for patients to attempt to insist on controlling 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 prolonged 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 patient is uncooperative and/or unreliable about making and/or keeping contracts, the therapy is in difficulty.

12. WHAT IS THE DEGREE AND PERVASIVENESS 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 approach that the patient makes toward therapeutic goals. Usually 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 DISCOVERY MUCH MORE THAN THERAPEUTIC ATTITUDES AIMED AT RESOLUTION?

Very often the MPD patient will become extremely preoccupied 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 patient demonstrates a preoccupation with that new material rather than with working toward resolution. Unfortunately, many MPD patients have complex and tragic pasts, and require extensive efforts to achieve its discovery. Here I refer to patients who will work toward discovery, but will not work toward resolution 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 dominating 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 therapeutic 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 experience as a therapist, his discussions with other therapists treating MPD patients, and his consultations to colleagues. He recognizes that there are and will be exceptions to any of the generalizations that he has reached, but concludes that such generalizations 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 research 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

Kluft, R.P. (1984). Treatment of multiple personality disorder. In B.G. Braun (Ed.), *Symposium on multiple personality. Psychiatric Clinics of North America,* 7, 9-29.