

PRELIMINARY NOTES
ON MPD AND ALLIED
FORMS OF DISSOCIATIVE
DISORDER NOT OTHERWISE
SPECIFIED IN PRACTICING
PSYCHOTHERAPISTS

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ABSTRACT

Dissociative disorders, including multiple personality disorder and allied forms of dissociative disorder not otherwise specified, were encountered in 20 practicing psychotherapists. Detailed reportage is precluded by considerations of confidentiality. Selected topics with regard to their professional functioning, diagnosis, phenomenology, treatment, and prognosis will be discussed.

Multiple personality disorder (MPD) and allied forms of dissociative disorder not otherwise specified (DDNOS) are increasingly appreciated to be relatively commonplace conditions. As more clinicians become sensitized to the dissociative disorders, and develop a higher index of suspicion for their subtle as well as their more overt manifestations, they are being discovered in patient groups with which severe dissociative psychopathologies are not traditionally associated. The first such patient group to be identified was children. Following upon the first modern reports by Fagan and McMahon (1984) and Kluft (1984a), a fledgling literature on this subject, recently reviewed by Peterson (1990), has developed. Adolescents with MPD were discussed by Bowman, Blix, and Coons, and by Kluft in 1985, and are the subject of two recent studies (Dell & Eisenhower, 1990; Kluft & Schultz, in press). MPD in the elderly was discussed by Kluft (1985, 1988a). Among the many other relatively novel and new groups in which these conditions are being appreciated are the pseudoretarded (Atlas, Fine, & Kluft, 1988), the blind (Ohberg, 1984), the deaf (Bowman, 1989), and those who function at a very high level (Kluft, 1986).

On an informal basis, the existence of MPD and DDNOS with features of MPD in mental health professionals is an increasingly appreciated phenomenon within the dissociative disorders field. Significant numbers of colleagues have identified themselves to experienced clinicians and scientific investigators within the field as suffering this sort of condition, often in conversation after the person to whom they reveal themselves has made a presentation they have attended, or by seeking consultation or treatment. I am informed by patients and colleagues who themselves are survivors of childhood trauma

that it is not uncommon for therapists who are survivors of child abuse and are making presentations on dissociative disorders at meetings of "survivors' groups" or support groups to identify themselves as suffering the condition about which they are speaking; on occasions presenters at scientific meetings on dissociative disorders have done the same. Therefore, it seems timely to present some preliminary observations on this group of individuals.

The published literature makes little reference to psychotherapists with dissociative disorders. A number of the dozen patients noted in my 1986 article on high-functioning MPD patients were, in fact, mental health professionals. However, in the interest of discretion, this was not discussed in the text of the article. In 1988(b) I described a psychologist who suffered fugues. I alluded to the difficulties of therapists who suffered dissociative disorders as a specific subgroup among psychotherapists overwhelmed by their work with MPD patients (Kluft, 1989). I observed that "Counteridentification often compromises their therapeutic capacities; they may find themselves triggered by the patient's memories and difficulties. It can be very difficult for such therapists, who may continue to heal themselves in others, to be objective about their difficulties with MPD patients. They often have knowingly or unconsciously gambled heavily upon their ability to achieve vicarious mastery by their treatment of others" (1989a, pp. 245-246). It is important to note that this was a discussion of overwhelmed therapists, and should not be understood to characterize all therapists who suffer dissociative disorders. In another account, I described my encounters with several impaired psychiatry residents and graduate students in psychiatry who suffered dissociative disorders (1990).

The current communication is based on experience with 20 practicing psychotherapists who suffered MPD or DDNOS with features of MPD. It does not include mental health professionals seen for psychogenic fugue, psychogenic amnesia, depersonalization disorder, and DDNOS without features suggestive of MPD.

DATA BASE

Several considerations argue for the presentation of an anecdotal and impressionistic report rather than a more rigorously constructed study. Issues of confidentiality preclude the presentation of data that present specific demographic details about individuals. Case vignettes with any degree of specificity, even if apocryphal, might be seen or interpreted by those who read the article as related directly to their own plight or that of someone known to them who has seen the author.

Many patients, aware of my publications and ongoing research, have stipulated that they do not wish to have their circumstances become part of a published report, even to the extent of having data relating to them tabulated. The publication of data from treatments in progress may introduce an iatrogenic complication to an already difficult situation. Furthermore, therapies that are carried out with the knowledge that they may be reported in the lay or scientific literature are subject to a number of pressures that have the potential to contaminate or even to derail the therapeutic process. For these reasons and several others, it has seemed appropriate to prioritize consideration of the patients involved and forego a more scholarly presentation.

I reviewed my files for patient contacts and consultations that involved MPD and DDNOS in practicing psychotherapists. From these were removed all records of those patients: 1) who had been seen while still in training; 2) whose files contained entries indicating that publication of information from that file was contrary to the patient's expressed wishes or against my best professional judgment; 3) who currently were in treatment with me; and 4) whose diagnosis had not been confirmed unequivocally. The second of these considerations eliminated many files. This left 20 records of patients who were practicing psychotherapists at the time of their evaluation or treatment; this report is based on information from those sources. In addition, I have drawn upon my notes on conversations with the therapists of those therapist-patients among the 20 whom I did not treat personally. These conversations had occurred in the context of my sharing my observations as a consultant or supervisor.

SELECTED CLINICAL FINDINGS

Demographics

The subjects included 18 female and two male psychotherapists who ranged in age from the mid-twenties to over eighty years of age. All but three were between 32 and 48 when first seen. Their disciplines included ten psychologists (five doctoral and five masters level individuals), five psychiatrists, two social workers (doctoral and masters level), two counselors, and one nurse practitioner. One individual had had additional psychoanalytic training. All had had several previous psychotherapies. Five reported attempts by at least one prior therapist to eroticize the treatment; four in fact had been seduced in this manner. Interestingly, ten had come after their current therapy had miscarried or was stalemated because their current therapists either disbelieved or seriously challenged the patient's increasing awareness that she or he (the patient) suffered a dissociative disorder or professed themselves unable or unwilling to treat the dissociative disorder that they appreciated that the patient suffered. Five were not currently in treatment and had come to suspect that they suffered a dissociative disorder. In all, fifteen sought consultation for diagnostic clarification or for possible transfer to my care because a dissociative disorder was suspected by themselves or their therapists, and five were diagnosed by me in the course of their psychotherapy with me. Of those five, three indicated they had entered treatment with me suspecting they suffered a dissociative disorder.

Diagnosis

Diagnostically, these patients often were difficult to classify for extended periods of time because of fluctuating, intermittent, subtle, and/or dissimulated manifestations. This had caused both them and their prior therapists some difficulty. In some instances rumination over the precisely accurate diagnosis had paralyzed their treatment, even though the treatment of MPD and DDNOS with features of MPD are quite similar (Braun, 1986). Three had florid undisguised MPD, but most were able to dissimulate their conditions quite well, and maintained that they rarely (to their initial conscious knowledge) showed the classic features outside of treatment. Consequently both they and their current therapists often were concerned with the question "Is this MPD?" even though many features of a dissociative disorder involving the presence of separate entities and amnesic episodes were unequivocally present. I found that many of these patients were largely unaware of or minimized how overtly they manifested the signs of a dissociative disorder. For example, I often have watched a psychotherapist patient switch frequently in therapy sessions, yet staunchly maintain that this had not occurred.

In my judgment, nine appeared to have functioned as if they had MPD for protracted periods and in all thirteen had shown classic MPD at least on an intermittent basis (although usually functioning with a less defined DDNOS picture). Eleven functioned as if they had DDNOS most of the time. This includes four who on occasion fulfilled criteria for full MPD, and seven whose manifestations were MPD-like but always fell short of DSM-III-R (American Psychiatric Association, 1987) criteria. These eleven patients represented quite a spectrum re: the overtness and the definition of their dissociative processes. They included patients who lived as if they had florid MPD but whose alters were not well-defined; patients whose alters never fully assumed executive control, but which influenced and occasionally dominated behavior by their impacts upon the alter ostensibly in control; patients whose alters emerged infrequently and/or very briefly; and patients whose alters rarely or never influenced current behavior outside of treatment, but were triggered into activity in sessions by the discussion of events and eras of the patient's life that were relevant to their reasons for being.

All 20 patients demonstrated amnesia in some form. Eighteen had contemporary periods of time loss, and all had gaps in their memory for some portions of their childhood. Interestingly, all 20 gave a history in which the manifestations of their condition fluctuated over time, consistent with the natural history of MPD and allied forms of DDNOS (Kluft, 1985).

Comorbidity

As a group, these patients had fewer diffuse indications of psychopathology than most MPD cohorts. This may well be related to their generally high level of function. Horevitz and Braun (1984) have demonstrated that the co-occurrence of other indices of discomfort and symptomatology in MPD cohorts may be correlated with their overall degree of dysfunction. It was very difficult to ascertain the diagnoses rendered by prior therapists because many of these patients did not want me to communicate with those who had treated them before.

On several occasions I came to learn that a consultation that I had been led to understand was undertaken with the full approval of the current therapist in fact had occurred without that therapist's knowledge.

It was my impression that only 2 of the 20 qualified for the diagnosis of borderline personality disorder. Four fulfilled criteria for a narcissistic personality disorder. One was sociopathic. In general, their character pathology was mixed, with more obsessive-compulsive, masochistic, and avoidant features than histrionic. Although many somatized, none satisfied criteria for any form of histrionic personality disorder, or any somatoform disorder other than conversion disorder. Most had anxiety, and many spoke of panic attacks, but in my opinion no specific anxiety disorder diagnoses could be made besides anxiety disorder NOS and post-traumatic stress disorder (PTSD), the latter being present in eight individuals at some time in their histories. A higher percentage demonstrated PTSD-related symptoms, and many manifested severe post-traumatic difficulties during periods of treatment when they were uncovering past traumata. With respect to affective disorders, all noted depression, but a formal major depression could be diagnosed only in four. These four responded well to anti-depressants. Depression NOS was diagnosed in three others, and dysthymia in another five, none of whom responded unequivocally to medication. Two had difficulties with psychoactive substance abuse but were sober when evaluated; a third was actively abusing psychoactive substances when seen. Although the majority were very concerned with issues related to body image and were quite food-conscious, and most had declared themselves to have an eating disorder, only five had diagnosable eating disorders.

Eight had been hospitalized in psychiatric facilities for substance abuse, eating disorders, or depression. Four had made serious suicide attempts as adults, and several recalled suicide attempts as children. However, a total of ten (including those who had made the attempts) frequently entertained fantasies of committing suicide. Interestingly, only two had engaged in self-mutilation, and their behavior in this regard was mild.

In sum, this cohort of patients was far less symptomatic as a group than most series of MPD patients (e.g., Putnam, Guroff, Silberman, Barban, & Post, 1986). However, as a group, there was a tendency on their part to overstate their co-occurring psychopathology (i.e., representing themselves as having a condition of which they manifested isolated features when in fact few or none of the DSM-III-R [American Psychiatric Association, 1987] diagnostic criteria for that particular disorder were fulfilled). Had I accepted the patients' self-diagnoses, the figures above would be highly inflated. I understood this as stemming from their subjective need to reduce their confusion and their cognitive dissonance, and from their obsessional need to give their dysphoria a name in order to begin to give themselves some sense of intellectual control over what was afflicting them rather than from a histrionic over-endorsement of symptomatology. As noted above, they endorsed fewer symptoms and indices of discomfort than most groups of MPD patients. They sought little secondary gain from their symptoms.

Professional Functioning

It was not always possible to gather objective data on the professional functioning of these individuals. In several cases, however, the patients had sent me or a colleague one or more patients for consultation before making their own appointment, and the future therapist had been able to form some impression of their professional functioning in that connection. Often they were quite candid in saying that they had done this as a test, having heard that "Dr. X diagnoses everyone as having MPD," or "Dr. X is too tough on his patients." On some occasions I had had occasions to have seen the therapists at work. In other instances, they had sought feedback from trusted colleagues when they realized that they might not be able to assess themselves accurately. Several reassessed their own capacities as they came to understand themselves better.

The psychotherapists' estimations of their professional functioning generally fell into one of four categories: masochistic, realistic, perplexed, and grandiose. Five therapists masochistically devalued their work. In two cases there was ample evidence that this was not an accurate assessment; in one case there was insufficient evidence; in one case the therapist had an excellent reputation but had just learned that she, in an alter, had seduced a patient, and was acutely depressed and devalued all her work; in the last it appeared that a major depression had both distorted the therapist's cognition to the negative and impaired her judgment to the extent that substandard treatment had been rendered for a circumscribed period of time.

In seven instances the therapists appeared to give realistic appraisals of their work. They indicated that they had areas of strength and weakness, and several, in some personalities or personality states, could give detailed self-appraisals that were rather ruthless and unflinching. In general, ancillary data supported their perceptions.

Four therapists were genuine perplexed about their circumstances. They were concerned that they might have done things of which they were unaware, and felt compelled to doubt everything that they had thought about themselves and their capabilities. They seemed basically competent, but anguished by their inability to be sure that they could trust their own perceptions.

Four therapists appeared frankly grandiose in their estimation of their abilities and performance. They tended to describe themselves as "special," "gifted," and "excellent," with unique gifts for understanding patients, especially the abused. Each stated that they had a specialized therapist personality that did outstanding work. In those instances for which ancillary data was available, the patients' self-assessments were disconfirmed. Indeed, on occasion they were quite successful. However, at times they did not do good treatment at all. On one occasion I witnessed such a therapist at work, and was appalled to observe frequent switches, the giving of contradictory advice, and the recommendation of inappropriate courses of action. It has been my experience that such therapists encounter serious difficulty in distinguishing between a patient with a positive transference trying to please them and a patient undergoing genuine therapeutic change. By assiduously cultivating a positive atmosphere in the therapy they create a situation in which they are receiving an ongoing stream of positive feedback from

the patient. This is so gratifying to their narcissistic and other needs that adherence to objective reality is forsworn, and the therapist becomes convinced of his or her special gifts as a healer. In view of these observations I find it alarming that in non-clinical settings I frequently encounter individuals who identify themselves as both suffering from a dissociative disorder and being exceptional therapists.

Based on extended conversations with the subjects I have attempted to classify their clinical functioning, an effort summarized in Table 1.

Therapists were classified as *fully functional* if they did not lose time from work due to their disorder and if they could work with a wide variety of clinical populations without any compromise to their competence and without considerable subjective distress. Therapists were classified as *inconvenienced* if they rarely (three or fewer days/year) lost time from work due to their disorder and/or if they could work with a wide variety of clinical populations with infrequent and/or minimal compromise to their competence albeit at the expense of at least occasional considerable subjective distress and/or chronic mild distress. Therapists were classified as *limited* if they lost more than three days but less than eleven days a year from work due to their disorder and/or if either their work with certain patient populations was compromised and/or they were triggered by patients or patients' material to the point that they were severely uncomfortable and had to limit their practice in anyway on these accounts. Therapists were classified as *impaired* if they lost eleven or more days a year from work due to their disorder and/or if they were hospitalized for their disorder and/or if there was evidence of severe and frequent distress in connection with their clinical work and/or if they were forced to seriously curtail or abandon clinical work. Illustrative vignettes follow. In the interests of confidentiality, all individuals described represent composite pictures assembled from several cases and will be listed generically as "female psychotherapists."

1. *Fully functional.* A female psychotherapist carried a full and demanding caseload with no evident difficulty. She was unaware of her MPD for many years. When she did become aware of it and sought consultation I learned that her alters, despite their inner turmoil, had determined never to interfere with professional activities. A single personality conducted the entirety of the professional career. She worked closely with a colleague whom she informed of her circumstances and who gave her ongoing supervision.

2. *Inconvenienced.* A female psychotherapist carried a full and demanding caseload with no evident difficulty, both before and after being found to have DDNOS with features of MPD. She never was forced to leave her practice, but working with certain patients, especially incest victims, caused her considerable inner pain, and occasionally impaired her concentration for brief periods, causing her to lose track of the session's process. On nights after working with such patients she often had flashbacks and traumatic dreams, and had to call either a friend or her therapist for support. With encouragement, she engaged a supervisor to whom she confided her circumstances.

3. *Limited.* A female psychotherapist with well-disguised but classic MPD was subjectively uncomfortable while working with trauma victims and with the perpetrators of sexual and physical abuse. She found herself "spacing out" briefly when hearing accounts of traumatic material, and often was so distressed that she had to cancel her subsequent patients. On many occasions her distress was so profound and prolonged that she had to call her therapist for support or felt obliged, after spending a sleepless night, to cancel her next day's appointments. Both she and her supervisor became aware that she rarely took a full history because she was avoiding making inquiry about matters of sexual trauma and difficulties in family relationships. She avoided helping her patients face and deal with painful material analogous to her own. She ultimately transferred the patients in her caseload whose material she found unsettling. For several years she restricted herself to specialized work that minimized intensive patient contact. After she integrated and worked through her difficulties, she was able to conduct an unrestricted clinical practice.

4a. *Impaired.* A female psychotherapist was aghast to find that she was involved in a sexual liaison with a former female patient, that this had begun in the course of her treatment of this patient, and that the former patient/lover had addressed her by a different name. She had not been aware of having sexualized the treatment, and did not know that she suffered a dissociative disorder in which other alters conducted themselves in a manner that was distinctly different from her usual behavior. She voluntarily withdrew from practice to enter intensive treatment.

4b. *Impaired.* A female psychotherapist discovered in the course of her own treatment that she suffered MPD. As she dealt with her own traumatic past she became suicidal and required a series of hospitalizations. In her practice, she began to switch overtly as her patients' material impacted upon her. On several occasions her patients' accounts induced so much turmoil in her that she regressed into a childlike state or sat in a quasi-catatonic state for several minutes. There were times when she abruptly absented herself from her office for days on end. Unable to function on a consistent and appropriate basis, she had to close her practice for the majority of the time she was in treatment.

Characteristics as Diagnosticians

It is of interest that this group of psychotherapists varied widely as to their tendency to suspect and to make dissociative disorder diagnoses. Some appeared to be excellent and objective diagnosticians. Many became sensitized to the dissociative

TABLE 1

Levels of Professional Functioning of 20 Therapists with MPD or DDNOS with the Features of MPD at Time of Assessment

Fully Functional	3 (15%)
Inconvenienced	5 (25%)
Limited	7 (35%)
Impaired	5 (25%)

disorders as a result of their own circumstances. Although several went through brief phases of "seeing MPD everywhere," this reaction rarely lasted more than a few days or weeks. Only one spent a sustained period of time diagnosing the majority of patients and colleagues she encountered as suffering MPD, much to her own detriment. Many allowed their own ruminations about their own diagnosis to influence their clinical judgment for periods of time ranging from weeks to months. For example, if they were insistent that they "dissociated" but did not have MPD, they were either inclined to be very conservative about making the diagnosis and rail against those who made the diagnosis more frequently (which often proved to be a thinly veiled attack upon the therapist who had diagnosed them, or upon a consultant whom they hoped would disconfirm the diagnosis), or to be inclined to make the diagnosis in others and to say that since she or he (the therapist) did not share the signs upon which the diagnosis had been made in her or his patient, he or she (the therapist) could not possibly suffer MPD.

Coping Styles

There were distinct differences in how those who were aware of their MPD and those who were not conducted themselves professionally. Those who did not appreciate their circumstances generally tried, with will power and determination, to exert self-control and do their best. Some had learned that they did not work well with certain patient groups, some had found that they worked well if they kept their caseload moderate and avoided exhausting themselves, and some allowed rather long periods in between patients to regain their equilibrium and composure. A small number medicated themselves extensively to get through the day.

Of those who were aware of their circumstances, at least across a number of major alters, while some relied on will power and blocking out the impact of other alters by suppression, others had evolved a number of strategies to facilitate the management of their professional activities. Many had a specialized "therapist personality" which attended to professional matters and was left undisturbed by the others. Many carried out their professional activities in the host personality, which was not intruded upon at such times. Two had evolved a "bug in the ear" arrangement whereby one alter coached the one doing the treatment by giving suggestions that were heard as inner voices. Two had a group of similar alters that collaborated and were rather indistinguishable upon superficial inspection. Two had a pattern of overt switching during session, which they erroneously believed to be imperceptible, and whichever alter thought it knew best at the time took over. In two the alters continued their inner battles even in the course of conducting therapy sessions. At times the alters' activities in some way impacted the work of the majority of the therapists, but only in five instances was this severe and sustained.

Their Interest in Learning about the Dissociative Disorders and Entering the Dissociative Disorders Field

Fourteen of the twenty read widely in the field after their diagnosis and attended scientific meetings in the field; six did not. The choice not to read about the field did not seem to be correlated with denial. Two feared intellectualizing their therapy,

two found the material too unsettling, and two found their ability to absorb the material was impeded by their dissociation. Long-term prognosis seemed unaffected by the decision to immerse one's self in the dissociative disorders field or the decision not to do so. However, in several instances such immersion proved the source of considerable resistances and complications, and prolonged treatment.

Four went on to teach about dissociative disorders in a variety of settings. Two made valuable scientific contributions in the abuse field, a third died of an intercurrent illness before her potentially important work was complete, and a fourth is considering doing research in the area of MPD.

SELECTED OBSERVATIONS ON ISSUES ENCOUNTERED IN TREATMENT

Overview

As a group, these therapist-patients were hard-working and dedicated in their therapies. Only three demonstrated severe and sustained difficulties in the therapeutic alliance and only two appeared to extract significant secondary gain from their circumstances. As a group they did well in treatment. All but four (three of whom were seen relatively recently in consultation) are currently in practice, and most are doing well and showing sustained personal and professional growth. Nonetheless, the discussion below will focus exclusively upon some of the problems encountered in their treatment, as noted by myself and by the others with whom they were in therapy.

Complex Relationships and Boundary Difficulties

One of the more ubiquitous issues concerned the complexity of relationships with this group of patients and the difficulty maintaining traditional and helpful boundaries. Because many of them had "auditioned" either me or their current therapist before applying for treatment, many of the treatments began already burdened by real and potential contaminations and double relationships. Because the overwhelming majority of these therapists became intensely interested in the dissociative disorders field and attended conferences and workshops at which their therapists played prominent roles, they frequently had difficulties distinguishing between their therapist as therapist, their therapist as a public person, and their therapist as a private person. Many, despite their intellectual awareness of the potential difficulties such double relationships impose upon the treatment process, were invested in denying the significance of such potential problems and/or assuring themselves and their therapists that their circumstances constituted legitimate exceptions (e.g., "If I don't take your workshop/attend the same study group, how can I render appropriate care to my own dissociative disorder patients," "You have to be my consultant. Who else can I ask about my MPD patient?"). Still others saw a potential double relationship as a mark of being special, of achieving forbidden gratification, and of denying that the therapist was a therapist instead of a personal friend, a mentor, etc. The potential for the acting out of narcissistic psychopathology on the part of both therapist and therapist-patient was considerable.

A few therapist-patients were persistently aggrieved that their therapist enjoyed collegial relationships with others in the

field that were precluded to them because of their status as their therapist's patient, and spent much time in treatment devaluing the colleagues with whom their own therapist collaborated or socialized. In such cases there was often a mixture of severe jealousy and profound shame and rage over their own circumstances. They felt that had they not suffered abuse and a consequent dissociative disorder, they would be their therapists' collaborators and friends. It was often quite a clinical challenge to bring to the therapist-patient's awareness that the boundary violations that were requested and entreated with such earnestness and persistence, and often enacted by the patient despite the therapist's cautions and warnings, were at one level a re-enactment of the same disrespect for boundaries and rules of conduct that had led to their own dissociative disorders. Despite these comments, it must be acknowledged that in several circumstances legitimate logistical constraints precluded the optimal protection of the therapeutic setting despite the therapist's best efforts and the patient's rational perception of the circumstances.

Narcissistic Issues

Although only 20% of the therapist-patients had a diagnosable narcissistic personality disorder, virtually all had suffered severe narcissistic injuries. Sensitization to issues of narcissism, shame, and self psychopathology proved extremely helpful to their therapists. The need of many of these patients to insist upon being "exceptions" has been noted above. Another not uncommon finding was the therapist-patient's apparent "need" to have the perfect and consistently empathically accurate therapist while continuing to test the therapist, to voice a profusion of criticisms of the therapist, to provoke the therapist, and to set traps for the therapist. The therapist's responses, whether the therapist was completely on target or had made a "forced error" under duress, would be found wanting. This would be followed by a series of sessions in which the therapist-patient would bemoan the "fact" that the therapist could not be trusted, and wonder whether they should change therapists or insist upon a consultation in order to help the current therapist understand them or to correct the current therapist's "errors" of empathy and judgment.

Entitlement was a frequent issue, as was a firm conviction that the therapist-patient's observations were unerringly accurate and objective, and that any attempt to interpret or confront distortions and/or projections was unduly defensive on the part of the therapist. A not infrequent type of comment took the form of: "Whenever I try to help you see how you could better understand me and be more helpful to me you get defensive or you say it is transference. It's *not* transference – you really are...." Often a therapist's initial actions of self-disclosure came back to haunt him or her – "You used to validate my perceptions. You used to be more honest and admit when you (did thus and so) – Now you just criticize me and say my feeling came from the past." It often is a difficult task for the therapist, who is dealing with a patient many of whose accurate perceptions in childhood were treated as if they were invalid, to make observations about the patient's misperceptions in the here and now without being seen as replicating the "gas-lighting" practices of those who once abused the patient yet acted and forced her or him to act as if everything were perfectly normal.

However, succumbing to the patient's imploring one to validate perceptions that are not valid is profoundly countertherapeutic as well. I myself and all of the therapists with whom I discussed this issue were forcefully struck by the prolonged insistence of the majority of this group of patient-therapists that *in their cases*, the usual issues of transference did not apply on a consistent basis, while those of countertransference remained salient.

Two additional issues that bear upon narcissism, entitlement, and the sense of being an exception are issues regarding physical contact and consultations. Three therapist-patients were exceptionally persistent and demanding with respect to their perceived need for physical contact with the therapist. They wanted to be held, comforted, and nurtured at a level beyond the holding of a hand, an arm around the shoulder, or the occasional hug. A typical mild verbalization might be: "Of course I need a hug – you're not going to give me that old line about boundaries and transference – be a real person with me!" It was curious that the patients who were more insistent upon this had incest histories and had been in therapies in which boundaries had been crossed.

Consultations proved a difficult area. Not only was the referral to a first consultant dynamically meaningful – even when transferred to either the original consultant or another person for treatment, the press to seek consultation persisted for a significant minority, and efforts to explore the function of such requests as a resistance to the therapy were dismissed as a rule. In general, over the last several years I and others have noted an intense press by such therapist-patients to rehabilitate their shattered selves by the use of the therapist as an idealized self-object. These phenomena, the insistence on consultations and the need for the therapist to be ideal, were not characteristic of the early patients in this series, and seem to have emerged with the wider dissemination of knowledge about dissociative disorders and the idealization accorded to many of the prominent therapists in the field in the first case and the rise in popularity of the concept of Heinz Kohut and his followers in the second. Several of the more recent therapist-patients in this series persistently expressed a wish to have additional consultations to check out whether their therapist was accurate in his or her diagnosis and/or therapeutic strategy. Although eloquent rationalizations were invariably offered for such pursuits, it was my experience that such requests (as opposed to the initial consultations) usually occurred in the context of patients' wishes to disavow their diagnosis; to delay or avoid difficult material or the intensity of the transference; to doggedly insist upon the validity of their perceptions in the flight from an accurate if unwelcome interpretation (usually in the transference); to attack, devalue, shame, or otherwise express anger to the therapist; to attempt to find a new and more perfect therapist in the context of their devaluing a previously idealized therapist; and combinations of these themes.

The wish to be written about or to "go public" was uncommon in this series of patients. One "went public" by announcing her plight in a scientific forum (before entering therapy), and a second began work on an autobiography and entertained grandiose fantasies of becoming wealthy by selling her story to the movies. The remainder were primarily motivated to get back to work and to reveal their circumstances to as few

people as possible.

In the study of these materials, it became clear that a patient-therapist's holding a grandiose opinion of her or his own capacities as a therapist was a poor prognostic indicator, and was associated with both long-term inability to return to professional activities and a longer course of treatment.

Transference

Work in the transference with therapist-patients can be very demanding and fraught with peril, for reasons noted above. Certainly transference interpretation is not the core of the treatment of MPD, as noted by Putnam (1989), who made many valuable remarks on the difficulty of working with transference in MPD patients. However, as noted above, work with transference resistances is very characteristic of the treatment of the therapist-patient sub-group. Unfortunately, both the sophistication of this group of patients and their tendency to test the therapist and devalue transference phenomena makes an already challenging task all the more formidable. It is useful to simply be aware that this difficulty is inherent in work with this patient population, and that the therapist-patient's increasing ability to attend to transference observations is a most optimistic landmark in the process of the therapy. In my experience, the more rapidly it is achieved, the more accelerated, smooth, and crisis-free will be the therapy, due in no small measure to the decontamination of the therapeutic alliance that is a natural concomitant development. The more clearly the therapist is seen through the negative projections, the more security the patient will experience in the therapy. Many therapist-patients' refusal to attend to such matters prolonged their difficulties.

Countertransference

Therapist's typical countertransferences to MPD patients have been discussed in the literature (Coons, 1986; Kluft, 1984b, in press a) and will not be discussed here. Also, all the therapists treating these therapist-patients were quite accustomed to treating mental health professionals and felt no undue pressures on that account. However, several of the other therapists and I found that we often were concerned about the well-being of our therapist-patients' patients, especially when those that we were treating were showing signs of severe distress and disorganization. This interfered with our ability to direct our efforts to our own patients' pressing concerns; on several occasions we had to intervene to insist on steps that safeguarded their patients. One therapist-patient had to be told that she was not capable of practicing; others received milder confrontations. After my first encounter with a therapist-patient whose stability as a practitioner appeared uncertain, I adopted the practice of insisting that therapist-patients in treatment with me engage as a supervisor a skilled colleague whom they do not know socially, do not work with professionally, and whose integrity and confidentiality they trust implicitly. They are to inform this person of their circumstances and of their being in treatment, and specifically ask the supervisor to help them identify and address instances in which their difficulties interfere with their professional practice. One of the most common areas of concern has been the worry that they are blocking out materials that bear on their areas of conflict, and thereby serving their

patients poorly. Excluding those whose estimations of their therapeutic capability was grandiosely inflated, all of the other therapist-patients with whom I have worked have feared failing their own patients and have found that having a supervisor attend to such matters gives them considerable peace of mind, and alleviates the pressure to convert therapy into supervision. Knowing that a competent colleague is overseeing my therapist-patients' professional work gives me a greater sense of security with regard to my work with this type of patient.

Confidentiality

Approximately half of these patients had extreme concerns about their confidentiality. Although the following expression of concern may be unique to the practices of those known to work with dissociative disorders, three patients in treatments with me declined to submit insurance forms because they were certain that to submit a bill with my name on it was a confession to their place of employment that they suffered MPD. Many therapist-patients, as noted above, stipulated that they and their circumstances could not be used in any publications or researches. In some cases these wishes had clear historical antecedents; i.e., there were past experiences of being used or exploited for someone else's aggrandizement or benefit. In others these wishes involved the need to be different or special, to exercise control, or to sadistically withhold.

Severe paranoia about matters of confidentiality was encountered in a small number of patients, and was usually associated with a grandiose overestimation of their capacities as therapists.

Masochism

The masochistic tendencies of this group of patients proved to be strong. They often overextended themselves and allowed themselves to be exploited in their own practices, and interpreted this as a virtue (which they often tried to teach to their therapists!). One had run into severe legal difficulties for giving in to the unreasonable and illegal requests of a pained but exploitive patient. It proved quite essential to address these overgiving and self-abnegating tendencies in their professional work as well as in their private lives throughout their treatments. Only three of the 20 did not have this difficulty: two who were able to control their masochistic tendencies with insight and self-control, and one who was quite preoccupied with herself.

Ancillary Therapies

Five of these patients (all either fully functional or inconvenient) were members of support groups or therapy groups of some type at the time their conditions were diagnosed, and remained as members of those groups without sharing their dissociative disorder diagnoses in those groups. Two, both classified as limited, insisted upon entering additional specialized therapist or support groups against their therapists' advice (because these actions seemed to be in the service of resistance). One appeared to benefit from these activities, the other did not. Another two, both classified as impaired, were referred to a specialized group for MPD/DDNOS patients, and found it useful.

Informing Others

As a group these therapist-patients shared their plight with a small number of good friends, a spouse, or no one. Two individuals attempted to mobilize support and sympathy by informing others; their efforts backfired sadly. As a group, they seemed to value the confidentiality and the ethos of intense individual psychotherapy, and saw their task as to recover as rapidly as possible and to interrupt the continuity of their careers as little as possible. They forfeited any potential secondary gain of the illness, and valued their privacy and confidentiality above the gratifications and potential support that might come from sharing their concerns with many others.

Responses to Workshops, Conferences, and Study Groups During Treatment

As noted above, 14 of the 20 therapist-patients did read widely in the field and attended education programs such as specialized conferences and study groups. At times they attended even in the face of their therapists' advice to the contrary. Nine (64%) of those who attended had at least one experience in which the material being presented, their reaction to seeing their therapist in another setting, the discouragement that they felt about their circumstances in comparison to the lot of others, or analogous issues caused them sufficient discomfort that they had to leave a particular presentation or the conference as a whole, or became severely symptomatic. Such experiences invariably were accompanied by depression, shame, guilt, and a profound sense of failure. Occasionally they caused periods of suicidal despair. This group appeared to believe that if they did not attend, they would feel inferior, disenfranchised, and deprived of experiences that were both educationally and personally significant.

Many proved to have surrounded these occasions with complex personal fantasies that offered valuable insights into their dynamics. The issue of attendance had become so suffused with fantasied wishes and fears that it held the potential to become a perilous experience. Interestingly, those who deferred attending such events until both they and their therapist agreed that they could handle them generally did not encounter significant adversity, and found the experience empowering and helpful. It is important to underline that in no case in this series did a therapist escort such a therapist-patient to a meeting.

REMARKS ON THE TREATMENT OF PSYCHOTHERAPISTS WITH MPD OR DDNOS WITH FEATURES OF MPD

The treatment of such therapist-patients can be quite successful and gratifying. However, it may prove to be longer in duration, slower in its pace, and occasionally less intense than the treatment of other MPD cohorts. Several factors contribute to this. First, it is essential that efforts be made so that the therapist-patient not be destabilized, and highly desirable that her or his treatment sessions be buffered from her or his professional activities by the passage of time. In addition, there may be a real or perceived need to restabilize between sessions, rather than plunge ahead in a "one foot after the other" manner. In some instances this means that the number of

sessions per week and the aggressiveness of the process must be titrated against the necessities of carrying on with a demanding professional life in a relatively unimpeded manner. Second, as in a training analysis, the treatment may need to be longer and more ambitious in order (in addition to the general goals of the treatment) to maximize the freedom of the individual's competence from her or his conflict areas and to minimize the likelihood that the individual's countertransference difficulties will impede her or his empathy and efficacy as a psychotherapist. Third, the therapist-patient brings to the treatment a number of concerns and resistances (as noted above) that have the potential to occupy a considerable amount of the treatment. It is difficult to understate the importance of this dimension in certain cases. I recently had to deal with the prolonged anguish of a very well-read therapist-patient who learned that another MPD patient whom she knew to be as complex as herself (but who was not a therapist and did not scrutinize the literature and use it against the process of the treatment) had entered therapy four years after she had begun and had come to a successful integration in relatively short order (two years) while she remained quite complex and distressed. She was mortified, suicidal, and felt sure that this meant that she could not be treated. In fact, over half of her time in treatment had been spent in the resistances and attacks described earlier in this article. Despite my most earnest efforts, for months after learning of the other patient's progress she remained convinced that either I was not treating her adequately, that I disliked her, that she was untreatable, or a combination of the above. She was most reluctant to accept responsibility for the impact of her massive resistances upon the length of the therapy.

In general, if the therapist-patient is able to function in a competent professional manner, accepts her or his diagnosis, and is willing to get supervision, the principles devised for the treatment of the high-functioning MPD patient (Kluft, 1986) will apply: "The therapy proceeds most smoothly when preservation of function takes priority over rapidity of results" (pp. 725-726). Symptom relief often will be pursued with a higher priority than long-range strategic goals. Hypnosis may have a useful role in attenuating the impact of the treatment (Kluft, 1989b). It may be necessary to schedule longer sessions for work on painful areas so that equilibrium can be restored before the patient leaves the office. Scrupulous adherence to the "rule of thirds" (Kluft, in press a, in press b) is desirable. In essence, the "rule of thirds" holds that unless the difficult material that the therapist and the patient have agreed to address in a particular session can be reached within the first third so that it can be dealt with in the remainder of the first third and the second third, preserving the final third for the processing of the material and the restabilization of the patient, it is best to abandon the planned agenda and work with other and less unsettling material, such as here-and-now problems and character issues. This is because it is desirable (whenever possible) to send the patient out of the office with a sense of reconstitution and mastery. The patient who leaves the therapy session in a state of mental disarray is likely to have a difficult day, call the attention of others to her or his plight, and come to see the therapy as a retraumatization rather than as a healing experience.

Whenever possible, it is desirable to see such therapist-patients at the beginning or end of the day, or on their day off. This, again, buffers them from going directly from an unsettling psychotherapy situation into a situation in which they must immediately assume substantial professional responsibilities. It is also useful to advise such individuals against undertaking new endeavors that will confront them with their problem areas in an intense and/or unrelenting fashion. It is understandable that many therapists with dissociative disorders find themselves drawn to the idea of working with dissociative disorder patients and other victim populations. They are curious about their own conditions, want to learn the skills essential to treat them, and undoubtedly hope to achieve a degree of vicarious mastery of their own circumstances by successfully helping others to overcome similar difficulties. However, my findings indicate that only a minority of such therapists are capable of doing so at a high level of competence during the difficult phases of their own treatment. It is probably best to defer pursuing such endeavors in a focused manner. Also, it seems almost inevitable that many of these therapist-patients, sensitized by their own situations, will encounter dissociative disorder patients in the course of their own routine work, and have to come to an honest understanding as to whether they can and should serve as therapist for this type of patient. My findings suggest that for most, until the latter phases of their treatments, discretion is the better part of valor.

It often is useful to advise therapist-patients who are in salaried positions to accumulate vacation and sick time against an emergency, and to advise those in private practice to avoid becoming locked in to long-range vacation commitments whenever possible. These precautions serve as a hedge against an emergency, a decompensation, or the transient dominance of an alter incapable of functioning professionally. They also may make possible absencing one's self from work for a period of very intense therapy, during which material that cannot be handled without severe dysphoria and upsetting symptoms can be addressed without the pressure of having to rapidly reconstitute to address professional obligations.

For the psychotherapist who begins treatment in a state of decompensation sufficiently severe so that an absence from professional activities is essential, a useful first step is to undertake a crisis-intervention oriented therapy directed at the restoration of equilibrium and function, followed by a treatment along the model indicated above. If this effort is not successful, it may be useful to begin treatment at a high level of intensity with the goal of bringing the patient through enough of the painful material to make a renewal of this type of effort more likely to succeed. If this is not possible, then it may be necessary to anticipate a longer absence from professional activities and to mount a sustained intensive endeavor, appreciating that a substantial portion of the work of the therapy may have to be completed before restoration of function becomes possible. In this series only five individuals were required to take a prolonged leave of absence from professional activities, and only two others required a briefer time away to regain their equilibrium, settle in to a definitive psychotherapy, and resume work.

CONCLUDING THOUGHTS

The treatment of one's professional colleagues is an honor and a privilege. Childhood trauma is truly non-discriminatory: no barriers of gender, race, religion, social standing, intelligence, courage, talent, or financial status serve as barriers to this type of experience. Our colleagues include an unknown number of intelligent and gifted individuals who have weathered the perils of an overwhelming beginning and emerged both as fellow mental health professionals and as sufferers of severe dissociative disorders. They require our compassionate attention and the full exercise of our skills. Their prognosis is good. However, some of the very traits and characteristics that have followed from and may have allowed them to withstand what has befallen them may prove serious barriers to their treatment. It is helpful to approach the psychotherapy of such individuals with patience, compassion, endurance, and resilience. ■

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