ASK Yourself a Question...

Recently considered rare and mysterious psychiatric curiosities, Dissociative Identity Disorder (DID) (previously known as Multiple Personality Disorder-MPD) and other Dissociative Disorders are now understood to be fairly common effects of severe trauma in early childhood, most typically extreme, repeated physical, sexual, and/or emotional abuse.

In Diagnostic and Statistical Manual of Mental Disorders-IV (American Psychiatric Association, 1994), Multiple Personality Disorder (MPD) was changed to Dissociative Identity Disorder (DID), reflecting changes in professional understanding of the disorder resulting from significant empirical research.

Posttraumatic Stress Disorder (PTSD), widely accepted as a major mental illness affecting 8% of the general population in the United States, is closely related to Dissociative Disorders. In fact, 80-100% of people diagnosed with a Dissociative Disorder also have a secondary diagnosis of PTSD. The personal and societal cost of trauma disorders is extremely high. Recent research suggests the risk of suicide attempts among people with trauma disorders may be even higher than among people who have major depression. In addition, there is evidence that people with trauma disorders have higher rates of alcoholism, chronic medical illnesses, and abusiveness in succeeding generations.

WHAT IS DISSOCIATION?

Dissociation is a mental process, which produces a lack of connection in a person's thoughts, memories, feelings, actions, or sense of identity. During the period of time when a person is dissociating, certain information is not associated with other information as it normally would be. For example, during a traumatic experience, a person may dissociate the memory of the place and circumstances of the trauma from his ongoing memory, resulting in a temporary mental escape from the fear and pain of the trauma and, in some cases, a memory gap surrounding the experience. Because this process can produce changes in memory, people who frequently dissociate often find their senses of personal history and identity are affected.

Most clinicians believe that dissociation exists on a continuum of severity. This continuum reflects a wide range of experiences and/or symptoms. At one end are mild dissociative experiences common to most people, such as daydreaming, highway hypnosis, or "getting lost" in a book or movie, all of which involve "losing touch" with conscious awareness of one's immediate surroundings. At the other extreme is complex, chronic dissociation, such as in cases of Dissociative Disorders, which may result in serious impairment or inability to function. Some people with Dissociative Disorders can hold highly responsible jobs, contributing to society in a variety of professions, the arts, and public service -- appearing to function normally to coworkers, neighbors, and others with whom they interact daily.

There is a great deal of overlap of symptoms and experiences among the various Dissociative Disorders, including DID. For the sake of clarity, this brochure will refer to Dissociative Disorders as a collective term. Individuals should seek help from qualified mental health providers to answer questions about their own particular circumstances and diagnoses.

HOW DOES A DISSOCIATIVE DISORDER DEVELOP?

When faced with overwhelmingly traumatic situations from which there is no physical escape, a child may resort to "going away" in his or her head. Children typically use this ability as an extremely effective defense against acute physical and emotional pain, or anxious anticipation of that pain. By this dissociative process, thoughts, feelings, memories, and perceptions of the traumatic experiences can be separated off psychologically, allowing the child to function as if the trauma had not occurred.

Dissociative Disorders are often referred to as a highly creative survival technique because they allow individuals enduring "hopeless" circumstances to preserve some areas of healthy functioning. Over time, however, for a child who has been repeatedly physically and sexually assaulted, defensive dissociation becomes reinforced and conditioned. Because the dissociative escape is so effective, children who are very practiced at it may automatically use it whenever they feel threatened or anxious -- even if the anxiety-producing situation is not extreme or abusive.

Often, even after the traumatic circumstances are long past, the left-over pattern of defensive dissociation remains. Chronic defensive dissociation may lead to serious dysfunction in work, social, and daily activities.

Repeated dissociation may result in a series of separate entities, or mental states, which may eventually take on identities of their own. These entities may become the internal "personality states" of a DID system. Changing between these states of consciousness is often described as "switching."

WHAT ARE THE SYMPTOMS OF A DISSOCIATIVE DISORDER?

People with Dissociative Disorders may experience any of the following: depression, mood swings, suicidal tendencies, sleep disorders (insomnia, night terrors, and sleep walking), panic attacks and phobias (flashbacks, reactions to stimuli or "triggers"), alcohol and drug abuse, compulsions and rituals, psychotic-like symptoms (including auditory and visual hallucinations), and eating disorders. In addition, individuals with Dissociative Disorders can experience headaches, amnesias, time loss, trances, and "out of body experiences." Some people with Dissociative Disorders have a tendency toward self-persecution, self-sabotage, and even violence (both self-inflicted and outwardly directed).

WHO GETS DISSOCIATIVE DISORDERS?

The vast majority (as many as 98 to 99%) of individuals who develop Dissociative Disorders have documented histories of repetitive, overwhelming, and often life-threatening trauma at a sensitive developmental stage of childhood (usually before the age of nine), and they may possess an inherited biological predisposition for dissociation. In our culture the most frequent precursor to Dissociative Disorders is extreme physical, emotional, and sexual abuse in childhood, but survivors of other kinds of trauma in childhood (such as natural disasters, invasive medical procedures, war, kidnapping, and torture) have also reacted by developing Dissociative Disorders.

Current research shows that DID may affect 1% of the general population and perhaps as many as 5-20% of people in psychiatric hospitals, many of whom have received other diagnoses. The incidence rates are even higher among sexual-abuse survivors and individuals with chemical dependencies. These statistics put Dissociative Disorders in the same category as schizophrenia, depression, and anxiety, as one of the four major mental health problems today.

Most current literature shows that Dissociative Disorders are recognized primarily among females. The latest research, however, indicates that the disorders may be equally prevalent (but less frequently diagnosed) among the male population. Men with Dissociative Disorders are most likely to be in treatment for other mental illnesses or drug and alcohol abuse, or they may be incarcerated.

WHY ARE DISSOCIATIVE DISORDERS OFTEN MISDIAGNOSED?

Dissociative Disorders survivors often spend years living with misdiagnoses, consequently floundering within the mental health system. They change from therapist to therapist and from medication to medication, getting treatment for symptoms but making little or no actual progress. Research has documented that on average, people with Dissociative Disorders have spent seven years in the mental health system prior to accurate diagnosis. This is common, because the list of symptoms that cause a person with a Dissociative Disorder to seek treatment is very similar to those of many other psychiatric diagnoses. In fact, many people who are diagnosed with Dissociative Disorders also have secondary diagnoses of depression, anxiety, or panic disorders.

DO PEOPLE ACTUALLY HAVE "MULTIPLE PERSONALITIES"?

Yes, and no. One of the reasons for the decision by the psychiatric community to change the disorder's name from Multiple Personality Disorder to Dissociative Identity Disorder is that "multiple personalities" is somewhat of a misleading term. A person diagnosed with DID feels as if she has within her two or more entities, or personality states, each with its own independent way of relating, perceiving, thinking, and remembering about herself and her life. If two or more of these entities take control of the person's behavior at a given time, a diagnosis of DID can be made. These entities previously were often called "personalities," even though the term did not accurately reflect the common definition of the word as the total aspect of our psychological makeup. Other terms often used by therapists and survivors to describe these entities are: "alternate personalities," "alters," "parts," "states of consciousness," "ego states," and "identities." It is important to keep in mind that although these alternate states may appear to be very different, they are all manifestations of a single person.

CAN DISSOCIATIVE DISORDERS BE CURED?

Yes. Dissociative Disorders are highly responsive to individual psychotherapy, or "talk therapy," as well as to a range of other treatment modalities, including medications, hypnotherapy, and adjunctive therapies such as art or movement therapy. In fact, among comparably severe psychiatric disorders, Dissociative Disorders may be the condition that carries the best prognosis if proper treatment is undertaken and completed. The course of treatment is longterm, intensive, and invariably painful, as it generally involves remembering and reclaiming the dissociated traumatic experiences. Nevertheless, individuals with Dissociative Disorders have been successfully treated by therapists of all professional backgrounds working in a variety of settings.

Dissociative Identity Disorder

(formerly Multiple Personality Disorder)

Dissociative Identity Disorder (DID), previously referred to as multiple personality disorder (MPD), is a dissociative disorder involving a disturbance of identity in which two or more separate and distinct personality states (or identities) control the individual's

behavior at different times. When under the control of one identity, the person is usually unable to remember some of the events that occurred while other personalities were in control. The different identities, referred to as alters, may exhibit differences in speech, mannerisms, attitudes, thoughts, and gender orientation. The alters may even differ in "physical" properties such as allergies, right-or-left handedness, or the need for eyeglass prescriptions. These differences between alters are often quite striking.

The person with DID may have as few as two alters, or as many as 100. The average number is about 10. Often alters are stable over time, continuing to play specific roles in the person's life for years. Some alters may harbor aggressive tendencies, directed toward individuals in the person's environment, or toward other alters within the person.

At the time that a person with DID first seeks professional help, he or she is usually not aware of the condition. A very common complaint in people with DID is episodes of amnesia, or time loss. These individuals may be unable to remember events in all or part of a proceeding time period. They may repeatedly encounter unfamiliar people who claim to know them, find themselves somewhere without knowing how they got there, or find items that they don't remember purchasing among their possessions.

Often people with DID are depressed or even suicidal, and self-mutilation is common in this group. Approximately one-third of patients complain of auditory or visual hallucinations. It is common for these patients to complain that they hear voices within their head.

Treatment for DID consists primarily of psychotherapy with hypnosis. The therapist seeks to make contact with as many alters as possible and to understand their roles and functions in the patient's life. In particular, the therapist seeks to form an effective relationship with any personalities that are responsible for violent or self-destructive behavior, and to curb this behavior. The therapist seeks to establish communication among the personality states and to find ones that have memories of traumatic events in the patient's past. The goal of the therapist is to enable the patient to achieve breakdown of the patient's separate identities and their unification into a single identity.

Retrieving and dealing with memories of trauma is important for the person with DID, because this disorder is believed to be caused by physical or sexual abuse in childhood. Young children have a pronounced ability to dissociate, and it is believed that those who are abused may learn to use dissociation as a defense. In effect, the child slips into a state of mind in which it seems that the abuse is not really occurring to him or her, but to somebody else. In time, such a child may begin to split off alter identities. Research has shown that the average age for the initial development of alters is 5.9 years.

I have come to recognize the 44 separate personalities residing within my one very tired, and crowded body

Dissociative Identity Disorder
(Multiple Personality Disorder)

A disorder characterized by two or more identities or personalities that alternatively take over the person's behavior.

Amnesia involving an inability to recall important personal information relating to some of the identities is present. Amnesia is not uniform in all personalities; what is not known by one personality may be known by another. Some personalities may appear to know and interact with other personalities in an elaborate inner world. For example, some personalities of which personality A is unaware may be aware of personality A and know what it does, as if observing its behavior. Others may be unaware of personality A or may be aware of personality A but lack co-consciousness (the simultaneous awareness of events by more than one personality) with personality A.

Dissociative identity disorder is serious and chronic and may lead to disability and incapacity. *It is associated with a high incidence of suicide attempts and is believed to be more likely to end in suicide than any other mental disorder.*

Several studies show that previously undiagnosed dissociative identity disorder is present in 3 to 4% of acute psychiatric inpatients and in a sizable minority of patients in psychoactive substance abuse treatment settings. It appears to be rather common, being diagnosed more frequently in recent years because of enhanced awareness of it, improved diagnostic methods, and increased awareness of childhood mistreatment and its consequences. Although some experts believe that increased reports of this disorder reflect the influence of physicians on suggestible patients, no firm evidence substantiates this view.

Etiology

Dissociative identity disorder is attributed to the interaction of several factors: overwhelming stress, dissociative capacity (including the ability to uncouple one's memories, perceptions, or identity from conscious awareness), the enlistment of steps in normal developmental processes as defenses, and, during childhood, the lack of sufficient nurturing and compassion in response to hurtful experiences or lack of protection against further overwhelming experiences. Children are not born with a sense of a unified identity--it develops from many sources and experiences. In overwhelmed children, its development is obstructed, and many parts of what should have blended into a relatively unified identity remain separate. North American studies show that 97 to 98% of adults with dissociative identity disorder report abuse during childhood and that abuse can be documented for 85% of adults and for 95% of children and adolescents with dissociative identity disorder and other closely related forms of dissociative disorder. Although these data establish childhood abuse as a major cause among North American patients (in some cultures, the consequences of war and disaster play a larger role), they do not mean that all such patients were abused or that all the abuses reported by patients with dissociative identity disorder really happened. Some aspects of some reported abuse experiences may prove to be inaccurate. Also, some patients have not been abused but have experienced an important early loss (such as death of a parent), serious medical illness, or other very stressful events. For example, a patient who required many hospitalizations and operations during childhood may have been severely overwhelmed but not abused.

Human development requires that children be able to integrate complicated and different types of information and experiences successfully. As children achieve cohesive, complex appreciations of themselves and others, they go through phases in which different perceptions and emotions are kept segregated. Each developmental phase may be used to generate different selves. Not every child who experiences abuse or major loss or trauma has the capacity to develop multiple personalities. Patients with dissociative identity disorder can be easily hypnotized. This capacity, closely related to the capacity to dissociate, is thought to be a factor in the development of the disorder. However, most children who have these capacities also have normal adaptive mechanisms, and most are sufficiently protected and soothed by adults to prevent development of dissociative identity disorder.

Symptoms and Signs

Patients often have a remarkable array of symptoms that can resemble other neurologic and psychiatric disorders, such as anxiety disorders, personality disorders, schizophrenic and mood psychoses, and seizure disorders. Most have symptoms of depression, manifestations of anxiety (sweating, rapid pulse, palpitations), phobias, panic attacks, physical symptoms, sexual dysfunction, eating disorders, and posttraumatic stress. Suicidal preoccupations and attempts are common, as are episodes of self-mutilation. Many have abused psychoactive substances at some time.

The switching of personalities and the amnesic barriers between them frequently result in chaotic lives. Because the personalities often interact with each other, patients with dissociative identity disorder often report hearing inner conversations and the voices of other personalities, which often comment on or address the patient. The voices are experienced as hallucinations.

Several symptoms are characteristic of dissociative identity disorder: fluctuating symptom pictures; fluctuating levels of function, from highly effective to disabled; severe headaches or other bodily pain; time distortions, time lapse, and amnesia; and depersonalization and derealization. **Depersonalization** refers to feeling unreal, removed from one's self, and detached from one's physical and mental processes. The patient feels like an observer of his life and may actually see himself as if he were watching a movie. **Derealization** refers to experiencing familiar persons and surroundings as if they were unfamiliar and strange or unreal.

Persons with dissociative identity disorder are often told of things they have done but do not remember and of notable changes in their behavior. They may discover objects, productions, or handwriting that they cannot account for or recognize; they may refer to themselves in the first person plural (we) or in the third person (he, she, they); and they may have amnesia for events that occurred between ages 6 and 11. Amnesia for earlier events is normal and widespread.

Because dissociative identity disorder tends to resemble other psychiatric disorders, patients typically give histories of having had three or more different psychiatric diagnoses and of prior treatment failure. As a group, they are very concerned with issues of control, both self-control and control of others.

Diagnosis

The diagnosis requires medical and psychiatric evaluation, including specific questions about dissociative phenomena. Under some circumstances, the psychiatrist may use prolonged interviews, hypnosis, or drug-facilitated interviews and may ask the patient to keep a journal between visits. All of these measures encourage a shift of personality states during the evaluation. Specially designed questionnaires can help identify patients with dissociative identity disorder.

The psychiatrist may attempt to contact and elicit other personalities by asking to speak to the part of the mind involved in behaviors for which the patient had amnesia or that were experienced in a depersonalized or derealized fashion.

Prognosis

Patients can be divided into three groups with regard to prognosis. Those in one group have mainly dissociative symptoms and posttraumatic features, generally function well, and generally recover completely with specific treatment. Those in another group have symptoms of other serious psychiatric disorders, such as personality disorders, mood disorders, eating disorders, and substance abuse disorders. They improve more slowly, and treatment may be either less successful or longer and more crisis-ridden. Patients in the third group not only have severe coexisting psychopathology but may also remain enmeshed with their alleged abusers. Treatment is often long and chaotic and aims to help reduce and relieve symptoms more than to achieve integration. Sometimes therapy helps a patient with a poorer prognosis make rapid strides toward recovery.

Treatment

Symptoms wax and wane spontaneously, but dissociative identity disorder does not resolve spontaneously. Drugs help manage specific symptoms but do not affect the disorder itself. All successful treatments that aim to achieve integration involve psychotherapy that specifically addresses the dissociative identity disorder. Some patients are unable or unwilling to pursue integration. For them, treatment aims to facilitate cooperation and collaboration among the personalities and to reduce symptoms. This treatment is often arduous and painful, and many crises tend to arise as a result of the personalities' actions and the patient's despair when dealing with traumatic memories. One or more periods of psychiatric hospitalization may be necessary to help some patients through difficult times and during the processing of particularly painful memories. Hypnosis is often used to help access the personalities, facilitate communication between them, and stabilize and interpret them. Hypnosis is also used to discuss traumatic memories and diffuse their impact. Eye movement desensitization and reprocessing (EMDR), applied cautiously, is a useful adjunct. EMDR tries to process traumatic memories and to replace negative thoughts about self that are associated with these memories with positive ones.

Generally, two or more psychotherapy sessions per week for 3 to >= 6 years are necessary to integrate the personalities or to achieve harmonious interaction among them that allows normal functioning without symptoms. Integration of the personalities is the most desirable outcome.

Psychotherapy has three main phases. In the first phase, the priority is safety, stabilization, and strengthening of the patient in anticipation of the difficult work of processing traumatic material and dealing with problematic personalities. The personality system is explored and mapped to plan the remainder of the treatment. In the second phase, the patient is helped to process the painful episodes of his past and to mourn the losses and other negative consequences of the trauma. As the reasons for the patient's remaining dissociations are addressed, therapy can move to the final phase, in which the patient's selves and relationships and social functioning can be reconnected, integrated, and rehabilitated. Some integration occurs spontaneously, but much must be encouraged by conversing with and arranging the unification of the personalities or must be facilitated with imagery and hypnotic suggestion. After integration, patients continue treatment to deal with some issues that have not been resolved. After postintegration treatment appears complete, visits to the therapist are tapered but are rarely completely terminated. Patients come to think of the psychiatrist as someone who can help them deal with psychologic issues, just as they periodically need assistance from a primary care physician.

At its meeting in Vancouver, BC, Canada, in May 1994, the Executive Council of ISSD adopted "Guidelines for Treating Dissociative Identity Disorder (Multiple Personality Disorder) in Adults (1994)." The guidelines present a broad outline of what has thus far seemed to be effective treatment for DID. The guidelines are not intended to replace the therapist’s clinical judgment, but they do aim to summarize what most commonly has been found to benefit DID patients. Where a clear divergence of opinion exists in the field, the guidelines attempt to present both sides of the issue.

Guidelines like these are never finished. This revision is the first since the adoption of the guidelines in 1994. The Executive Council is aware of several areas that the present guidelines overlook, such as partial hospitalization/day treatment programs and the treatment of children with DID. In addition to adding new domains, future revisions of the guidelines will take account of new knowledge arising in the dissociative disorders field.

The guidelines were written by the members of the ISSD Standards of Practice Committee, a diverse and opinionated group who nevertheless found much common ground. Following seven revisions in three years, the committee invited input from ISSD members by publishing a draft in the October 1993 ISSMP&D News. I received about 100 letters from members of the society. Most of the respondents liked the document but wanted minor changes. I summarized their comments and passed on another draft to the committee members. The committee's feedback was incorporated into a final draft that received minor changes from the Executive Council. The Executive Council updated the guidelines in 1996.

I would like to thank the members of the committee for their contributions. Writing this document was a time-consuming and exacting job requiring thought, creativity, and tact from all contributors. I would also like to thank members of ISSD who sent comments after reading the draft published in ISSMP&D News. I hope that ISSD members will continue to provide suggestions and comments to the Executive Council to aid in the next revision of the guidelines.

Given the complexity of dissociative disorders, patients have been frequently misdiagnosed for a period up to 20 or more years. However, considerable progress has been made in the diagnosis, assessment, and treatment of dissociative disorders during the past decade, as reflected by increased clinical recognition of dissociative disorders, the publication of numerous scholarly works focusing on the subject, and the development of specialized diagnostic instruments. As there are at present no controlled outcome studies of different treatment regimens, future research, depending upon the use of new specialized clinical and research tools, will further add to our present understanding of the efficacy of the various therapies for the dissociative disorders.

The guidelines attempt to summarize the numerous publications on the dissociative disorders, including case reports, open clinical trials, and investigations utilizing standardized tools. The guidelines reflect current scientific knowledge and clinical experience specific to diagnosing and treating dissociative identity disorder (DID), supplementing generally accepted principles of psychotherapy and psychopharmacology.

Given the fact that ongoing research on the diagnosis and treatment of dissociative disorders will undoubtedly lead to further developments in the field, therapists are advised to consult relevant published literature subsequent to the publication of these guidelines. It should be noted that the guidelines are not intended to dictate the treatment of specific patients, as treatment should always be individualized. Therapists should always conform to the local mental health code and related laws, as well as to ethical principles of their professional disciplines.

I. Diagnostic Procedures

Accurate clinical diagnosis of the dissociative disorders allows for early and more appropriate treatment and may be supplemented by standardized tests. Such tests, while not designed to replace the clinician's judgment, may provide additional information critical to both diagnosis and/or adequate treatment planning. A mental status examination augmented with questions concerning dissociative symptoms is an essential part of the diagnostic process. Specifically, the patient should be asked about episodes of amnesia, fugue, depersonalization, derealization, identity confusion, and identity alteration (Steinberg, 1995) as well as age regressions, autohypnotic experiences, and hearing voices (usually internal) (Putnam, 1991).

Screening tools such as the Dissociative Experience Scale, Dissociation Questionnaire, Questionnaire of Experiences of Dissociation and informal office interviews are available to identify patients who are at risk for a dissociative disorder (Bernstein & Putnam, 1986; Loewenstein, 1991; Riley, 1988; Vanderlinden, Van Dyck, Vandereycken, Vertommen, & Verkes, 1993). While some investigations also indicate that psychological testing, such as the Rorschach, may help to improve understanding of the patient's personality structure (Armstrong, 1991), other investigators note that the use of tools such as the MMPI and WAIS-R contribute to misdiagnosis of dissociative disorders (Bliss, 1984; Coons & Sterne, 1986). As screening tools and psychological tests are not able to diagnose the dissociative disorders, identified patients should then be evaluated further to rule out a dissociative disorder utilizing more comprehensive methods.

Structured interviews for the detection of dissociative disorders are now available and can be used to confirm a clinician's diagnosis or to identify a previously undetected case. Such tools include the Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised (SCID-D-R) (Steinberg 1994a, 1994b), which allows clinician to systematically evaluate and document the severity of specific dissociative symptoms and disorders, and the Dissociative Disorder Interview Schedule (Ross, 1989), a highly structured interview developed to diagnose dissociative and other psychiatric disorders. Investigations using a diagnostic interview demonstrate that the diagnosis of DID can now be made as reliably as any other psychiatric diagnosis for which a structured interview exists.

The existence of DID might also be unexpectedly revealed during hypnotherapeutic treatment of another condition. Patients with DID who are diagnosed by using hypnosis do not differ with respect to diagnostic criteria and symptoms from DID patients diagnosed without hypnosis (Ross & Norton, 1989). When alternative diagnostic measures have failed to yield a definite conclusion and diagnosis is necessary or in situations of urgency when the establishment of a diagnosis is a matter of medical necessity, hypnosis or amytal interviews may be helpful. However, it should be noted that amytal and hypnosis, which alter the patient's state of consciousness, may yield symptoms that mimic dissociative pathology in patients who do not have DID. Such procedures should avoid leading and suggestive questions and should be used by trained practitioners.

II. Comprehensive Treatment Planning

Depending on individual circumstances, treatment teams may include a variety of professional disciplines. Goals are symptom stabilization, control of dysfunctional behavior, restoration of functioning, and improvement of relationships. These goals must be addressed in an ongoing way, both through direct approaches and through psychotherapeutic work that leads to increased coordination and integration of mental functioning. Close coordination with other medical specialists may be required when there are (1) physical sequelae of child abuse or other violence, (2) prominent somatic expression of traumatic material (i.e., functional or sensory changes that correlate with the patient's reported abuse history) or other psychophysiological symptoms, (3) fears about medical care or similar symptoms. When comorbidity is a problem, the associated diagnoses may require specific treatments. Frequent diagnoses in this category include addictions, eating disorders, sexual disorders, mood disorders, and anxiety. Treatment plans may also include psychoeducational interventions, especially when illness has intruded on normal development. Such interventions may include retraining, education, bibliotherapy, expressive therapies, and other treatments. Patients may have multiple legal involvements, which also may require supportive intervention. In patients who have legal involvement, it is wise to try to avoid planned therapeutic interventions that may compromise the credibility of the patients in forensic proceedings at a later point in time.

III. An Outline of Psychotherapy for DID

A. Integration as an overall treatment goal

The DID patient is a single person who experiences himself/herself as having separate parts of the mind that function with some autonomy. The patient is not a collection of separate people sharing the same body. The terms personality and alter (short for alternate personality) refer to dissociated parts of the mind that alternately influence behavior in DID patients. Some clinicians prefer terms such as disaggregate self state, part of the mind, or part of the self.

Wherever possible, treatment should move the patient toward a sense of integrated functioning. Although the therapist often addresses the parts of the mind as if they were separate, the therapeutic work needs to bring about an increased sense of connectedness or relatedness among the different alternate personalities. Thus, it is counterproductive to urge the patient to create additional alternate personalities, to urge alternate personalities to adopt names when they have none, or to urge that alternate personalities function in a more elaborated and autonomous way than they already are functioning in the patient. It is counterproductive to tell patients to ignore or get rid of alternate personalities. Also, the therapist should not play favorites among the alternate personalities or exclude unlikable or disruptive personalities from the therapy, although such steps may be necessary for a period of time at some stages in the treatment of some patients.

Additionally, the DID patient is a whole person, with alternate personalities of adult patients sharing responsibility for his or her life as it is now. In the psychotherapeutic setting, therapists working with DID patients generally ought to hold the whole person to be responsible for the behavior of all of the alternate personalities.

B. Framework for Outpatient Treatment

The optimal primary treatment modality for DID is usually individual outpatient psychotherapy. Although the patient's feelings and preferences need to be explored while devising and implementing a treatment plan, the therapist, not the patient, ought to be the primary architect of the treatment plan. The minimum number of sessions provided per week should reflect the patient's functional status and stability. The minimum recommended frequency of sessions for the average DID patient with a therapist of average skill and experience is twice a week. Some therapies, especially with patients of high motivation and strength, can be conducted on a once-a-week basis either with a single prolonged session or with a single session. Some therapists of considerable skill and experience are able to treat many such patients in once-a-week psychotherapy. With some patients, a greater frequency of scheduled sessions (up to three per week) aids the patient in maintaining the highest possible level of adaptive behavior and (as an alternative to hospitalization) in containing disruptive behavior. For patients newly discharged from inpatient treatment, a period of sessions at a greater frequency may sometimes be necessary to help the patient make the adjustment from the high frequency of sessions provided in many inpatient programs. If more than three sessions per week are routinely provided, the therapist should note the risk of fostering regressive dependence on the therapist.

Marathon, or lengthy sessions (i.e., sessions longer than 90 minutes), if used, should be scheduled, structured, and have a specific focus such as completion of amytal- or hypnosis-assisted processing of traumatic memories and imagery, or administration of a diagnostic battery. Lengthy sessions may also be used judiciously for the provision of structure and support in dealing with difficult material. They may also be indicated when logistics force the patient to come to the therapist infrequently, but to work intensely when there.

Opinions diverge on the length of treatment. Early anecdotal reports on treatment outcome showed that over 2-3 years of intensive outpatient psychotherapy, patients could reach a relatively stable condition in which they did not experience a sense of internal separateness. However, most therapists now see 3-5 years following the diagnosis of DID as a minimum length of treatment, with many of the more complex patients requiring 6 or more years of outpatient psychotherapy, often with brief inpatient stays during crises. The length of treatment varies with the complexity of the patient's dissociative pathology, usually lengthening with severe Axis II pathology or other significant comorbid mental disorders.

The most commonly cited treatment orientation is psychodynamically aware psychotherapy, often eclectically incorporating other techniques (Putnam & Loewenstein, 1993). For example, cognitive therapy techniques can be modified to help patients explore and

alter dysfunctional trauma-based belief systems; however, standard cognitive therapy protocols for depression and anxiety usually require modification when used in the treatment of DID. Most therapists employ hypnosis as a modality in the treatment of DID (Putnam & Loewenstein, 1993). The most common uses of hypnosis are for calming, soothing, containment, and ego strengthening.

Behavioral analysis, or operant conditioning, has not been shown to be an optimal primary modality for treating DID. Aversive conditioning is particularly not recommended because the therapeutic relationship and treatment procedures may unconsciously resemble abusive experiences. However, behavior modification techniques may be useful when taught to the patient as self-control techniques for symptom management.

C. Inpatient Treatment

There is general agreement that inpatient treatment for DID should be used for the achievement of specific therapeutic goals and objectives. Treatment should occur in the context of a goal-oriented strategy designed to restore patients to a stable level of function so that they can resume outpatient treatment expeditiously. This remains the case, whether the hospitalization is emergent or planned, on a specialized or a general psychiatric unit. Efforts should be made to identify what factors have destabilized or threaten to destabilize the DID patient and to determine what must be done to alleviate them, if possible, and to minimize their impact. Emphasis should be placed on building strengths and skills to cope with the destabilizing factors. Optimally, these interventions should be planned and contracted for prior to or very early during an admission, but it is acknowledged that this may not be possible. Planned judicious processing of traumatic material (sometimes called abreactive work), confronting traumatic material in the supportive structure of a hospital setting, and working with aggressive and self-destructive alters and their behaviors are frequent concerns.

There is a general agreement that decompensation or failure to improve during a hospitalization may occur in several circumstances. There is consensus that DID patients often require hospital care for other intercurrent mental disorders, such as major depression or anorexia nervosa. There is consensus that a small minority of DID patients, including massively decompensated and dysfunctional individuals, and those destabilized by severe present-day trauma, may require prolonged inpatient treatment in order to be restabilized. Treatment-related factors that may impede clinical improvement include unfocused inpatient treatment or inpatient treatment with global and unrealistic goals, such as “getting out all of the memories,” an exclusive focus on past traumatic material to the exclusion of contemporary issues, or pushing for rapid integration early in treatment.

There is a divergence of opinion as to whether brief stays are less likely to be associated with regressive dependency than longer stays. Some find instances in which they suspect that longer hospital stays are conducive to regression. Others find instances in which it appears that a pressure to keep hospital stays short leads to discharge of the patient in an insufficiently stable state and at greater risk for readmission or undue suffering. Regardless of the length of the patient’s hospitalization, the therapist should maintain a stance that encourages progression and independence.

There is agreement that DID patients optimally should be treated in a manner that prepares them to do the work of therapy on an outpatient basis, including processing traumatic material when necessary. There is also agreement that for some overwhelmed patients and for a variety of patients under some circumstances, the structure and safety of a hospital setting make possible therapeutic work that would be impossible or prohibitively destabilizing in an outpatient setting.

D. Group Therapy

Group psychotherapy is not a viable primary treatment modality for DID. However, some believe that time-limited groups are a valuable adjunct to individual psychotherapy in promoting a sense in patients that they are not alone in coping with dissociative symptoms and traumatic memories. Carefully structured groups with a high leader-to-patient ratio, a clear focus, and clear time frames seem indicated. Some have found that open-ended therapy groups promote acting out among the group members and do not have a positive outcome; others report that such groups have been a helpful adjunct to individual psychotherapy, particularly where the leader describes clear expectations in areas such as extra-group contact among members and therapeutic boundaries (see Appendix 1). Some patients utilize 12-step groups effectively as an adjunct to their individual psychotherapy. Marathon groups (i.e., longer than 2 or 2_ hours) may prove destabilizing for some DID patients.

E. Electroconvulsive Therapy

ECT has not been shown to be an effective or appropriate treatment for dissociative disorders, but it may be important in relieving an associated refractory depression.

F. Psychosurgery

There is no evidence to support the use of psychosurgery in the treatment of DID.

G. Pharmacotherapy

Psychotropic medication is not a primary treatment for dissociative disorders, and specific recommendations for pharmacotherapy of dissociative disorders await systematic research. However, anecdotal reports support the use of various medications for purposes such as treating some anxiety-related dissociative symptoms, posttraumatic stress disorder symptoms, and coexisting affective symptoms or disorders. Most therapists treating DID report that their patients have received medication as one element of their treatment (Putnam & Loewenstein, 1993). Therapists prescribing medication need to make patients aware when any medication protocol is experimental in nature, following applicable ethical and legal guidelines. Doctors who prescribe medication and therapists who treat patients on medication need to be aware that personality states within the same patient may report different responses and side effects to the same medication.

H. Therapist telephone availability

Because many DID patients are prone to crises at certain points in treatment, patients need a clear statement about the therapist's availability in emergencies. Generally, offering regular, unlimited telephone contact is not helpful, but providing for limited availability to the patient on a predefined basis is essential. Except under unusual circumstances, regular calls initiated by the therapist to check in with the patient are not recommended. The payment policy for telephone contact should be discussed with the patient in advance wherever possible.

I. Scheduling extra sessions

Although extra sessions are sometimes needed, when the patient frequently requests or requires the scheduling of extra sessions because of crises, the therapist needs to examine whether the patient perceives the scheduled frequency of sessions to be adequate for his or her needs. As in any requested gratification of a patient's need, the therapist needs to examine such requests in the light of the patient's unconscious wishes for reparenting or for other emotional gratification from the therapist. Repeated crises may also reflect the patient's inability at that time to function outside a structured full or partial hospital setting.

J. Physical contact

Physical contact with a patient is not recommended as a treatment technique. Therapists generally need to explore the meanings of patient requests for hugs or hand-holding, for example, rather than fulfilling these requests without careful thought and consideration. Simulated breast-feeding or bottle feeding are unduly regressive techniques that have no role in the psychotherapy of DID. Some therapists find that for some patients undergoing planned abreactions, holding the patient's hand or resting a hand on the patient's arm may help the patient stay connected to present-day reality. However, other therapists feel that patients may misinterpret such contact and that it should be avoided. Some patients may seek out massage therapy or other types of body work; the risks and timing of such work should be carefully discussed with the patient and the adjunctive therapist.

Sexual contact with a current patient is never appropriate or ethical. Laws and ethical standards of the various healthcare disciplines regulate such contact with a past patient. Because DID patients have a relatively high vulnerability to exploitation and because of the intensity of the therapeutic interactions that DID patients have with their therapists, any sexual contact a therapist might have with his or her former DID patient would be likely to be exploitive and therefore inappropriate.

K. Physical restraint

There is a divergence of opinion on the value of voluntary physical restraint in treatment. Some believe that the technique is a helpful last resort when physically aggressive or self-destructive alternate personalities are otherwise unable to participate in therapy. Others believe that voluntary physical restraint is inappropriate and that verbal techniques will suffice to involve all the personalities in therapy. If physical restraint is being used with great frequency and/or for prolonged periods, the therapist should reassess the pace of the therapy and the dynamics of the patient-therapist relationship.

In inpatient treatment, seclusion and physical restraint may be indicated for the DID patient who is acting out violently and has not responded to verbal or pharmacological interventions. These treatment modalities should always be applied in accordance with the legal and ethical standards applicable to the inpatient unit and the professional disciplines involved in implementing them.

L. Hypnotherapy

DID experts generally agree that hypnotic techniques can be useful in crisis management to help patients terminate spontaneous flashbacks and reorient themselves to external reality when these states occur outside therapy. Hypnotic techniques are also useful for ego strengthening and for supporting DID patients during crises, and to help patients remain stable between sessions in which they are recalling or discussing traumatic material. Other commonly described uses of hypnosis include its roles as an aid in the safe expression of feelings (e.g., the "silent abreaction" for the release of anger), cognitive rehearsal and skill building, relief of painful somatic representations of traumatic material, and fusion rituals (when previous psychotherapeutic work has caused a particular separateness to no longer serve a meaningful function for the patient's intrapsychic and environmental adaptation and when the patient is no longer narcissistically invested in maintaining the particular separateness). In the hospital, staff can be trained to calm the patient exhibiting violent behavior by means of temporizing techniques but without using formal hypnosis unless credentialed to do so by the

hospital (Kluft, 1992). When these techniques are employed, the patient is generally informed beforehand and the intervention becomes part of the nursing treatment plan.

There is a divergence of opinion concerning the role of hypnosis in the ongoing psychotherapy of DID. Some believe that hypnotic techniques are useful in increasing communication between alternate personalities or in bringing alternate personalities into communication with the therapist. Some believe that hypnotic techniques are useful in memory retrieval; others believe that hypnotically facilitated memory processing increases the patient's chances of mislabeling fantasy as real memory and increases the patient's level of belief in "retrieved" imagery that may actually be fantasized. The therapist needs to be aware that hypnosis induced by the therapist may leave patients with an unwarranted level of confidence in the accuracy of the details in hypnotically retrieved material. The therapist should minimize the use of leading questions that may in some cases alter the details of what is recalled in hypnosis.

The therapeutic use of hypnosis should be conducted with appropriate informed consent provided to the patient concerning its possible benefits, risks, and limitations.

M. Veracity of the patient's memories of child abuse

Frequently, DID patients describe a history of abuse, usually including sexual abuse, beginning in childhood. Many DID patients enter therapy having continuous memory for some abusive experiences in childhood (Barach, 1996; Ross et al., 1990). In addition, most also recover memories of additional previously unknown abusive events, with recovery of material occurring both inside and outside of therapy sessions, and sometimes prior to the commencement of psychotherapy. Discussion of this material and its relationship to present beliefs and behaviors is a central aspect of the treatment of DID.

Clinicians and researchers have issued several statements concerning recovered memories of abuse (American Psychiatric Association, 1993; Australian Psychological Society Limited Board of Directors, 1994; Working Group on Investigation of Memories of Childhood Abuse, 1996; Working Party, 1995). These statements all concluded that it is possible for accurate memories of abuse to have been forgotten for a long time, only to be remembered much later in life. They also indicate that it is possible that some people may construct pseudomemories of abuse and that therapists cannot know the extent to which someone's memories are accurate in the absence of external corroboration. Patients' recall of child abuse experiences, as well as their recall of other experiences, may at times mix literal truth with fantasy, confabulated details, or condensations of several events. Therapy does not benefit from telling patients that their memories are false. Neither does therapy benefit from telling patients that their memories are accurate and must be believed. A respectful neutral stance on the therapist's part, combined with great care to avoid suggestive and leading interview techniques, seems to allow patients the greatest freedom to evaluate the veracity of their own memories.

There is a divergence of opinion in the field concerning the origins of patients' reports of seemingly bizarre abuse experiences. Some believe that patients' reports can be the result of extremely sadistic events experienced by the patient in childhood, perhaps distorted or amplified by the patient's age and traumatized state at the time of the abuse. Others believe that alternative explanations suffice to explain these patients' reports. Therapists who take extreme positions on either side in the therapy setting may diminish the likelihood of timely progress toward the patient's clarification of the historical accuracy of such memories.

N. Management of Traumatic Memories (abreactions)

Traumatic material may surface spontaneously, or its processing may be planned; both situations occur in the treatment of DID patients. The use of planned processing of traumatic material (abreactions) is a treatment technique of value with many patients but is not a therapy in itself. Patients benefit when the therapist helps them use planning, information, exploration, and titration strategies to develop a sense of control over the emergence of traumatic material. When patients spontaneously experience intrusive traumatic imagery, they often benefit from learning strategies that help them delay or control the level of intrusiveness of the traumatic material into their daily functioning. However, some patients develop such control more rapidly than others.

Clinicians experienced in treating DID agree that therapeutic attention to emergent traumatic material is an essential part of the resolution of dissociative pathology. Ignoring this material does not make it "go away," although the timing and nature of therapeutic attention paid to this material will vary according to the needs of each patient.

Many clinicians believe that occasionally extending preplanned trauma memory-processing sessions beyond their usual length is of distinct value in the treatment of some patients. At certain times such a session will unavoidably extend past its scheduled endpoint, but the therapist should try to minimize this. Therapists need to attempt to help patients to reorient themselves to external reality and end processing of traumatic memories before the scheduled end of therapy sessions, although they can only influence, never control, the patient's ability to reorient to the present.

O. Nonverbal adjunctive therapeutic approaches

Like other victims of childhood trauma, DID patients are often uniquely responsive to nonverbal approaches. Art therapy, occupational therapy, sand tray therapy, movement therapy, other play therapy derivatives, and recreational therapy are reported as helpful toward achieving treatment goals, including integration. Nonverbal therapies need to be conducted by appropriately trained

persons and be well timed and well integrated into the overall treatment plan. Many psychotherapists find nonverbal techniques (such as patients' drawings and journals) useful as part of ongoing psychotherapy.

P. Fees

Therapists should follow relevant legal and ethical guidelines concerning disclosure of fees, payment arrangements, barter, and collections procedures.

IV. Publications and Interactions with the Media

In all interactions with the media concerning DID, the therapist's primary responsibility remains the welfare of his/her patients. Thus, the therapist must maintain the highest ethical and legal standards of confidentiality with respect to clinical material.

Appearances by patients in public settings with or without their therapists, especially when patients are encouraged to demonstrate DID phenomena such as switching, may consciously or unconsciously exploit the patient and can interfere with ongoing therapy. Therefore, it is generally not appropriate for a therapist actively to encourage patients to "go public" with their condition or history.

V. The Patient's Spiritual and Philosophical Issues

Like other victims of trauma by human agency, DID patients may struggle with questions of moral responsibility, the meaning of their pain, the duality of good and evil, the need for justice, and basic trust in the benevolence of the universe. When patients bring these issues into treatment, ethical standards for the various professional disciplines specify the need to conduct treatment without imposing one's own values on patients. Although patients may experience certain personalities as demons and as not-self, therapists should approach exorcism rituals with extreme caution. Exorcism rituals have not been shown to be an effective treatment for DID, have not been shown to be effective for "removing" alternate personalities, and have been found to have deleterious effects in two samples of DID patients that experienced exorcisms outside of psychotherapy. Exorcism rituals may provide a way for some patients to rearrange images of their personality systems in a culturally syntonic manner. Education and coordination between therapist and clergy can be helpful in ensuring that patients' religious and spiritual needs are addressed

VI. Patients as Parents

Because many DID patients may have difficulty in parenting and a minority admit to being abusive toward their children, and also because DID may involve a biological predisposition to dissociate, some have recommended that the children of DID patients be assessed by a therapist familiar with dissociative disorders and indicators of child abuse. Other family interventions, such as couples therapy and sibling group sessions, may be indicated.

Appendix 1: Boundary Management

Victims of child abuse or neglect have generally grown up in situations where personal boundaries were either not established or were invaded. For this reason, their treatment ought to include a therapeutic relationship with clear boundaries. The therapist is responsible for clearly defining such a therapeutic relationship.

Boundary issues arise throughout treatment, with negotiation and discussion of these issues occurring as needed. Most experts agree that the patient needs a clear statement near the beginning of treatment concerning therapeutic boundaries. This statement may not always be understood immediately by the patient, may take several sessions to convey, and may require repetition at various points in the therapy. The discussion concerning therapeutic boundaries might include some or all of the following issues: length and time of sessions, fee and payment arrangements, the use of health insurance, confidentiality and its limits, therapist availability between sessions, procedure if hospitalization is necessary, patient charts and who has access to them, the use (or nonuse) of physical contact with the therapist, involvement of the patient's family or significant others in the treatment, discussion of the therapist's expectations concerning management by the patient of self-destructive behavior, legal ramifications of the use of hypnosis as part of the treatment (i.e., material recalled in trance is not likely to be admissible evidence in any legal action undertaken by the patient), among others.

Treatment should ordinarily take place in the therapist's office. It is not appropriate for a patient to stay in the therapist's home or for members of the therapist's family to have ongoing extratherapeutic relationships with the patient. Treatment usually occurs face to face instead of on the analytic couch, though the latter is also acceptable for therapists with psychoanalytic training. Treatment should ordinarily take place at predictable times, with a predetermined session length under most circumstances. Clinicians experienced in treating DID generally strive to end each session at the planned time.

Therapists need to follow relevant legal and ethical codes with respect to gifts exchanged by the therapist and patients, dual relationships, and informed consent for treatment.

What is D.I.D. or Multiple Personality Disorder?

Multiple Personality Disorder (MPD) was defined in DSM-III-R[1] as being:

A. The existence within the person of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these personalities or personality states recurrently take full control of the person's behavior.

In DSM-IV[2] MPD was renamed Dissociative Identity Disorder.

Dr. Colin Ross one of the leading experts in the field, is a psychiatrist whose experience is primarily within a hospital setting and in research. In his book on MPD he provides a wealth of information on this condition. He describes MPD (using a female patient as an example) as follows.

MPD can be diagnosed with a high degree of validity and reliability. However, it will not be recognized without making a specific inquiry for its signs and symptoms. This inquiry is not part of a standard psychiatric assessment, which is why so many cases are missed....

What is MPD? MPD is a little girl imagining that the abuse is happening to someone else. This is the core of the disorder, to which all other features are secondary. The imagining is so intense, subjectively compelling, and adaptive, that the abused child experiences dissociated aspects of herself as other people. It is the core characteristic of MPD that makes it a treatable disorder, because the imagining can be unlearned, and the past confronted and mastered....

MPD is not a fantastic curiosity in which there is more than one person in the same body. There is only one person, an abuse victim who has imagined that there are other people inside her in order to survive. This is an adaptive use of the human imagination that, at least in its rudiments, appears to be available to a large segment of the population. Because childhood sexual and physical abuse are common and the ability to create alters is common, MPD should be far from rare, both in its full classical form and in partial forms.[3]

Dr. Frank W. Putnam, another leader in research about MPD, and who has significant experience in both in-patient and out-patient treatment of MPD, has described the alternate ("alter") personalities in his book on MPD:

The core feature of MPD is the existence of alter personalities who exchange control over an individual's behavior. It is important to state from the outset that whatever an alter personality is, it is <u>not</u> a separate person....

For our present purposes, however, the most useful clinical definition is the one developed by Braun and Kluft over the course of several American Psychiatric Association workshops on MPD. They define an alter personality as "an entity with a firm, persistent, and well-founded sense of self and a characteristic and consistent pattern of behavior and feelings in response to given stimuli. It must have a range of functions, a range of emotional responses, and a significant life history (of its own existence)."[4]

The first cases of MPD diagnosed had complete amnesia between personalities. It was this particularly striking feature of MPD that made its discovery possible and can simplify its diagnosis. A primary "host" personality would generally come to therapy and be completely unaware of the other personalities. ("Host" is the designation given to the personality who has control of the body the greatest percentage of the time. (Putnam, 1989) When another "alter personality" (also known as a "part") would be in control of the body or "out" (also called having "executive control") the "host" would have a blackout or "lose time." (Changing executive control is called "switching."[5]) When the "host" would come back out, he or she would often find him or herself somewhere with no recollection of how he or she got there, or notice that he or she lost a block of time. The time could be minutes, hours, days, or even longer.

As more has been learned about MPD, other forms of the condition have been identified, including systems in which the "host" is totally amnesic to the other parts, but the other parts are fully aware of the "host," systems in which some parts are amnesic and others are co-conscious,[6] and systems where all parts are co-conscious. There are also different degrees of amnesia and co-consciousness between parts.[7] Generally, when parts are co-conscious, they are aware in the background of the alter who is out, can see and hear everything that is going on outside the body, but do not control what the shared body is saying and doing. Likewise, when co-conscious, the part which is out is aware of any mental comments of the alters in the background.

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Shouldn't multiples be hospitalized?

MPD has been presented in the media and most biographical material at its most "interesting." An example of this would be the movie "Sybil." Most multiples, however, do not switch into child alters in the course of their normal workday and start playing in a fountain in the park. Some multiples are "high functioning," never require hospitalization and take little, if any, time off from their jobs or responsibilities in the home in order to complete the intense therapeutic work required to heal. Many are professionals and highly educated.[8] Some multiples need to go on short-term disability while they are are going through the most difficult phases of therapy. Others require temporary hospitalization, not because they are out of touch with reality, but for their own protection when they

become suicidal as the extreme traumas surface.

MPD is classified as a dissociative disorder, not a psychosis. Multiples are not crazy; they are people who have developed a very sophisticated way of coping with severe childhood abuse.

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Why does it take so much therapy, hard work and time to heal?

People with MPD almost without exception developed the condition in response to extreme trauma in childhood. It takes time to bring to the surface the repressed memories and work through the feelings that it was not safe to experience at the time the abuse took place. It is recommended that sessions an hour and a half to two hours in length be scheduled two to three sessions times a week for out-patient treatment (Putnam, 1989). And before this work can start, it is necessary to establish safety and trust in the therapeutic relationship. This, in itself, can take considerable time depending on the individual and the depth of the traumas. Ross observes:

MPD patients are among the most disturbed individuals who seek the services of mental health professionals, yet they are often among the most treatable. The treatment must be guided by an understanding of the nature of MPD and its historical antecedents. The complex details of the personality system can overwhelm the therapist who doesn't have a broad framework within which to conduct therapy.

The process of diagnosing an MPD patient leads naturally into the treatment, because the vast majority of patients have been severely traumatized in childhood. The trauma makes itself known in an array of symptoms and disturbed behaviors that fall into a pattern if the diagnostician knows what pattern to look for.[9]

Once diagnosed correctly, work must be done with the personalities to develop co-operation with each other and co-consciousness.[10] Also normal therapy for childhood abuse must be pursued,[11] with the added complication of working with more than one personality in therapy. Once co-conscious the multiple can function with less disruption to his or her life due to losing time, and this is less stressful and confusing for those he or she is in relationship with. Once co-operation and co-consciousness is established, and the painful work (often including abreactions) of remembering and healing from the abuse that caused a part to split is done, integrating personalities may be done.[12] When the parts integrate, they do not die (although they commonly fear they will) but merge or fuse together. All of the characteristics of each separate part are retained in the merged, single personality.[13] At some point, the client must eventually decide whether or not to continue therapy through all the way to full integration.

From diagnosis to integration, one study found that it typically took two to five years *with a skilled therapist knowledgeable about MPD.* Less than two years to integration is only possible with a handful of particularly expert therapists.[14] Also, the number of personalities affects how long the healing process will take (Putnam, 1989, p. 124). And some additional post-integration therapy is also required to help the integrated multiple (or former multiple) to learn new coping skills. However, the success rate (without relapse) is good. Ross, who studied almost exclusively cases which required hospitalization, estimated that 80% of the cases would reach stable integration (27% already had at the time the book went to press) (Ross, 1989). Former multiples who have attained stable integration typically prove to be very talented and successful.

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Why can't multiples be cured with drugs?

MPD is not an organic disorder or chemical imbalance. Sometimes antidepressants are prescribed to help the multiple through a suicidal phase, but antipsychotic drugs generally only make matters worse. Electroconvulsive Therapy in particular is definitely not helpful in treating MPD (Ross, 1989, Putnam, 1989). There is nothing wrong with a multiple's brain (in fact, most multiples are mentally and/or artistically gifted).

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What is the likelihood of successful treatment?

Richard P. Kluft, M.D. studied multiples who attained integration of all personalities into a single, whole person. He followed fifty-two patients for over eight years post-integration. Of those patients, only eleven had the return of dissociative symptoms. These are not always true relapses. Some are personalities who resplit (this is generally due to insufficient working through of trauma memories and feelings) and some are the discovery of additional groups of personalities that were present, but unknown, at the time of their apparent final integration. In other cases, the patient faked their integration or created new alters. This means that 78.8% had no further problems with dissociation, and of the whole group, 94.2% never returned to full MPD (Kluft, 1986).

There are several factors which contribute to relapse. Sometimes personalities will pretend to be integrated in order to avoid dealing with painful memories or issues. Some personalities will "hide out" in order to maintain their separateness: some for selfish reasons, others because they felt they were still needed to help the host personality in some way. When personalities resplit, it is often because additional traumatic material still needs to be worked through. It is easy to think that the personality is finished when a lot of very painful material has been already worked through. Sometimes it is hard to imagine that anything *worse* could have happened, when it has. In other cases, personalities resplit when integrations were rushed in order to please the therapist or a client would feign full integration in order to avoid true full integration. A slower pace of treatment and a deemphasis of integration usually lessens these pitfalls (Kluft, 1986).

The return of dissociative symptoms within the first week of full integration was usually associated with the previous pitfalls or any external pressure to integrate. From one week to three months, the return of dissociative symptoms was most commonly due to resplitting in order to work through additional trauma memories and feelings or insufficient coping skills. When a multiple does not have good coping skills, when painful life experiences cross his or her path he or she will often resort to dissociating in order to be able to deal with distress, stress or conflict. After the first three months are past following full integration, Kluft found that for the next two years the most common reason for dissociation to appear to return was the discovery of preexisting alters that had not yet been treated in therapy. This tended to happen more in patients with over eighteen personalities. After those two years had passed, the reemergence of dissociative symptoms was rare (Kluft, 1986).

In Kluft's study, the most important factors in preventing the return of dissociative symptoms were: patient motivation, the experience and skill of the therapist, the quality of the relationship between therapist and patient, and continuing on with therapy after full integration. Sometimes it is necessary for post-integration therapy to be longer than the time required to attain full integration (Kluft, 1986).

How many personalities can multiples have?

This depends on several different factors: how old the child was when the abuse started, the nature (Putnam, 1989), extent and frequency of the abuse, and aptitude for dissociation.[15] In clients with MPD, Ross found an average of 16 personalities.[16]

The personalities are of varying ages: as young as babies, children, teenagers, as old as the multiple's physical age, or even older. Both child and adult parts can carry memories of the abuse. Some of them may be created to have no knowledge of the abuse, so that the child could go to school, be with friends, etc., without revealing the abuse. Many multiples will also have opposite sex personalities (Putnam, 1989). This is not a reflection of the multiple's sexual preference.[17]

There are many kinds of personalities. The host personality is typically the one who is "out" most of the time. He or she will often be depressed or anxious, have problems feeling his or her emotions, be perfectionistic, and will often suffer from various physical symptoms, especially headaches (Putnam, 1989).

There are protectors, who can be calm and mature or aggressive and volatile. Protector personalities are very important to the multiple's survival and are often enlisted by the therapist to keep other personalities from causing physical harm to the multiple's body.[18]

Observers are parts who generally sit in the background and watch what's going on and may signal different parts to come out as needed (Ross, 1989).

Some of the most difficult personalities to work with can be persecutor personalities. Ross describes them as often appearing to be:

"...tough, uncaring and scornful, but this is usually just a front for an unhappy, lonely, rejected self-identity. One persecutor I worked with was abusing the other personalities because she felt rejected, because she felt they did not appreciate the hard work she did holding all the anger, and because they were always blaming her for everything that went wrong."[19]

And Putnam observes about persecutors:

Many multiples become socially isolated because the persecutors deliberately alienate their friends.... They may threaten to harm the patient if significant information is revealed to the therapist and in some cases they may threaten to harm the therapist unless the host withdraws from treatment....

They usually express extreme contempt toward the host.... paradoxically, the dominant emotion of the persecutor toward the host may really be love....

The persecutors also function to maintain the silence and secrecy that have surrounded the past abuse. Initially, this may also have been a life-protecting role....

In many instances, the host is actually abusing the persecutors. Usually this is through an unknowing suppression or a dimly aware rejection of the persecutor.... Many of these destroyers become healers at a later stage in the therapy.[20]

But when an effort is made to understand the persecutor's reasons behind the abusive behavior, the persecutor may spontaneously take on another role, often the role of protector.

Some multiples will have a personality or personalities who handle sexual matters, and not always in functional ways.[21]

There will frequently be other personalities who take on certain jobs in the multiple's life, such as going to work, raising children, handling social functions. Some of these may be very specialized "personality fragments" who "lack the depth and breadth of a personality and have only a very limited range of affects, behaviors and life history" (Putnam, 1989) and who do only one thing, such as the dishes.

Each multiple's inner family of per sonalities is different and unique, just as all human beings are different and unique.

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I thought the personalities were really demons. Why can't we just exorcise them?

Writers in the field of MPD differ as to whether or not they believe in the existence of demons or negative entities, however, in the DSM-IV a new disorder which describes possession, called Dissociative Trance Disorder, has been provided for further research. In discussing differential diagnosis, the manual states:

Individuals with Dissociative Identity Disorder can be distinguished from those with trance and possession symptoms by the fact that those with trance and possession symptoms typically describe external spirits or entities that have entered their bodies and taken over.

This proposed disorder should not be considered in individuals who enter trance or possession states voluntarily and without distress or impairment in the context of cultural and religious practices.[22]

Alter personalities show many characteristics which distinguish them from demonic possession as illustrated in the Bible and Christian literature. One of the most telling differences is that alter personalities cannot be exorcised or "cast out." The alter personalities are *parts* of the whole person, not separate beings. And by the same token, by definition, if present a demon *cannot* be integrated to become truly unified with the rest of the personalities to make one single personality when integration of all alters is completed.

To present one opinion representing a Christian perspective, James G. Friesen, a psychologist, suggests the following criteria for distinguishing between demons and alters:[23]

1. Most alters, even "Persecutor" alters, can become strong allies. There is a definite sense of relationship with them, even if it starts out negative.

Demons are arrogant, and there is no sense of relationship with them.

2. Alters initially seem ego-dystonic but that changes to ego-syntonic over time.

Demons remain ego-alien -- "outside of me."

3. Confusion and fear subside with appropriate therapy when only alters are present.

Confusion, fear and lust persist despite therapy when demons are present.

4. Alters tend to conform to surroundings.

Demons force unwanted behavior, then blame a personality.

5. Alters have personalities with accompanying voices.

Demons have a negative voice which has no corresponding personality.

6. Irritation, discontent and rivalry abound among alters.

Hatred and bitterness are the most common feelings among demons.

7. Images of alters are human in form and remain consistent during imagery.

The imagery of demons changes between human and non-human forms, with many variations.[24]

Friesen observed using these criteria that occasionally both alters and demons will be found in the same client. The demons could be exorcised, never to return or resurface. If, however, a mistaken attempt to exorcise an alter was made, the alter personality would go "underground" for a while and resurface later (Friesen, 1991). When a mistake of this kind is made, much work has to be done to undo the emotional and spiritual abuse done to the alter personality in being labeled a demon and asked to leave. In addition, in the process

of being subjected to spiritual abuse as a child, some alters were told they were demons, when they were not, and to "cast out" (or exorcise) such an alter, reinforces the childhood abuse. Further, if someone attempts to cast out a personality, and the personality actually believes he or she is a demon (and is not in truth a demon), he or she won't believe he or she can change for the better! If this mistake is made by the multiple's therapist, it will require much work to restore the therapeutic relationship with that alter.

Readers with a Christian world view that includes the active presence of demons in the world today, may wish to note the following comments. Many Christians who work with multiples[25] believe it is possible to have the following situations: 1) someone who is not multiple, but is possessed by one or more demons, 2) someone who is multiple who has no demons whatsoever,[26] and 3) someone who is multiple and also has one or more demons.[27] In the third case, it often happens that a demon, or demons, is attached to an alter personality instead of the host. In this case, sometimes it is the alter personality who receives the deliverance ministry and renounces for him or her self whatever led to the demonization in the first place. Unfortunately, however, when a multiple is in need of deliverance there are often more than one demons associated with more than one personality and other demons which are not associated to any one particular personality, but rather to the person as a whole. In these cases it is much less time consuming to rid the person of groups of demons at once and this may be done for groups of alters at once. Using this approach only God differentiates the demons from the personalities, eliminating the possibility of human error resulting in alters being inadvertently treated as demons. Space does not permit a detailed description of this approach.[28] More recently several books on deliverance now make mention of the possibility of MPD and demonization co-existing, however to date very little detailed information is available on how to proceed in such cases.[29]

Within some Christian circles today there is a lot of talk of "spiritual warfare" and "deliverance." We recommend that before performing an exorcism or deliverance, due consideration be given to whether or not what is happening really is demonic, and that a trained professional Christian counselor, knowledgeable in dissociative disorders, be involved in this determination.[30] We also recommend that counselors be involved in the deliverances performed. Even if no MPD is present, exposure to demons is traumatic, and caring professional help during and after deliverance would be very beneficial.

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My friend says he or she is multiple, but since he or she started therapy he or she seems to be getting worse, not better!

This is typical for any kind of treatment for childhood trauma. It is a bit like having an infected wound: to open it up again to clean it out and apply antibiotics is very painful, but it is the only way to heal. Some multiples will accuse a therapist of "making them worse" when they go through their healing process because of the extremely painful memories and feelings that are uncovered (Putnam, 1989).

Like most healing processes, an improvement is often followed by a relapse (Putname, 1989). And like many survivors of trauma who do not have MPD (sometimes called "singletons,"[31] although the word "singular" is sometimes preferred as sounding nicer), suicidal and self-destructive urges are not unusual and are often chronic and pronounced. "Episodes of self-mutilation are frequently triggered by disclosures in therapy of past trauma, and the warning or messages left by the persecutors often explicitly specify that any further revelations will be met with more injury or death." (Putnam, 1989) Other times suicidal urges will come from the amount of pain and changes in their life, powerful feelings of anger that they cannot express outwardly, and fears of being abandoned or rejected by friends and loved ones, and especially their therapist. Over 61% of MPD therapists reported having a patient attempt suicide. Although lethal attempts are infrequent, they have been known to occur. (Putnam, 1989) This is one of the jobs that protector personalities take on, they frequently step in, take executive control away from the suicidal alter and get help before it is too late.

Before a multiple is diagnosed, he or she will often be unaware of the switching. This lack of awareness is generally due to amnesia ("losing time" while another personality is "out") or because the other personalities work so hard at hiding the multiplicity that they try to act as much like each other as possible, to keep the secret of their condition. When the secret is exposed, when someone else knows he or she is a multiple, then the personalities can "relax" and be themselves. Putnam (1989) says that, "the diagnosis of MPD is often a liberating event for multiples...." This makes them appear to become more distinct from each other, when they may just be behaving more naturally. Also, once someone else knows a person is multiple, the person becomes more aware of the alters because he or she starts looking for the differences between personalities. (Putnam, 1989) As the multiple learns to accept and work with his or her alternate personalities, he or she gains more control over switching between personalities. (Putnam, 1989) One way to facilitate this control to learn to switch between alters by choice.

Another dynamic of healing from MPD is that as some alters are allowed to express themselves and be known, others that have been "hiding" for years may feel safe to come out and be known too. As more and more personalities become known, the multiple's life will appear to be growing more chaotic. Also, many multiples find that as they integrate parts together, other parts which have been previously unknown to the host will surface to take the niche left open by the joining together of personalities. And some multiples have personalities that are organized in groups or layers. (Putnam, 1989) An observer personality in one group or layer may think he or she knows all the personalities, only to find later that he or she was unaware of whole other groups or layers.

Many multiples will tend to "switch" more after entering therapy because the "host" or other dominant personalities are learning to love and accept the other personalities and share the opportunity to be out in the world to receive love and nurture in order to heal.

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What can I do to support someone who has multiple personalities?

Some of Ross's recommendations concerning the treatment of multiples include:

1. Help each alter personality to understand that he or she is one part of a whole person.

2. Use the alters' names as convenient labels, not licenses for irresponsible autonomy.

3. Treat all alters fairly and empathically.

4. Encourage empathy and cooperation between personalities.

5. Be gentle and supportive. Remember the severity of the trauma.

6. Do not dramatize symptoms such as amnesia.[32]

This writer also adds the following suggestions.

Multiples, particularly the "host," will frequently have a lot of denial about the diagnosis and will sometimes go in and out of denial about it. Occasionally they will claim to have "made it all up."[33] Some host personalities will remain in denial up until the final integration.

Most multiples will contract with all their parts to respond to a single "joint" name (usually the host's)[34] as a courtesy to others. Usually it is only necessary to refer to a part's individual name during therapy or to distinguish one part from another. Let the multiple tell you his or her preference in this matter.

To learn that someone who is a friend or relative is multiple can bring about all kinds of emotional reactions. If you are trusted with the details of the abuse, you may find yourself feeling anxiety, anger, revulsion and perhaps vague fears about death. You may feel a lot empathy and concern. (Putnam, 1989) And if you are a recovering codependent, you may find your recovery from codependency undergoing some pretty strong tests to avoid caretaking your multiple friend or relative. If he or she introduces you to her personalities, it may seem like you cannot keep track of it all. Most multiples, especially those with more than a few alters, do not expect their friends and relatives to always know who is out when. In fact, many multiples themselves cannot always tell who is out at any given time. (Putnam, 1989)

Another big adjustment for friends and relatives is the "ceaseless changing" (Putnam, 1989). The multiple switches between personalities, different personalities grow and change dramatically as they heal, and then there are integrations! Integrations can bring about a very dramatic change in a personality. You may feel like the original "person" you have known all this time is no longer there. You may need to grieve this loss. The part that you knew before an integration is still there, but you only knew a portion of a whole person before, now you know *more* of him or her! At the same time, however, you may find yourself uncovering unexpected treasures in your friend that you never expected as he or she grows and changes.

Because of the intensity of the healing process and the occasional disruption of work and personal life involved in healing, many multiples will talk about leaving therapy at one time or another. Discourage him or her from quitting before integration[35] and an adequate period of post-integration therapy. Integration can be frightening for multiples. In addition to the real loss of the separate relationships between alters, an alter often fears that he or she will die, and multiples will often fear big changes in their relationships with friends, relatives and their therapist. With a final integration comes the fear of losing their old coping mechanism of switching between personalities, the ability to be anything and everything to everybody. (Putnam 1989)

Trust does not come easily to multiples, not solely due to the abuse they suffered in childhood but also in response to experiences with relationships as adults. Multiples are often misunderstood and can be very sensitive to rejection.[36] Because the different personalities are *different,* they will also have different opinions and reactions to situations. Co-conscious multiples are sometimes aware that they do this and are embarrassed by it. This changeability can appear to be evasive or dishonest to others. It isn't, it is how multiples survived their traumatic childhoods. When a multiple allows his or her parts to be seen, this is an expression of trust, not deception or manipulation. (Putnam, 1989)

Please do not ask a multiple to "perform" for you or others by switching on request. Occasionally, however, it may be appropriate to ask a child part to let you speak to an adult, especially if the multiple has amnesia between parts, the child cannot drive and it's time to drive home!

It is not unusual for co-conscious child alters to have all the motor skills and intellectual knowledge of the adult(s) they are co-conscious with, but they will often have the behavior and attention span of their "age." For this reason, it is not unusual for multiples whose hosts are co-conscious with their child alters to allow the older children to do such things as drive cars, cook meals, and so on. Putnam (1989) states: "I believe that the reparenting process must occur from within the multiple. The adult personalities must come to first acknowledge and then ultimately protect, care for, and raise the child alters. In my experience, this works well. The adult alters learn to let the child alters 'out' at appropriate times in appropriate contexts and to provide the child alters with nurturant experiences." (Putnam, 1989) When a multiple is co-conscious with the child alters, discipline and correction should come from within the multiple. If a multiple is allowing the children to behave in ways that cause discomfort to others, the best approach is to either ask the child directly, "Would you please...?" and if you are not comfortable interacting with child alters, to ask to talk to one of the grownups. That is as simple as saying, "Could I talk to one of the grownups now please?"

Please leave it up to the multiple's own discretion whether or not he or she introduces you to any of her other personalities in addition to the one you generally associate with. It is usually acceptable to say something like, "I would welcome meeting your other parts

whenever they feel comfortable talking to me." Some parts may not want to identify themselves by name, but will come out to visit for a while. You may not notice when a multiple switches between adult personalities if they talk and act somewhat alike, but if amnesia becomes obvious you can help by not making a big deal out of it. Simply try doing things like saying, "The other day when you said/did.... I was thinking..." If the multiple "lost time" you give him or her a clue as to what was going on while the other personality was out and how he or she was acting without embarrassing him or her by making it obvious that you noticed the switch. When another personality is "out" and the host is co-conscious, he or she will sometimes not be aware, even after knowing his or her diagnosis, that he or she has switched. This most often happens when another same sex alter about the same age is out. Since he or she can "hear" the alter thinking about saying or doing something before the alter does, it almost feels to the host like the host is the one actually doing it. The experience of being in the background when another personality is in control is often surrealistic. The "host" feels like he or she is "not all here" or "doing things on automatic pilot." The "host" may frequently say after doing or saying something uncharacteristic, "I have no idea why I did that."

Immediate family members and roommates need to be aware that multiples require a lot of personal privacy. (Putnam, 1989) They need a lot of time alone to process all that they are learning and the changes that are happening to them. They also require a lot of privacy for extensive journaling and other recovery activities.

Sometimes in recovery for adult child issues or child abuse, counselors and friends will urge the person to disclose to his or her family of origin that he or she is in recovery and perhaps confront the offending persons with their behavior when abuse is involved. Due to the complexity of MPD and the severity of the abuse involved, it is very important that no one pressure a multiple to even be in any form of contact with, much less confront, anyone in his or her family of origin. For the vast majority of multiples, it will only be *after* full integration of all parts that confrontation with the abuser(s) will be considered.[37] And even then, in many cases, it may not be wise, or even safe, to do so.[38] That is an issue to be carefully worked out by the multiple in consultation with his or her therapist. Many multiples will need to cut off *all* contact with much or all of their family of origin during their healing process, if this is possible. At the very least, they will need to set limits on that contact. Friends and relatives need to be very supportive of this course of action, especially as parts of the multiple may resist or even sabotage this decision.

The knowledge of someone's diagnosis as multiple should be treated with exceptional discretion and care. Relationships and careers can be seriously affected by careless gossip. Only the multiple has the privilege of revealing to others his or her condition, no one else.

Encourage him or her to find a support group. Survivors of Incest Anonymous supports individuals with MPD (as well as singulars) and has even provided some information specifically for multiples in their excellent collection of recovery literature. Many churches provide support groups for people sexually abused in childhood, however, care should be exercised to find out in advance whether or not they accept MPD as something other than demonic and if they are prepared to accept a multiple in their group.

Multiples, if they are fortunate enough to know other multiples, need to spend time with each other. Only another multiple can completely understand and appreciate what the experience is like. To try to explain what it is like to be multiple to someone who is not is often like trying to explain child bearing and the birth experience to someone who has never been through it. Others can grasp the concepts, but never truly know what it is *like.*

Always keep in mind that some or all of the other personalities may hear what you say about them to whoever is out at the time.

At the same time, you have the right to set limits on the behavior of your multiple friend, relative or spouse. The multiple should respect your needs and wants too. A multiple should not be allowed to get away with abusive behavior by blaming it on an alter personality. Each part should take responsibility for the behavior of every other part and negotiate together who will be out when, in order to avoid unnecessary confusion and disruption of others' lives.

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How can I tell if I or someone else has multiple personalities?

Most multiples have spent their lives hiding from themselves and others the fact that they have multiple personalities. This is a protective behavior reinforced by society's misconceptions and misunderstanding of this condition. This denial also protects the multiple from exposing the childhood trauma before he or she is ready to face it. The following questions provide clues to MPD, but diagnosis should be done by a professional who has been trained in dissociative disorders. The first set of questions give clues that a person may have full MPD with amnesia between parts, particularly if any one of these occur fairly frequently:

Have you ever noticed that things are missing from your personal possessions or where you live?[39]

Have you ever noticed that there are things present where you live, and you don't know where they came from or how they got there? e.g. clothes, jewelry, books, furniture?

Do people ever come up and talk to you as if they know you but you don't know them, or only know them faintly?

Do people ever tell you about things you've done or said, that you can't remember, not counting times you have been using drugs or alcohol?

Do you ever have blank spells or periods of missing time that you can't remember, not counting times you have been using drugs or alcohol?

Do you ever find yourself coming to in an unfamiliar place, wide awake, not sure how you got there, and not sure what has been happening for the past while, not counting times when you have been using drugs or alcohol?[40]

This first set of questions is designed to bring to light "losing time," or blank spells. Ross has some important observations about this symptom:

Like childhood abuse, blank spells occur in virtually all cases of complex MPD, but not in all cases across the full spectrum of MPD. Some patients do not remember having had blank spells and are "amnesic for their amnesia." Others may fill the blank spells with confabulation or be so afraid to acknowledge them that they will deny amnesia. Besides voices in the head, the blank spells are often the symptom that most frightens patients. The blank spells and the voices make patients think they are going crazy.[41]

There is some controversy surrounding dependence on the symptom of amnesia in diagnosing MPD. In DSM-III amnesia was included, it was dropped in DSM-III-R and reintroduced in DSM-IV criteria.[42] In this writer's opinion, care must be exercised in using this symptom in diagnosing MPD. Many multiples have a great deal of fear, and therefore denial, surrounding this symptom and will fail to report it, under report it, or be completely unaware of it. As a multiple progresses in his or her healing process, this symptom, when present, may quickly disappear. Also, when this symptom is present, it may not be the host personality that experiences it. The DSM-IV expanded as follows on this symptom.[43]

Individuals with this disorder experience frequent gaps in memory for personal history, both remote and recent. The amnesia is frequently asymmetrical. The more passive identities tend to have more constricted memories, whereas the more hostile, controlling, or "protector" identities have more complete memories. An identity not in control may nonetheless gain access to consciousness by producing auditory or visual hallucinations (e.g., a voice giving instructions). Evidence of amnesia may be uncovered by reports from others who have witnessed behavior that is disavowed by the individual or by the individual's own discoveries (e.g., finding items of clothing at home that the individual cannot remember having bought). There may be loss of memory not only for recurrent periods of time, but also an overall loss of biographical memory for some extended period of childhood...

Also older multiples may experience fewer symptoms of MPD.[44]

The next questions provide clues that would apply both to multiples who have amnesia between their parts, and other forms of being multiple, such as being co-conscious:

Do you ever have memories come back to you all of a sudden, in a flood or like flashbacks?

Are there large parts of your childhood after age 5 which you can't remember?

Have you ever noticed that your handwriting changes drastically or that there are things around in your handwriting you don't recognize?

Do you ever have long periods when you feel unreal, as if in a dream, or as if you're really not there, not counting when you are using drugs or alcohol?

Do you hear voices talking to you sometimes or talking inside your head?

If you hear voices, do they seem to come from inside you?

Do you ever speak of yourself as "we" or "us"?

Do you ever feel that there is another person or persons inside you?

Is there another person or persons inside you that has a name?

If there is another person inside you, does he or she ever come out and take control of your body?[45]

A yes answer to just one of these questions (except perhaps the first two) may indicate MPD.

Concerning the "voices" mentioned in these questions, multiples who have not been diagnosed can often believe that everyone "hears" voices in their mind talking, that that is the way people normally think.[46] Ross writes about how to distinguish the "voices" that multiples experience from the auditory hallucinations that sometimes accompany schizophrenia.

MPD taught me something about the clinical examination of auditory hallucinations.... In the routine clinical assessment of auditory hallucinations one should determine whether it is possible to talk to the voices....[47]

Ross then suggests asking the person who hears voices to relay his questions to one of them and to report the response. In a multiple this can be done without any form of hypnosis.

In severe acute schizophrenia the voices are often bizarre and irrational. The patient may describe... Martians talking through a microphone implanted in his brain. The content of the voices' speech may be incoherent, irrational, or bizarre. Such voices tend to be psychotic, rather than dissociative. One cannot engage them in conversation, nor can the patient.... Schizophrenic voices tend to be crazy....[48]

In contrast, the "voices" that multiples "hear" may sound "different" in personality but are generally rational and sane. Ross also states that these "voices" even assist in therapy:

One can converse directly with the alter personalities who hold the memories. The alters commonly control the rate of release of traumatic memories to the primary personality, and in fact I contract with them for this staged recovery of memory.[49]

Therapists will usually not make a diagnosis of MPD until they have actually met one of the alternate personalities.[50] It often takes time to develop the therapeutic relationship well enough for the other parts to feel safe to come out and talk to the therapist. Therapists will look for specific criteria in determining if they are speaking with an alter. They will look at behavior, mannerisms, speech, whether or not the personality is consistent from one contact to the next, at the personality's activity in the client's life history and if he or she ever takes control of the individual's behavior.[51]

It can be tempting to label yourself or others as multiple. It is important that diagnosis be done by someone who is trained in dissociative disorders. The label may appear to some to be "exotic" or "novel," but it is difficult and painful to deal with the realities of the widespread ignorance and stigma associated with this diagnosis. The above information is designed to help someone determine if they should investigate with the help of a trained therapist, preferably knowledgeable about dissociative disorders, whether or not they have MPD. **It is critically important that laymen do not tell someone else that they are, or are not, multiple.** In particular, it is important not tell someone who has been diagnosed with MPD that they are not multiple. Most multiples experience a lot of denial about their diagnosis, and often go to great lengths to hide their symptoms from themselves and others. Because a layman cannot see the symptoms of MPD, does *not* mean they are not present. Some multiples will only "switch" under certain circumstances, and some alters will only come out in therapy. To encourage a multiple's denial, even with the well-meaning, but misguided, intention of reassuring him or her that she is "really okay" can put a multiple into crisis. Such reassurances can later feel like the person is telling the multiple that being multiple is a "bad" thing. Nothing can be further from the truth. MPD is one of the most functional responses a child can make to a very traumatic childhood. On the subject of diagnoses, the DSM-IV states the following.[52]

DSM-IV is a classification of mental disorders that was developed for use in clinical, educational, and research settings. The diagnostic categories, criteria, and textual descriptions are meant to be employed by individuals with appropriate clinical training and experience in diagnosis. It is important that DSM-IV not be applied mechanically by untrained individuals. The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in cookbook fashion. For example, the exercise of clinical judgment may justify giving a certain diagnosis to an individual even though the clinical presentation falls just short of meeting the full criteria for the diagnosis as long as the symptoms that are present are persistent and severe. On the other hand, lack of familiarity with DSM-IV or excessively flexible and idiosyncratic application of DSM-IV criteria or conventions substantially reduces its utility as a common language for communication.

If you think you yourself may be multiple, try to find a therapist who is trained in dissociative orders and expect it to take time to determine if this is true for you. If you know someone who is multiple whose therapist appears to be helping him or her, ask if he or she minds giving you the name of his or her therapist. There are still not all that many therapists who are trained and experienced in this area and considerable harm can be done by mishandling of MPD by a therapist. In consulting a therapist trained in dissociative disorders, you need not be afraid that he or she will "create personalities" that do not already exist.[53]

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I thought that multiples were supposed to be rare! Is this some kind of new fad?

It has only been in recent years that child abuse, especially extreme child abuse such as incest, has been recognized as a harsh reality. Because MPD is caused by extreme abuse, and because there was so much denial about child abuse by the helping professions (and also the world in general), the memories reported by multiples were dismissed as delusions or fantasies. Putnam has reported:

The National Institute of Mental Health (NIMH) survey of 100 MPD cases found that 97% of all MPD patients reported experiencing significant trauma in childhood. Incest was the most commonly reported trauma (68%), but other forms of sexual abuse, physical abuse, and a variety of forms of emotional abuse were reported.... Most patients reported experiencing three or more different types of trauma during childhood.....

Some multiples report being used in "Black Masses" and other Satanic rituals....

I have seen several cases of MPD in children and adolescents who came from war zones, such as Cambodia and Lebanon. In each case, the child had witnessed the massacre of several family members through military or terrorist actions.[54]

In view of this, it is not surprising that MPD has also been found in concentration camp survivors; Calof mentions a "high incidence of MPD among Holocaust survivors in Israel who were young children in the Nazi death camps." (Calof & LeLoo, 1993)

Until 1980 therapists were not even given the diagnostic criteria to be able to recognize MPD. It took another five years before scholarly books and scientific measures of MPD began to be published. Even though MPD was recognized in the 1800s very little was known about it until recently. Most multiples were commonly misdiagnosed as schizophrenic, manic-depressive, obsessive-compulsive, and so on. Multiples are not suddenly appearing out of nowhere; they are just finally being diagnosed correctly. This is a reflection of several things: the understanding of Post Traumatic Stress Disorder as a result of the Vietnam Era, the breakdown of denial about child abuse, a greater awareness of the effects of child abuse that are carried into the adult's life, and increased publication to counselors, psychologists and psychiatrists of the symptoms to look for in diagnosing MPD.[55]

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So how common is MPD then?

In a study of university students, using scientifically verified instruments, depending on how stringently the criteria were applied, between 2 and 5% of those tested had MPD. (Ross, 1989) Even taking into consideration that the average university student would probably have a slightly higher IQ than the general population, and that there is some correlation with intelligence, that is certainly far from rare! Another study of the general population found that one in a hundred adults may be affected by MPD.[56]

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A short history of the diagnosis of MPD:

The following is a brief review the history of psychology and psychiatry, particularly as it applies to childhood sexual abuse and MPD.

...from 1914 to 1926 there were more diagnoses of MPD than of schizophrenia made in North America. During that period 15 cases of MPD and 10 of schizophrenia were reported in the literature... the diagnosis of schizophrenia "caught on" in the United States in the late 1920s and 1930s. Following this catching on, there was a sharp increase in diagnoses of schizophrenia and a sharp decline in diagnoses of MPD. How is one to understand this?

It is commonly said today that MPD is an iatrogenic[57] artifact and a transient diagnostic fad. What about schizophrenia? Could it be that many diagnoses of schizophrenia are incorrect and that they lead to negative iatrogenic complications? Could it be schizophrenia that is the fad, one driven by biological reductionism? Why should this not be the case? Why is MPD singled out for the criticism of iatrogenesis by mainstream psychiatry, but not schizophrenia? Because of data? No. Because of ideology....[58]

Alfred Binet (1857-1911) wrote two major treatises on dissociation containing a great deal of theory, observation and experimental information on MPD and dissociation. He experimented with deliberately creating alters in people. He found a crucial difference between these "iatrogenic" alters, and alters created by the person him or herself. Only the person who created the alter in another person could call out that alter. In persons with MPD, anyone can call out the alters (Putname, 1989, Ross, 1989). In his own studies, Ross found that MPD clients who were never hypnotized at any point did not differ in *any* respect (not in symptoms nor in number of alters) from those who had been hypnotized (either before or after diagnosis) (Ross, 1989).

The normal highly hypnotizable mind has the ability to erect amnesia barriers. The MPD patient has used the ability to create amnesia barriers between her imaginary "people." As the abuse goes on year after year, the amnesia and the illusion that the alters are really different people are reinforced and entrenched. What is surprising or difficult to understand about this process? In my view, MPD is a commonsense disorder that draws on the capacities of the normal mind. The evidence used by iatrogenesis theorists to invalidate MPD actually points to its essential nature and helps us to understand why MPD is treatable....

I think that MPD is singled out for the accusation of iatrogenic artifact primarily because of the link between MPD and childhood physical and sexual abuse. Not long ago, incest was thought to be as rare in North America as one in a million families.... That estimate, it is now known, was out by four orders of magnitude.[59] Memories of childhood incest are still assumed to be fantasies by many North American psychiatrists, however. In this social and ideological context, it is not surprising that MPD is singled out for dismissal as an iatrogenic artifact. The charge of artifact is a second line of defense against dealing with the reality of childhood abuse in North America.[60]

Between Ross' research on late 1800's work on MPD and Masson's book on Freud[61] it looks like the psychological community of the late 1800's was in two camps -- a very small group that believed that women with serious psychological problems who reported being sexually abused in childhood *really were* sexually abused in childhood, and those who did not believe this.[62] Before Freud, they were doing work with multiple personalities, but with the rise in popularity of Freud's theories and the disbelief of sexual abuse in childhood, the diagnosis of MPD dropped dramatically (Ross, 1989). MPD is caused by serious childhood trauma, which is the *only* known factor in common between MPD patients (another factor, but not as closely correlated, is high intelligence).

In 1890 William James, considered one of the founders of psychology, published *Principles of Psychology,* and discussed MPD in a theoretical chapter on the consciousness of self. Others wrote about MPD in the early 1900s as well. Two major errors were made in the theory of MPD at that time. One was to assume a biological predisposition, some sort of mental defect. This does not match what

is seen in integrated multiples, which is no sign of mental defect at all. Had this predisposition been seen as a talent or ability, theory would have matched reality more closely. The second major error in the field was to try to force the disappearance of the "alters" and the ascendancy of one single personality. This fails because the "bad" alters have a function and only seem to be "bad" because their role is misunderstood and their means of achieving the goal no longer appropriate to the multiple's survival. "This kind of treatment is a secular version of exorcism that does not heal the pain, resolve the conflicts, or lead to integration, and that reinforces the dissociation."[63] As a result of these two fundamental errors, the study of MPD fell into disrepute.

In Freud's early works there are cases of MPD described. In his study with Breuer, *Studies in Hysteria* (1895), the clients described had dissociative disorders and in particular Anna O. and Emmy Von N. had MPD. Ross states, "Up until 1895 Freud considered these patients to be suffering from the adult consequences of real childhood abuse. His treatment took the reality of the trauma into account both technically and theoretically."[64]

The whole history of psychoanalysis and sexual abuse is like a mixture of soap opera and politics. Freud had a patient named Emma who suffered from hysterical symptoms.[65] When he first started treating her he believed her accounts of childhood sexual abuse by her father and she started getting better. Then Freud's surgeon friend Wilhelm Fliess had a theory that sexual problems in women were connected to their nose (sounds bizarre, but there are letters from Freud to Fliess to back this up), and Fliess performed surgery on Emma's nose. She didn't get better, she got *worse.* Fliess bungled the operation (to the point of leaving some surgical gauze in her nose by mistake) and Emma suffered from hemorrhaging in her nose for the rest of her life. Meanwhile, while treating Emma, in 1896 Freud had presented to his colleagues a paper called *The Aetiology of Hysteria,*[66] in which he presented childhood sexual traumas as the cause of hysteria in adult life. He came under a lot of fire from his colleagues for this (because, as is only natural, they didn't want to believe that that kind of abuse was really going on). He became professionally isolated; even his good friend Wilhelm Fliess did not agree with him. Rather than stand his ground, and use medical evidence then available (such as studies done by Ambroise Auguste Tardieu[67] in Paris on the severity and frequency of sexual assault as a part of, or actual cause of death in young children), Freud folded under the pressure and came up with his Oedipal (or Electra) complex theories, explaining away his patient's memories as "fantasies." Rather than face the fact that his good friend Wilhelm had been guilty of malpractice, Freud blamed Emma's bleeding on *her* "Electra complex" and discounted her childhood memories as fantasies.

That Freud could blame on her "fantasies" Emma's continued problems with bleeding *from her nose,* bleeding which was actually caused by a bungled operation that he had recommended, illustrates with frightening clarity just how powerful a person's denial of the facts can be, when those facts are uncomfortable! Freud's reversal of his position from sexual abuse memories to "fantasies" took place between 1897 and 1903. To add to the whole soap opera flavor, Robert Fliess, Wilhelm Fliess' son, wrote a series of volumes on psychoanalytic theory. In this series he not only stated that he believed that repressed memories of sexual abuse were real (not "fantasies"), but even implied that his own father had sexually abused him. Robert Fliess was born in 1895, and if his father abused him, it would have likely been during the period of time that Freud made his reversal of opinion.[68] Many of the abusive fathers of Freud's clients were part of Freud's own social circle. (Ross, 1989) Freud's lack of courage in facing the truth (there is some reason to believe he himself was incested by his father) set back the whole field of psychiatry for seventy years!

So why this "sudden" recent reversal of a longstanding denial of the reality of repressed memories of childhood sexual abuse and MPD? For one thing the *reality* of childhood sexual abuse has become more and more widely recognized in recent years. This made the memories of multiples more believable to the those treating them, and thus they were less likely to be labeled delusional or schizophrenic. Also, as the definitions for other disorders, such as schizophrenia, were made more precise, fewer multiples were misdiagnosed. (Putnam, 1989)

Another factor has been the Vietnam Era. When Post Traumatic Stress Disorder as a result of battlefield trauma was recognized and studied, PTSD symptoms from childhood sexual abuse began to be recognized as well. Partial and complete amnesia for combat experiences have been reported, as have feelings of being detached and unreal. Flashbacks and abreactions are also found in combat post-traumatic stress reactions. (Putnam, 1989) Incidents of amnesia due to psychological causes are ten to fifteen times as frequent after combat as those found in hospital emergency rooms. (Putnam, 1989) And abreaction was seen as an important part of healing for "shell shock" during World War I. (Putnam, 1989) All of these features of PTSD are also symptoms of MPD that used to tend to lead to false diagnoses of schizophrenia until they were recognized as reactions to traumatic experiences.

A major turning point occurred in 1980 when MPD was given official diagnostic status in DSM-III. Concerning studies of the incidence of cases of MPD, Ross reports the following.

Greaves counted 33 cases of MPD reported from 1901 to 1944, and only 14 from 1944 to 1969. In his paper, however, he tabulates 50 cases either known to him personally or reported in the literature during the decade 1971-1980.... Braun (1986a) estimated that 500 cases of MPD had been identified by 1979. According to Braun's estimates, this number had increased to 1000 by 1983, and 5000 by 1986. Coons (1986c) estimated that 6000 cases had been diagnosed in North America by 1986.[69]

So we see that *simply by publishing the symptoms to look for* the number of diagnoses rose dramatically. Even still, from 1980 to 1983 Ross states that:

...most residents in psychiatry did not receive a single lecture, handout, reference, or other didactic material on MPD. Most residents would not meet anyone who had diagnosed a case of MPD, would never hear MPD considered in the differential diagnosis of a patient, and would not hear anyone mention MPD in a lecture or seminar.[70]

Then, in 1983 Frank Putnam presented a serious of 100 cases reported by 92 clinicians of MPD at the American Psychiatric Association (Ross, 1989). Another major turning point contributing to increased diagnoses of MPD was the first major conference

held on MPD in 1984. It was during this year also that scientific journals published special issues on MPD (Ross, 1989). It was during this year that the International Society for the Study of Multiple Personality and Dissociation was formed. By 1988 its membership grew steadily to over 1000 members (Ross, 1989). From 1985 to 1988 a number of centers formed MPD inpatient units, structured programs, study groups and research collaborations. One example of kinds of research performed is testing for people being able to "fake" the condition. Research into MPD has found that actors cannot reproduce the kind of differences seen between alter personalities, some of which can be scientifically measured.[71] In addition, actors used in physiological tests will go out of character when stressed, tired or distracted. (Putnam, 1989)

In 1985 and 1986 six scholarly books on MPD were published in North America and the first scientific instruments for the measurement of dissociation and the making of dissociative diagnoses were published and/or presented at conferences. By 1988 a journal devoted to dissociative disorders was launched, called *Dissociation.* (Ross, 1989) Ross believes "the exponential increase in the rate of diagnosis of MPD is not an isolated phenomenon: it is a correlate of a great deal of organizational and educational effort."[72]

In Ross' and Putnam's studies published in 1989, multiples had been given an average of three different diagnoses prior (like manic depressive or schizophrenic) in error, and it took an average of seven years of therapy prior to being diagnosed with MPD. (Ross, 1989) This means that, currently in treatment in 1989 there would be a backlog of seven times as many cases of MPD waiting to be diagnosed than would otherwise be the case if all therapists and counselors were trained in dissociative disorders.

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About the Author

The author of this handout has read the following books about MPD and many others about incest and ritual abuse. She attends Twelve Step meetings and has come to know through these meetings over a dozen multiples in various stages of their healing process. Several of these multiples have trusted her with the privilege of meeting their precious child alters, as well as many adult personalities.

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