

## EDITORIAL

### TODAY'S THERAPEUTIC PLURALISM

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A few short years ago, the clinician beginning the treatment of a patient suffering multiple personality disorder (MPD) had very few resources or authorities to which to turn for guidance and direction. Scientific publications were few, and the number of identified experts in the field was very limited. In the span of a few short years, a vigorous literature has developed, and the number of clinicians who have acquired a reasonable degree of expertise in the diagnosis and treatment of MPD has expanded exponentially. Now the neophyte can study a helpful literature, and, in an increasing number of areas, is able to seek adequate consultation and may choose to join a local study group in order to further his or her professional growth with regard to the dissociative disorders.

One of the interesting milestones of the increasing recognition, treatment, and study of the dissociative disorders in general and MPD in particular has been the growing realization that although certain approaches have been described in the literature and have demonstrated their effectiveness in the hands of experienced clinicians, a good many psychotherapists have not elected to utilize these methods of treatment. Instead, they have undertaken the psychotherapy of MPD from a variety of perspectives and with an increasing diversity of treatment philosophies, and are beginning to share their differing approaches and experiences at the International Conferences on Multiple Personality/Dissociative States and in their local communities. Today's neophytes may be confronted not with a dearth of information, as in the past, but with the dilemma of reconciling the different points of view (both explicit and implicit) to which they have been exposed, and finding some way to utilize what they have learned from these different sources.

It is premature to offer a definitive description of the emerging therapeutic pluralism in our field in terms of the technical and theoretical diversity that is currently represented in contemporary practice. It is impossible within the confines of an editorial to pull together the common factors within thousands of colleagues' well-intentioned attempts to grapple with the challenge of treating MPD. However, I will attempt to offer an overview of what I have encountered in the literature, in conferences in North America and elsewhere, and in conversations with colleagues working with MPD patients in North America, South America, the Caribbean rim, Asia, Europe, and Australia. It is my hope that both expert and neophyte alike will find it useful to contemplate which of the several orientations listed below inform the materials they read and the advice that they receive, and thereby be better able to appreciate why different authori-

ties and colleagues may give advices that are not consistent with one another. I have chosen to describe orientations rather than theoretical and technical approaches because I have found that clinicians' statements about their preferred methods and their belief systems often prove unrelated to what they actually do in their work with MPD.

It is my impression that seven approaches to the treatment of MPD are being practiced today, and five have been articulated and advanced as such. The first two of the seven have been observed naturalistically, but never advocated formally.

The first is what I call "Nantucket Sleigh Ride" therapy. This expression comes from the days of whaling. Once the whale was harpooned, the whaleboat that had carried the harpooner and his crew was dragged along until the whale tired and died. Many therapists encountering their first cases of MPD appear to treat in this manner, which is best described as a diffuse conglomeration of theories and practices conceived in desperation and employed in the fervid hope that one will find something that works. Advice given from therapists who have treated in this manner often are overgeneralized from a limited data base and may reflect the unique or serendipitous circumstances of their experiences or the idiosyncrasies of their personal styles. Often they attribute therapeutic importance to whatever temporally preceded an improvement or the resolution of a crisis, indulging in post hoc, propter hoc reasoning. The prevalence of this approach should not be understood as indication of its validity or appropriateness. It is acknowledged, but not recommended.

A second perspective that also is quite common but cannot be advocated is the stance I will term (facetiously) "Modality Mavin" therapy. Its practitioners are all descendants of the mythical innkeeper Procrustes who, having but one size of bed, either shortened or lengthened his guests accordingly. Such therapists are determined to treat MPD patients with their modality of choice and explain MPD and its therapy with their theory of choice. They are prepared to defend their stance with the zeal of a fanatic, and rationalize away any advice and/or data to the contrary. It is my impression that such individuals are so threatened by the challenge posed to their preferred paradigms by MPD that they redouble their efforts to insist upon their correctness. Such colleagues give advice that flows readily from the basic tenets of their preferred models, and frequently minimizes the importance of findings that are anomalous with regard to those principles.

Among the major stances in the literature and in work-

shop settings is the third approach, and the first of the formally articulated ones, that of strategic integrationism. It focuses upon rendering the dissociative defenses and structures that sustain MPD less viable, so that the condition in essence collapses from within. Its ideal goal is the integration of the personality in the course of the overall resolution of the patient's symptoms and difficulties in living. It is consistent with the psychoanalytic tradition of the analysis and resolution of pathological defensive structures. Within this tradition, particular techniques and interventions are valued less for themselves than for the long-term goals to which they can contribute. Some strategic integrationists may use hypnotic, cognitive-behavioral, and other techniques quite liberally, but others use them rather sparingly. Many clinicians eager to receive concrete advice or preoccupied with their patients' immediate crises may find strategic integrationists' recommendations frustrating and unsatisfying, because these therapists characteristically are focused upon the entire course of the treatment and the flow of transference and countertransference. With experience and increasing equanimity in the face of the vicissitudes of work with MPD, many therapists move toward this orientation.

Tactical integrationism, a fourth stance, espouses the same ideal goal as strategic integrationism, the integration of the personality in the course of the overall resolution of the patient's symptoms and difficulties in living. However, an examination of treatments conducted by therapists with this orientation reveals a predominant focus on tactics, toward interventions that serve as adroit devices for the accomplishment of objectives. Such therapies are often quite eclectic, and employ specific techniques and modalities quite ingeniously and creatively. Often the deliberateness and planfulness of the treatment is quite conspicuous. Tactical and strategic integrationists' behaviors often are indistinguishable when one observes a brief spell of therapy; their different emphases emerge more clearly over a longer period of study.

A fifth stance may be described as personality-focused. Clinicians who work in this manner fall into two large groups: those who do so on the basis of a thoughtful theoretical orientation that does not regard dividedness per se as problematic, and those who appear to accord the personalities a face validity as people and attempt to nurture them into health via some variety of corrective emotional experience. The first group often pursues a therapy that takes the form of a problem-solving inner diplomacy or group or family therapy among a number of selves, all of which are encouraged to collaborate more smoothly and harmoniously without necessarily ceding their separateness or autonomy. Integration is not devalued and may well be pursued if the patient so desires, but a more facile and functional arrangement among the elements of the mind is the major objective of the treatment. The second group of personality-focused therapists emphasize nurture as a curative agent. They are usually intent upon providing the patient with a rather tangible corrective emotional experience in an attempt to undo the hurts of the past. Although occasional dramatic successes are reported with such approaches, a large number of unfortunate excesses have been committed under its

aegis, and the risks for misadventure are high. Because of the frequency with which such therapies run into difficulty, the second group's approaches cannot be recommended.

A sixth stance that has emerged recently and gained a certain degree of popularity might be described as adaptationist. In essence, this is the stance of a number of distinguished therapists who designate themselves primarily as pragmatists, and who prioritize the attempt to help their MPD patients manage their daily lives more smoothly and effectively above other goals, such as integration. It is often associated with less intense treatment in terms of the frequency of the sessions and the duration of the therapy. There is no doubt that this is a legitimate and useful clinical stance, especially with patients primarily motivated to achieve symptomatic relief, with scant resources, or whose life circumstances preclude an intensive therapy. Unfortunately, this stance has also been advocated by a number of therapists who are overwhelmed, burned out, inadequately prepared for work with MPD, and nihilistic.

A seventh and final stance that has been articulated is based on the assumption that many current methods promote a dysfunctional and unnecessary regression, and that clever interventions can stabilize the patient in a functional state and discourage the symptomatic expression of MPD. It remains for this approach, which has much in common with the "leave it alone and it will go away" attitude of an older skeptical point of view, to demonstrate its worth.

I am confident that the readership of *DISSOCIATION* appreciates that the skills and orientations of many of the stances outlined above should be within the repertoire of any therapist who works with MPD, and that these stances have been described, for the sake of illustration, as if they existed in pure form and were more dramatically different than they might appear in clinical practice. It is important to identify these pluralistic trends and study both their independent progress and their interplay over the next few years. If our field can avoid divisive fractionalism on the one hand and the premature exaltation of one particular stance as invariably correct and inevitably superior on the other, in time studies may emerge to allow the determination of which stances inform effective psychotherapy and which do not. Furthermore, it may be possible to learn whether there are subgroups of MPD patients for which one stance is more useful than another, providing an opportunity to match particular patients to therapeutic approaches that will address their problems more efficaciously. ■