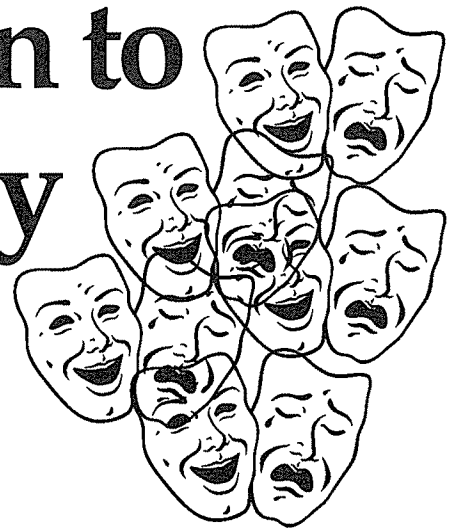
A Basic Introduction to Multiple Personality Disorder



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Introduction

The good news about Multiple Personality Disorder (MPD) is that more therapists are learning about it and asking their clients in their initial interviews the basic questions in regard to dissociation: "Do you ever experience lost periods of time or time lapses?" "Do you ever hear voices from inside your head that tell you to do things or comment on things that you do?" "Do you ever feel like you have personality shifts?" Therapists are realizing that children often go into a state of trance when they are abused so trance or hypnosis is needed in the assessment and treatment of child abuse. Increasing numbers of therapists are joining the International Society for The Study of Multiple Personality and Dissociation at (708) 966-4322 and the American Society for Clinical Hypnosis at (708) 297-3317.

Multiple Personality Disorder is the existence of more than one personality with unique behavior patterns. This subpersonality or alter can take control of the body at different times and make the client unconscious or amnesiac to what is happening during those times.

For the sake of clarity, I will use the pronoun "he" to refer to the therapist and "she" to refer to the client. There are many men with MPD, but they often end up in prison. Dissociation and amnesia is one explanation of why so many male sex offenders deny doing the abuse, because another subpersonality actually did the abuse and there is no conscious memory of it. More women have been abused, thus more women have MPD.

MPD typically originates in the client's childhood when she suffers a traumatic experience that is too painful for her personality to handle. The client deals with the experience by spontaneously developing a subpersonality that takes over during the trauma and holds the feeling and the memory of the trauma. The client and often the subpersonality can repress the memory and go about her life as though it had never happened. The client can create several subpersonalities from any specific trauma or a number of traumas. Having MPD can help a client survive terrible traumas, but it obviously complicates a client's life considerably and can put her life at risk with suicidal alters.

The therapist must be able to recognize this disorder so that he either treats the client appropriately or refers the client to a specialist for treatment. Failure of a therapist to recognize MPD or another dissociative disorder puts the client at a medical risk such as suicide, self-mutilation, substance abuse or eating disorders. It also puts the therapist at the legal risk of a malpractice lawsuit for ignoring the condition of MPD. Also it delays the therapeutic healing process by not correctly diagnosing and providing subsequent treatment interventions that are appropriate to that diagnosis.

A therapist may want to treat clients with MPD or they may want to refer these clients to specialists. The important factor is that every therapist needs to know how to assess and diagnose MPD not only for the above mentioned reasons but because of the high prevalence of some type of dissociative disorder. Ross (1989, p. 130) says "I think that MPD, psychogenic amnesia, and atypical dissociative disorder together are as common in the general population as anxiety disorders."

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Putnam et al. (1986) found that 100 MPD patients had averaged 6.8 years between their first mental health evaluation for symptoms related to MPD and receiving an accurate diagnosis. Many clients suffer unnecessarily by losing their childbearing years before the completion of their therapy, as well as suffering with their symptoms longer than they should. They also often have unnecessary hospitalizations and deplete their insurance benefits. Richard Kluft (1989) says the aver-

age MPD client often needs six years of therapy while twelve years is normal for cult abused MPD clients.

A correct diagnosis can be a real comfort to the client in understanding what has been going on in her life, and the subpersonalities are often relieved to be acknowledged and accepted. Many maladaptive symptoms can be cleared up quickly if the therapist addresses the subpersonalities directly and contracts with them to stop the behavior. These acts are often used as a way to punish the original personality for not listening to their feelings and stories of their memories.

Definitions

A client with *Dissociative Disorder Not Otherwise Specified* (DDNOS) does not meet the criteria for a specific dissociative disorder and has fewer distinct subpersonalities or ego states. These operate covertly, influencing the client by telling the client or other alters what to do, but do not take over the body and cause amnesia. To dissociate means "to sever the association of one thing from another" (Braun, 1984d, p. 171). The extreme on the range of dissociation is the polyfragmented MPD client who has usually been ritually abused and has hundreds of fragments. Braun (1986) defines a fragment as "an entity that is less than a personality. Fragments have a consistent and ongoing set of response patterns to given stimuli . . ." Other terms in the literature that Braun (1986) defines are:

Host Personality:
The personality that has executive control of the body for the greatest percentage of time during a given period.

Presenting Personality:
The entity that first comes in for therapy; it may be the original personality; the host personality; or a fragment.

Original Personality:
The entity that developed first after birth and split or remained separate from the rest of the thought processes. The original personality is often difficult to locate and work with, but this needs to be done to achieve a stable and lasting integration.

Splitting:
The creation of an entity by the splitting off or coalescing of energy that forms the nucleus of a separate personality or fragment.

Switching:
Going back and forth between already existing personalities and fragments.

Co-presence:
The simultaneous presence of two or more personalities with or without their knowing of one another's existence or current presence. Co-presence can occur with or without an influence of one upon another.

Co-consciousness:
The state of being aware of the thoughts or consciousness of another personality. It can be uni-directional or bi-directional, with or without co-presence, and/or with or without an influence of one upon another.

Fusion:
The act or instance of bringing together two or more personalities or fragments in order to blend their essence into a single entity. This is usually accompanied by some neuro-psycho-physiological signs.

Integration:
The process of bringing together the separate thought processes (personalities or fragments) and maintaining them as one. It is a process that starts before fusion and continues after it.

Another term to be familiar with is Internal Self Helper (ISH). This is an alter that helps the internal system of the client and gives information to the therapist, which may or may not be accurate. Some people have an atypical MPD that would fit under DDNOS and some people have "ego states that are organizations of behavior and experience separated by semi-permeable boundaries" (Watkins & Watkins, 1988, p. 67). All of us have an inner child in the general sense of a view of ourselves when we were children.

General Information

A therapist could have a long term relationship with a client for treatment of other diagnoses such as Borderline Personality Disorder, substance abuse, eating disorders, depression, suicide, panic attacks, phobias, Post-traumatic Stress Disorder (PTSD), child abuse, etc., before the dissociative disorder gets correctly diagnosed. Rather than cause further trauma by referring them to another therapist specializing in dissociative disorders, after the original therapist has treated the client for years, the therapist can assess and diagnose early in the treatment. It is always a good idea to have an assessment period even if the therapist specializes in the treatment of dissociative disorders because it may take time to uncover whether the client has been cult-abused or is still involved in a cult. The latter would be grounds for terminating therapy.

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Clinical Suggestions

Therapists also need to be willing to help clients go into a trance, whether with guided imagery or hypnosis. State Dependent Learning Theory teaches us that a person who is traumatized often goes into a trance and represses the memory of the trauma into the unconscious. Thus the client needs to go into trance to reach the memory of the abuse. A client can present with no memory of child abuse or awareness of any dissociative parts and the therapist can facilitate the client into a trance and discover that there are parts that hold the memories of the abuse. Anyone who has been abused as a child has a higher risk of having MPD or DDNOS.

Many therapists have MPD or DDNOS and do not become aware of it until they are treating these clients or until they have been assessed with a trance to find subpersonalities or ego states. If the therapist has a dissociative disorder, he needs to work through his memories and integrate those parts as much as possible before treating clients with dissociative disorders. It is very difficult for any thera-

pist to do this work without going through some extensive therapy. By focusing on his own inner child and working through his childhood deficit he can then tolerate the emotional depth and strong dependence these clients need to transfer on to him.

MPD clients are often extremely sensitive to the therapist's incongruities. Clients often have extreme fears of abandonment and are very vulnerable to narcissistic injuries or disruptions in the relationship with the therapist. These clients often have different age or sex subpersonalities that have dual diagnoses, e.g., a thirty year old woman can have a teenage boy alter that has a borderline personality and the therapist might be talking to the adult woman when the younger alter takes offense to what the therapist says.

The therapist needs to be able to work with the client's fear of psychosis or work through a psychosis. If the therapist is not a psychiatrist, he needs to work closely with a psychiatrist for medications and hospitalizations. The therapist needs to be trained in hypnosis and dissociative disorders so he is able to empathize with the client's feelings of fear and threat about having other parts. The more centered the therapist can be because of confidence in his training, the better. The best training after learning the basics is the experience of working with MPD or DDNOS clients and consulting with more experienced therapists.

It is important for a therapist to normalize the possibility of MPD when introducing the notion to a client.

I use many generalizations such as the diagnoses themselves for the sake of training and presenting information, but each client is unique and can teach the therapist a great deal. Each person has her own self that has a natural tendency toward actualization and fulfillment. Some of these clients have been so injured at so young an age that their potential for self-realization is debatable and they are untreatable for a variety of reasons.

It is important for a therapist to normalize the possibility of MPD when introducing the notion to a client. One way is to give the example of people passing out when they have extreme physical pain. Likewise, people split or dissociate when they suffer from a trauma such as physical, emotional, or sexual abuse as a child. The client needs to be informed that a person can undergo trauma and develop separate parts that might also have repressed the memories from their consciousness or awareness. These parts can be so separate that they have their own identities and personality characteristics that vary in body image, age, sex, and other ways. MPD is a very creative way to cope with extreme traumas in childhood. Many MPD clients are geniuses and Dr. Braun has shown how each alter uses a different part of the brain.

The therapist can invite the other parts to all listen in the present moment as he explains how the original personality took the abuse as long as it could and then split off. The other part came in automatically at that point, but the client was already gone and had no knowledge of it, and so is not the one responsible for the other parts experiencing the abuse. The therapist often needs to remind the client and the alters that the perpetrator is always the one that is responsible for the abuse. The other parts often do not realize this and blame the host or the original personality, both for the abuse and for being created in the middle of the abuse. This information about who is really responsible often has to be repeated for each part even if the therapist requested that they all listen. The parts can be in different layers or levels of consciousness, not co-conscious or present and listening. These other parts are often very angry and hostile. Not only did they suffer the abuse and believe they were stuck with it, they are also often angry that the host does not listen to them or even acknowledge that they exist. They are very afraid that they will be annihilated with integration and need to be reassured that they can choose if and when they want to integrate. They will still exist on a deeper and more united level as one, or they can choose not to integrate and just work as a team or a family sharing the same body. The alters often do not believe that they even share the same body because they have such different body images.

The host needs to hear that she can be her own best therapist or friend to the other parts. If she can be as empathic as possible, get in her shoes and understand how that part thinks and feels, each part will learn to be empathic with each other as well as with the host. They can then all share in the intensity of the feelings and thus dissipate the intensity. This empathy carries over to thoughts, because in addition to sharing feelings, they can often read each others' minds. It is similar to group therapy, and the host needs to be as polite and diplomatic as possible so there is a trusting alliance with each of the alters. Of course, the therapist needs to do the same and realize that the others are probably listening while he is talking to the host. This is useful for speaking through one personality to another who might not be willing to or feel safe to come out because of violent tendencies. The therapist can also request that everyone listen and then ask the deeper mind or unconscious mind to keep a videotape of the memory of the session and store it in their own mental library. Sometimes these requests work and sometimes they do not, usually because someone inside is blocking. It is then important to meet this personality and discover the purpose for the blocking.

Assessment Scales

Some useful scales in assessing and diagnosing dissociative disorders are "The Dissociative Disorders Interview Schedule in *Multiple Personality Disorder Diagnosis, Clinical Features, and Treatment* by Colin Ross (1989, p 314-334), "The Dissociative Experiences Scale" (DES) by Eve Bernstein Carlson and Frank Putnam (1990), and "The Child Dissociative Checklist" (CDC) by Frank Putnam (1990). Some questions from these scales to ask adults are:

- Do you have a history of incest or other abuse?
- Do you have a history of injuring yourself or attempting suicide?
- How do you experience time?
- Do you ever experience lost periods of time or time lapses where you are amnesiac?

- Do you ever hear voices from inside your head that tell you to do things or comment on things that you do?
- Do you ever use the pronoun "we" instead of "I" to refer to yourself?
- Do you ever feel like you have personality shifts or different parts of yourself ?
- Do others report seeing personality shifts or behavior that you cannot remember?
- Do you ever find art work, writings or articles for which you cannot account?
- Do you ever have inexplicable skills like playing a musical instrument which you do not remember learning?
- Do you ever get severe headaches?
- Do you have inconsistent handwriting ?

Some useful questions to ask children are:

- Do you daydream a lot or feel like you are in a different world?
- Do you ever use a different name?
- Do you forget things a lot?
- Do you get called a liar much?
- Do you ever feel like you are good at school, work, sports, music, or skills and then other times you are not?
- Do you ever feel like you have different parts of yourself?
- Do you have any imaginary friends?
- Do you ever want to injure yourself or kill yourself or wish you were dead?
- Has anyone ever hurt you seriously?

Unless the alters switch right out and say they are there or an alter actually initiates the therapy, the therapist needs to use hypnosis or guided imagery. Usually dissociative clients are highly hypnotizable because they went into a trance to cope with the abuse. Sometimes they do not want to trust anyone or to let them know they exist and will not show themselves the first or second time the therapist asks for them. The therapist needs to explain that he understands they have different body images and ages in their internal world, but that in this world they share the same body. He must let them know he only sees the same body with each alter and they must let him know who is present in the body when they switch. Sometimes there are dramatic face and voice changes between alters and often there are not.

Once the therapist has developed rapport, trust, and a therapeutic alliance with the client by casually explaining some facts, the client can see that the therapist is not afraid yet can empathize with the client's feelings of fear and threat. The therapist can use different kinds of inductions to get the client relaxed and then use ideomotor signals (a system of finger signals to communicate while in a trance) to decide whether to invite the alters out.

The therapist can ask: Which part of you is here now?

Switching Back To The Host

After talking to the alters, find out which other alters in the system they know and if they are willing to meet the others. The therapist can then introduce the alters to each other by saying: "Let the deeper mind guide each of you to a level of relaxation where you can both be co-conscious and meet each other. I can either hear both of you talk to each other aloud or one of you can translate and fill me in on how it is going." After some practice, the alters can check in with each other and send out the ones who are in need of some time with the therapist. They can support each other afterwards with older alters taking care of younger alters internally. Ideally, the therapist can allow enough time before the end of the session for the host to transition back into the body and process the session. The therapist can ask the alters to go back inside to their quiet places and can say: "Go inside," to themselves and can tell the host to come on out and say, "Come on out," to herself. If there is difficulty coming back, the therapist can say: "As I count from five to one, let the different parts of your body come back to normal. Let yourself come on back as if a magnetic force is pulling you on out. Let your deeper mind guide you to a level of relaxation where you can come out easily and comfortably as I count from five to one."

After the therapist gets to know the internal system and key players, and when everyone seems ready to deal with memories safely, the therapist can have them view each memory on a movie screen. First, it is important to contract with all the alters as a group, and contract regularly with each alter that is dangerous, not to hurt anyone inside or outside their system on purpose or accidentally. It usually helps alters make a contract if they can feel understood about their strong desire to escape the intensity of pain about the abuse and the sense of hopelessness that these intensely painful feelings will never end. After the therapist has been empathic with their pain and hopelessness, he can emphasize the difference between experiencing feelings and acting on feelings inappropriately or impulsively. He can then contract with the alters for time to work through the intensity of these feelings. Hypnotic subjects take language quite literally. The therapist needs to be very careful in wording contracts that are time-limited to the next appointment by saying: "Until the next time I see you in a session." This will cover any cases in which something happens to the therapist and he does not make it to the regular meeting time, and is especially necessary with suicidal alters.

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When the alters are ready to look at the memory, an alter or internal self-helper (ISH) is often able to read the mind of the persons with the memory and inform the therapist as much as possible before an abreaction. The therapist can ask the deeper mind to count backwards from fifteen to one (or whatever ages are appropriate for that client). The therapist can say: "Scan the year from the fifteenth birthday to the sixteenth birthday for any memories that need to be discussed in therapy. Now, scan the year from the fourteenth birthday to the fifteenth birthday, etc." The memo-

ries that need to be discussed in therapy and the number of memories in each year can be indicated with finger signals. As mentioned earlier, angry alters or alters that are introjects or imitators of their perpetrators need to look at their first memory to see how they came into existence. Hospitalization is often indicated at these times. After they abreact or feel the intensity of the feelings of that memory or series of memories, angry alters are often more willing to help the others with their memories.

After an abreaction and once the therapist has invited the alters to go back to their quiet places, it is usually a good time to deepen the trance to place some positive messages, such as Corey Hammond (1990) recommends. Sometimes it is good for the original personality or the host to be co-conscious during the sessions. This does not always work because someone might be blocking or not trusting the host. Sometimes the host is not up to dealing with the memory yet, but the alter still needs to proceed with an abreaction. So the host might not be present during this abreaction, or the host might recall the memory and feelings later at a safe pace. It is important to work these things out when possible and have as few secrets as possible. It is also important to respect the system by asking the alters permission to break the secrets, whether that means meeting other alters or recalling memories. Sometimes the memory is too much to handle at the time so the therapist can suggest the memory be erased.

It is usually best for the host to be the one that begins and ends the session. This gives her a feeling of control and keeps her from panicking or getting amnesiac, but this does not always work. Once in awhile, the alters are more highly functioning than the original personality or the host for a particular time or for extended periods of time so these alters will enter and leave the session. It is important to work out agreements. Sometimes the host is glad to have a break if she can trust the alter in charge. Other times an alter might need to take a destructive alter away or lock them up inside somewhere like a penthouse suite or a meadow until the next time that alter meets with the therapist. Of course, the hospital needs to be used any time the MPD client needs to be safe and cannot control a destructive alter with an internal hospital or quiet place.

Sometimes alters will advance in age before looking back in time to their memories. When they get to an older age, they can redecide many irrational decisions they made about the events, themselves, and the world with more information and from an adult perspective. Before alters can more permanently advance to an older age, the other alters need to share the feelings of the memories. Sometimes an alter can range in age or represent a group of alters of different ages. This technique works better with clients who are healthier such as those with DDNOS.

Often the alter will advance to an age where there is a repressed memory like in their teen years and stop there until that memory or memories are worked through. As with any technique, sometimes they do not work and child alters do not advance in age.

As they get their turn, they will hopefully draw closer together and become more of a team or integrated as a whole where they all co-exist and eventually are co-conscious as one person.

Summary

The therapist needs to meet the various alters, introduce them to each other and give them some education about dissociation and MPD. The therapist needs to contract with them not to hurt anyone inside or outside their system. Sometimes the therapist needs to take the lead and be very directive with these clients and sometimes the therapist needs to follow the lead of the clients. Therapists new to MPD treatment should consult with more experienced therapists. When the alters abreact these memories, they relive painful feelings. They often have panic attacks and need medication to help them cope with extreme fears and depression. I recommend Richard Kluft's article "Playing for Time: Temporizing Techniques in the Treatment of Multiple Personality Disorder" (1989). As the alters abreact each memory, feel some relief, another one comes up. Eventually the ones that have done their work help the ones that have work to do by sharing the intensity of the emotions. As they get their turn, they will hopefully draw closer together and become more of a team or integrated as a whole where they all co-exist and eventually are co-conscious as one person.

Clients ask regularly "Why should I bother to open up this Pandora's box of memories?" Some clients are so fed up with their lives that they just want change even if it is extremely painful. Some clients have an inner knowledge that their life needs healing and wholeness. And some clients do not really know what they are getting into, but they are already being flooded with nightmares and flashbacks so they decide to embark on their journey of therapy.

It takes a great deal of courage for clients to do this work. The pay-off is that they feel freer from the pain of their abusive pasts and more in touch with their full potential and true selves. □

References Available Upon Request

Patrick Purcell specializes in the treatment of child sexual abuse and the treatment of multiple personality disorder and dissociative disorders. He was trained in hypnosis and stress reduction.