PRECURSORS OF INTEGRATION IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER: CLINICAL REFLECTIONS

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ABSTRACT

At the present time it is, as a practical matter, quite impossible to describe a treatment paradigm by which multiple personality disorder (MPD) is cured. Fathoming the languages of the discourse among the various schools of psychotherapy is itself much like trying to communicate with the myriad workmen who sought to build the Tower of Babel. Despite this problem, patients themselves regularly present "marker events" which indicate they are getting better or worse. This paper is an analysis of such events.

The question most often put to me over the past several years by clinicians seeking assistance is "How do you integrate a patient with MPD (multiple personality disorder)." It is an ill-formed question to begin with since therapists do not integrate such patients. The therapy of MPD is transactional in nature; the therapist applies certain skills to the bipersonal process which creates the stimulus conditions under which integration takes place.

Having drawn this distinction, the problem remains: how to succinctly describe the treatment process. This is especially difficult given that 1) therapists from many schools of psychotherapy treat multiple personality disorder (MPD) patients, and 2) the literature on generic treatment methods has been slow to evolve as compared with the description of tactical interventions, and hence cannot be cited by way of background.

Thankfully, textbooks have been appearing which contain discussions of the treatment of MPD in a most general sense (Bliss, 1986; Braun, 1986; Putnam, 1989; Ross, 1989). Missing from the literature has been a generic yet focused readily-obtainable article applicable to almost any case of MPD, and in some respects to all, which covers the vicissitudes of various treatment undertakings. It is the purpose of this paper to begin to fill this gap.

I am writing from the perspective of what Kluft (1988) calls a "strategic integrationist." I do not view multiple personality disorder patients as a host of souls or different people living in the same body. Rather, MPD is the ultimate psychological example of the failure of continuing identity consolidation during any and every developmental period, arising out of psychic fixation due to so-called actual trauma, and mediated by autohypnotically-induced amnesias. The one proviso to the above is that the essential process, while it may endure through well-established primitive mechanisms reaching far into adulthood, begins in the pre-Oedipal stage of development, or during early Oedipal stages in which strategic regression to pre-Oedipal psychic functioning is readily available. In the sample of more than a hundred MPD patients that I have either treated or interviewed, I have never encountered an example of this condition in which its first roots are traceable to the latency stage of development or beyond.

The language of object relations theory is freely employed below because it fits so well with the internal-external experience of MPD patients, works well in describing the phenomena and interactions of the bipersonal field of psychotherapy (Langs, 1976), and is readily grasped by therapists of almost any theoretical persuasion.

The Process of Integration

The vehicle chosen for this paper is that of the *processes of integration.* The thesis is that the so-called "final integration" event in a case of MPD—that point at which MPD patients no longer display any signs or symptoms of the presence of alter personalities, and which "well condition" persists over a substantial period of time—is, in a sense, a trivial event. Final integration is not trivial in the sense that it is unimportant, but in the sense that it is but one more step in a long series of integrative "precursor events," much like the breaking of the tape in a race is but one event preceded by thousands of previous steps, in dozens of previous races and heats, prepared for, in turn, through scores of coached practice sessions, and perhaps hundreds of individual practice sessions.

What I wish to demonstrate in this paper is that the processes of integration in the treatment of MPD, or what I will for convenience call "the integrative process," begins very early on in treatment and consists of numerous precursor events, cumulative in effect, and aggregately necessary to cross into the territory of final integration.

Such precursor events serve as "markers" to the experienced MPD therapist that progress is, indeed, on course and proceeding well. Such markers can, in turn, be interpreted as evidence of progress to the patient, although the patient may be terrified by many of the accompanying precursor integrative events, interpreting them as ominous experi-

ences. This is usually because such events are novel and startling in their consciousness, easily interpreted by patients as a sign that she or he is "going crazy" rather than getting well. The last thing a post-traumatic stress disorder (PTSD) victim wants (and almost all MPD victims also suffer from PTSD) is a surprise, especially a surprise from within.

In the absence of a knowledge of precursor signs or markers of integration, therapists are not only unable to evaluate the scores of major events that ordinarily occur in MPD therapy in an often cyclical fashion, they are unable to evaluate the treatment process or progress. Over the past several years many patients have been referred by other therapists, most of them quite competent, who have simply become lost, and as a result the treatments they were conducting had reached impasses.

Some of this, to be sure, is due to the fact that few therapists who are presently treating MPD patients have ever seen a case completely through, so even if they have come to recognize some markers through experience, they are confused as to what to make of others. Many are disappointed that despite years of work, not a single personality integration has taken place, or perhaps only one or two integrations among scores of personality states have occurred. Except in those few cases I receive in which the approach to the patient has been so woefully ill-conceived that it takes months of working with a patient to undercut staunch resistances that have been formidably reinforced by an unwitting therapist, most patients been given at least adequate care, albeit by therapists inexperienced with MPD, and some have been given excellent care, which I can begin building upon immediately in the treatment.

A final value inherent in the knowledge of precursor events or "markers" of integration is that it allows both patient and therapist to move much more rapidly through the therapy process. When I first began to encounter major events in MPD therapy which I had never witnessed before, it often took me several sessions, if not several weeks, to evaluate what was happening. Inevitably my patients would detect my hesitation, about which I spoke to them openly. Patients often marshalled my confusion in the service of resistance and regression. Consultations with more experienced therapists, who could construe or at least surmise what these therapy events indicated, inevitably got both me and my patient through these moments of impasse. Having now seen the same events hundreds of times across scores of patients, I can now describe and name some of them, recognize them almost instantly, and mollify a patient's concerns in a few minutes.

Every mainstream clinical researcher in the field of MPD is looking for less time-consuming, more effective, less expensive, less painful ways of effectively treating MPD. All know how to diagnose, treat and ameliorate MPD; all have done it, repeatedly. As Dr. Richard Lowenstein observed at the recent Mount Vernon Hospital conference on MPD (reconstructed as accurately as my notes allow): "Never in the history of psychiatry have we come to understand so much about a major mental illness in so short a time. We know its etiology; we know how to diagnose it; we know how to treat it; we know its psychobiosocial parameters; we know the natural course of the [untreated] illness" (Lowenstein, 1989). It is my thesis that appreciating the nature and implications of precursor markers contributes to facilitating treatment.

When Integration Begins

Integration begins at the moment when variously-cathected parts of the patient's fragmented personality begin to cathect to the therapist as a commonly-recognized external object.

It matters not whether the sub-parts of the patient's dissociated personality begin to form cathexes (libidinal, attraction-invested emotionality) or anticathexes (aggressional, rejection-invested emotionality). The point is that when various of the dissociated personality aspects of the patient begin to be aware of the therapist as a common point of external reference, be he/she experienced as all good or all bad, the external reference point of the therapist becomes a place of focus for the patient's emotions in the external object world, hence a vehicle of eventually-integrated experience.

The Therapist of the MPD Patient

Having stated where integration begins in the treatment of an MPD patient, a moment's elaboration is in order.

The therapist who successfully undertakes the complete treatment of an MPD patient cannot be a "moving target." MPD patients, by virtue of the origins of their illnesses, by way of their recapitulations of family-of origin events through seeking out familiar, unstable individuals, cannot be successfully treated by a therapist who is just one more waffling, manipulable, constantly changing entity in the patient's life. The MPD patient in the early stages of treatment has an impaired capacity for forming object constancies. Internal objects are a hodge-podge of introjects of chaotic people from their past, complicated by a lack of non-integration of affect complexes, sensations, and memories normally organized into what we call a "self system."

It is inconceivable to me, in both theory and observation, that a therapist who colludes with a patient to recreate inconstant characters from her/his past, could ever successfully guide a patient out of the fly-trap of MPD.

The only chance I see that an MPD patient has of obtaining object constancy, either internally or externally, is through the internalization of an object-constant therapist or some equivalent person in her/his life.

By an object-constant therapist I do not mean one with no personality, no threshold of perturbability, no personal life–but a person with a consistent range of emotion and behavior who, upon repeated probings, explorations, and provocations by the patient, will not be budged, unless the therapist's modifications are the result of honest and lasting transactional agreements between patient and therapist.

By "transactional" I mean that requests for modification of treatment procedures are negotiated by both, make sense to both, work for both, continue to work for both, and both uphold their end of the bargain. Therapists who are object constant to the extreme of being stubborn and rigid in their treatment lose their MPD patients. Those who are exces-

sively gratifying to patient demands become enmeshed with, and lose (or at least lose the opportunity to offer definitive help to) their MPD patients. A "struck agreement," when there is compelling grounds for it, can serve as a therapeutic model for cooperation, growth, and the contractual nature of human agreements (Greaves, 1988).

Resistances

Richard Kluft has a unique talent for encapsulating thousands of hours of experience in working with MPD patients into memorable aphorisms. One of these is "the treatment of MPD is the [art of] the analysis of resistance."

The failure of Kluft's adept aphorism is that most therapists, or at least many, see resistance as stubbornness on the part of the patient against dealing with what she/he "really needs to work on." When the key word "analysis" is left out of Kluft's aphorism, it is easily overlooked that patients resist therapy for a wide variety of reasons, including the conduct of the therapist. To treat "resistance" as a barrier to be assaulted by the therapist is to be disrespectful of the whole psychological elegance of the phenomenon of resistance and its protective intent. It is no wonder that the "crashing" of a patient's resistance leads to so much "trashing" of the therapist's boundaries—to use the term in current vogue. Resistance, as it is manifested by a patient, is an attempt at setting boundaries on the treatment, much the same as a therapist sets and maintains boundaries on the treatment.

"Moving against" patients' resistances, to borrow Karen Horney's term only partially out of context, is fraught with struggle. To analyze a resistance is to explore it, to identity its source, work on it, and work through it. When this stage of the process is complete, the patient is free to engage with the therapist as a participant in the resolution of the underlying complex.

Markers of Integration

1. *Convergence Phenomena*

The first class of markers that arise in successful therapy, and continue throughout, are what I call convergence phenomena. These include a wide variety of behaviors on the part of the patient which require *focusing* of attention in order to be carried out successfully. Such focusing implicitly requires the cooperation of several alters; cooperation itself is a convergence phenomenon. This includes keeping appointments regularly and on time, expressing curiosity about the therapist, beginning to produce analyzable verbal material previously unknown by the patient, and the successful carrying out of homework assignments such as journaling, writing down dreams, or producing drawings.

Certain convergence phenomena are of such crucial importance as markers that I highlight them separately below.

2. *Spontaneous Appearance of Alter Personalities*

Under diagnostic conditions, where time is often the essence of the procedures chosen, it may be necessary to request the patient's permission to use hypnotic procedures to ascertain whether, in fact, alternative psychic systems ("personalities") exist. Under treatment conditions, where the relationship between patient and therapist is the essence of nearly everything that follows, such intrusions into the natural psychological defenses are rarely indicated. The major exception is a small group of multiple personality patients who are so phobically-organized and brittlely-defended against experiencing intense affect of any sort that hypnotic incursions may be the only avenue open to establishing any highway of internal communication.

For example, a patient came to me who objectively had received quite substandard treatment from her previous therapist. Knowing that the transferences to me would be strong from her egregious misadventures with her previous trusted authority-object, and being determined not to repeat any of the recapitulation of childhood trauma that that therapist had recreated, it required 76 regularly-scheduled daily sessions over a period of four months before the first child-alter states appeared spontaneously in session.

When the child states finally emerged, they were quick to tell me they had been watching me for some time to see if I was going to do what the other doctor had done.

The spontaneous emergence of alter personalities under transference-intensive conditions is a marker of trust. Once this patient made this initial adventure into trust, she rather quickly began producing and working on her sexual interactions with her father during and before latency, which were quite cruel, and upon how her former therapist had directly recapitulated this cruelty. In the language of transference phenomena, she had begun to discriminate me as a neutral figure she could at least begin to talk to. She began to realize that, at the very least, I would not hurt her for talking.

3. *Presentation of Broad-band, Vague Physical Illnesses of Undefined Medical Origin*

The complex I see most consists of: 1) severe, disabling headaches, nausea, dizziness, vomiting, diarrhea, all in the absence of significant fever; 2) insomnia, nightmares, severe unremitting localized pain and/or spasms in the pelvic area, rectal area, or lower abdomen without objective findings; 3) paresthesias, anesthesias, hyperesthesias, weakness of limbs, intermittent tics, pseudoseizures, without significant neurological findings; and/or 4) intermittent blurred vision, photophobia, near-sightedness alternating with far-sightedness, requiring different glasses prescriptions. The above sub-groupings are intended only as approximate, in the sense of common clusters of findings; I do not intend to imply that these groupings imply sub-complexes as such.

Often MPD patients present with a long, puzzling medical history, with concurrent symptoms encompassing several physiological systems. Hypotheses generated by physicians as to the nature of medical syndromes which might explain these complex of symptoms infrequently are borne out either through laboratory tests or continued clinical observation. It is, of course, possible for an MPD patient to suffer from any acute or chronic illness, and all such distressing physical symptoms should be followed by a physician. The point to be made is that the above symptom-complexes may be generic to the "body memories" of MPD patients and their autohypnotic proclivities, which have enabled them to delay or defer physical-memory experience through the dissociation process.

Such "somatic memories" are often sensory precursors to the full memories of the original events which they represent. Once the original memories are fully acquired and abreacted, the somatic symptoms typically disappear.

4. *Spontaneous Appearance of a Hostile Alter.*

This is a major convergence marker. Viewing alter personalities as internal objects, the patient tends to be split between what are seen by her, or her co-conscious alters, as "good" personalities and "bad" personalities, which are anti-cathectic to one another. This results in an internal split the patient can never resolve on her own. When a hostile alter attempts to anti-cathect with the therapist, this externalizes the internal conflict onto a common unsplit object, producing convergence, albeit the convergence consists of cathected and anti-cathected drives. The direct appearance of the hostile alter makes it possible for the first time to work with the anti-cathected elements within the overall personality in the therapy field for the first time.

5. *Cooperation by a Formerly Hostile Alter.*

Hostile alters typically bring with them intensely negative transference projections onto the therapist around past issues of terrible experiences with authority figures, parent figures. Historically, they often arose as the patient attempted to assert or protect her sense of worth, honesty, and integrity, however circuitously. Once the therapist is able to explore, understand, and empathize with the reasons for the existence of the hostile alter, a therapeutic alliance can almost always be formed, since the therapist and the hostile alter nearly always share the goal of promoting the integrity of the patient. It has been my experience that originally hostile alters, once willing to interact, become fiercely loyal allies in the treatment. When this occurs the anti-cathexis is transformed into a cathexis with the therapist, and is returned to the patient as a cathected internal object, a powerful step in integration.

6. *The Presenting or Host Personality begins to Hear Voices for the First Time.*

Since all the patients I presently see have received extensive previous treatment before they have been referred to me, they all "hear voices," almost always identified as "internal" in origin. However, I am well-familiar with this phenomenon from my earlier work with previously-untreated MPD patients, and from the numerous consultations I have had with other therapists who become alarmed when their patients suddenly start having "auditory hallucinations," blaming this either on their therapy or upon their failure to have diagnosed the patient as schizophrenic.

First of all it would be unusual, indeed, for cardinal schizophrenic symptoms to first make their appearance among the age range when MPD patients are typically first diagnosed, roughly between age 25 to 35 on average. Secondly, it has been well-known for ten years, and since well-established, that most MPD patients "hear voices."

What happens psychodynamically that produces this treatment marker is that as the various "psychic tracks" or "personalities" of the patient begin to converge and cathect to and interact with the therapist, it alters the internal object relationships of the patient until, as it were, she begins to interact with herself. The hearing of internal voices is the first major marker of the beginning of this process. The therapeutic approach is to instruct the patient to listen to this voice or these voices as best she can and to report back the content in sessions. The patient may be initially quite frightened of this experience and state that it makes her feel or believe that she is crazy. Such fears and concerns need to be dealt with through exploration and interpretation.

7. *Increased Internal Communication.*

The patient typically states that she "knows a lot more about what is going on inside her." This is another convergence phenomenon. This comment should never be elicited from the patient by way of inquiry, otherwise it cannot be considered a marker, but only compliance to a suggestion on the part of the therapist.

8. *Increased Co-consciousness.*

Co-consciousness differs from internal communication in the way that hearing about President Kennedy's death, as devastating as that information may be, was different from viewing the videotapes of his assassination. Co-consciousness, for MPD patients, is experienced as a sense of immediacy and presence, of knowing, seeing what is "going on" with another alter, both in her past remembrances and present experiences, though viewed as "kind of through a fog." Co-consciousness between alters waxes and wanes, depending on the particular content of conflictual, anxiety-laden material being worked on in therapy at the moment. Usually the conflict which divides the personalities is focused on an event or series of events in the patient's life, traceable to a traumatic event which produced the original split in consciousness which the patient has thereafter never been able to resolve, and has faced in various versions, thus reinforcing and perpetuating that portion of her "dual" or "multiple" identity conception of herself which is constantly inconstant. As the theme(s) around the conflict between these parts of the personality are worked on, the therapist sees an increased presence of the co-conscious elements, as expressed, for instance, in rapid back and forth switching between the two or more personalities who are organized around this series of events, during session.

9. *Copresence.*

Copresence is a hallmark indicator of impending integration. In copresence the patient will indicate, and it will be obvious to the therapist, that "both of us (or all three of us, etc.) are here." The patient is usually energized while in the copresent state and may make comments like: "There are just a few more things we need to talk to you about."

10. *Major Alter Personalities Cannot be Distinguished by Therapist.*

As integrative processes ensue, the therapist may not be able to orient himself/herself to which personality he/she is seeing by sight, mannerisms, vocal inflections, or any of the normal complex of cues as to which personality is predomi-

nant. When this happens, integration is imminent.

11. *Personalities Cannot Distinguish Themselves from One Another*

The personalities that are undergoing integrative processes may not be able to identify themselves at times, may be unable to distinguish themselves from one another at certain moments, and may experience identity diffusion in various forms.

12. *Patient Requests Integration of Two or More of Her Parts.*

The motive for integration needs to be explored. For instance, the patient may have a fantasy that through integration she can destroy one of her "parts." In practice this is uncommonly the case in a well-treated patient, though early on in treatment such requests are frequent. My preference is to suggest that if the patient desires to be integrated with another part they decide how to do so and do it. Some patients, and I think this is a transference-dependency issue, prefer that I guide them through it. Others will simply ask me how to do it.

13. *Spontaneous Integration.*

The whole strategy of integrative therapy with MPD patients is to undercut the defenses which divide the patient from herself. When this is done, there is no longer a need for a continuing separateness. By "undercut" I do not mean assaulting dissociative defenses. I mean analyzing and interpreting the original need for the dissociative strategy and the perceived need for its contemporary maintenance.

Ambiguous Markers

There are three principle ambiguous markers I have identified in work with MPD patients. These are: 1) *flooding of memories*, 2) *redissociation*, and 3) *prolific reports of previously unknown personalities*. Each can be either a marker of integration or an indicator that therapy is well off-track. Fortunately their meanings can be distinguished by the overall context in which they occur.

1. *Flooding of Memories.*

Flooding of memories — meaning that the patient is overwhelmed with "new" memory material much faster than it can be processed and becomes increasingly dysfunctional due to being concurrently overwhelmed by anxiety — is a common precursor event to impending final integration if it occurs in the later stages of the therapeutic process. For many patients who have successfully abandoned the use of pathological dissociation as a way of life, the final weeks of treatment have been the stormiest of all. Once the Berlin Wall and the Iron Curtain begin to fall, it is an accelerating process. The therapist who knows this and anticipates this can help the patient contextualize these events and assist the patient through these trying circumstances.

When flooding occurs early in therapy or during the middle stage of the therapy process, it is usually a sign that either the patient or therapist or both are trying to "hurry the process" by trying to identify all the dragons of the mind in the hope that naming them will substitute for the working on and working through processes.

In a highly-specialized MPD-oriented hospital unit, flooding of memories may be a positive sign of progress if the patient is able to make use of the milieu, program, and staff to sufficiently process material between sessions with the primary therapist. Such flooding of traumatic material and the patient's attending reliance on several kinds of external systems may indicate a marker of great trust, the sign of a realliance with an external, admittedly imperfect world.

2. *Redissociation.*

Redissociation may be both a sign of stabilization through strategic regression into dissociative defenses or as an indicator of the excessive rush of therapy. Repeated, irretrievable dissociation in the ordinary therapy situation (i.e., non-hypnotic repression of previously uncovered material) is often a sign of an excessive pace in discovery with too little therapeutic processing.

The introduction of traumatic memories into consciousness often has to be by fractionation or titration, especially in outpatient treatment, where prematurely-induced "flooding" may result in the emotional disablement of the patient. Non-dissociated retrieval of traumatic material is the goal. Partial retrieval is the norm throughout the early and middle stages of treatment. Completely redissociated material, especially among inpatients, is a cardinal sign of too fast a pacing, whether due to excessive use of hypnosis, overfocusing on content with insufficient attention to the maintenance of the transference, or underemphasis on processing material retrieved.

3. *Prolific Reports of Previously Unknown Personalities.*

Reports of previously unknown personalities may result from: 1) the discovery of a new personality sub-system in the course of ordinary treatment, 2) creations of new personalities as a defense against the excessive rigors of therapy, 3) obsessive-compulsive retreats into internal world analysis to throw the therapy off track, 4) resistances to anticipated termination of therapy, and 5) hold-out personalities.

To understand these five markers is to understand what has been called, by the oral tradition, both "Braun's rule" or "Kluft's rule." I have heard it stated in many forms; I have never seen it in writing. My version is "The first final integration of a multiple personality isn't."

Patients always hold out, however unconsciously, as treatment nears the final stages. They are not about to abandon their last "nifty tricks," buried as deep as the last diamond sewed in the ear of a widow's pillow. The ability of a newly "post-integrated" patient to share a "hold out position" with her therapist is a positive marker sign.

Negative Markers

Just as certain clinical markers indicate progress in the therapy of MPD, other markers indicate that the treatment is either not proceeding or is off course. The most common of these markers will be examined below and their most frequent causes explored.

1. *Patient Ceases to Produce Analyzable Material.*

The most frequent scenario is one in which a new

patient comes in, frightened, but willing to talk about the things she/he finds frightening. Matters seem to move along well for some time until the therapist realizes that the patient is no longer revealing inner thoughts to be discussed ("worked on"). The inexperienced therapist, once aware of this situation, will typically respond by asking more questions, trying to dig more deeply, or even attempting to introduce completely new techniques into the treatment, such as the use of hypnosis "in order to get to the source of the blockage." Such variances in technique often produce short-term results — hence reinforce the therapist to further vary his/her technique — with just as often long-term negative consequences which can take much time to repair, if they are repairable at all.

The first warning should be a therapeutic approach which has been working well, followed by a sense of urgency on the part of the therapist to gradually or abruptly change technique.

Impasses of revelation on the part of MPD patients are nearly always examples of transference-based resistance phenomena, resistances arising out of conflicted internal object relations giving rise to acute anxiety managed through denial mechanisms, or a combination of the two.

In the first instance the disturbing material in preconsciousness or in actual consciousness may be judged by the patient as so socially offensive, even if it is ego syntonic, that she/he fears the rejection (loss) of the therapist if the material is revealed. In the second instance, the material arising is so ego dystonic to the patient that she/he fears verbalizing it since, upon analysis, it may prove to be true, hence giving rise to the anxiety-producing processes of working through. The third instance is self-explanatory.

If one fails first to recognize and analyze the cessation of productions as a resistance phenomenon, and instead launches a direct assault against the resistances (as has been commended in certain schools of therapy), one runs great risk of recapitulating the role of the aggressor in the patient's life which is clearly countertherapeutic and not unsurprisingly leads to the phenomena of countertherapeutic behavior on the part of the therapist.

2. *Patient becomes frequently psychotic following sessions.*

This is most often a matter of "pacing" in which patient and therapist conspire to "skip steps" in therapy. Viewing the psychodynamic therapy process as a matter of exploring, identifying, working on, and working through complexes of material — each of which category has a number of sub-steps — patient and therapist collude to explore and identify such complexes, but to avoid the arduous work of working on them and working them through.

If I may risk a homely analogy, the psychotherapy of the MPD patient is rather like trying to fit together a thousand piece puzzle. If treatment begins or is allowed to regress into opening the puzzle-box and flinging the pieces of the puzzle willy-nilly throughout the room, however exhilarating that initially may be, it will take a very long time to work the puzzle. To work a puzzle successfully, and within a reasonable time, one needs to lay out the pieces in groups, by shape, by plan, by color, by design, according to an increasingly modified and successful strategy, keeping all the pieces on the table.

3. *Patient Becomes Consistently Externalized in Focus.*

Examine as a resistance defense as in 1) above, or as a pacing-based resistance (moving too fast), as in example 2). Kluft's dictum that "slower is faster" in the treatment of MPD often applies here.

4. *Patient Acts Out against the Therapist/therapy Process with Unruly Behavior.*

This phenomenon is almost always due to transference-based resistance and/or a broach in the therapy frame. However, a few individuals who are phobic and brittle in their character structure may resort to similar behavior in order to avoid the affect-stimulating properties of psychotherapy.

5. *Therapist Grows Increasingly Annoyed with Patient and Experiences Himself/herself as Becoming Less and Less "Therapeutic" with Patient.*

This situation is easily blamed on unresolved countertransferences in a therapist working with an unusually sadistic patient. My experience, however, is that this phenomenon most frequently results from the therapist colluding with the patient in broaching the treatment frame through counter-identification and countertransference, which sets the stage for escalation on both sides of the bipersonal field.

SUMMARY AND ADDITIONAL COMMENTS

MPD may be treatable by various strategic means. If therapists, patients and those reviewing such treatment become familiar with the "road signs" of progress and pathological regression, an amelioration of the dissociative process may well be facilitated.

Kohut (1971, 1980) postulated that persons have a drive for identity so strong that it rivals sex and aggression as the surviving human instincts. Were this hypothesis to be true, one could postulate that MPD patients withhold productions through denial because they are afraid of what they will discover as starkly ego-alien memories about themselves.

This notion is plausibly-supported by common statements of MPD patients: "I don't think I want to know what happened next." "It didn't happen." "It couldn't have happened(meaning it 'shouldn't have happened')." "I'll never believe that happened in a thousand years." A plausible theory of identity-disturbance has already been been built from Kohutian theory, from the intensive study of narcissistic character disorders, but not yet applied to multiple personality, which I surmised 10 years ago was a disorder originating in the narcissistic period of development (Greaves, 1980).

This important theoretical point aside—that there may exist resistances of revelation arising solely from the emergence of painful ego-dystonic material—the fact remains that the utterances of the patient made within the purview of the therapist/analyst are all subject to interpretation as transference-based resistances. Were this not so the patient

would not dare mention them at all.

The deepest underlying fantasies of the patient are that if emerging material is revealed, even made available to herself to be revealed, the therapist will reject her — even through reading the material in her face or in her eyes—just as the patient surmises she was originally rejected/punished through the most private means of self-betrayal: linear thinking. The intense interference anxiety experienced by MPD patients through sustained linear thinking is the source, I believe, for the prominent "thought withdrawal" phenomena common to this syndrome (Kluft, 1987). ■

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