# ON GIVING CONSULTATIONS TO THERAPISTS TREATING MPD:
## Fifteen Years' Experience-
### Part II
#### (The "Surround" of Treatment, Forensics, Hypnosis, Patient-initiated Requests)
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## ABSTRACT

*This paper concludes a review of the author's experience in rendering consultations regarding multiple personality disorder (MPD) over the 15 year period 1973-1988. It describes consultations regarding the "surround" of treatment, the use of hypnosis, forensic cvnrern.s, and patient initiated requests. As noted in Part I, which described this study and reviewed experiences rendering consultations with regard to diagnosis and general treatment issues, the publication of several articles and DSll'f-III in 1980 and the publication of our special journal issues in 1984 were watershed events, and marked notable shifts in its nature of many of the consultation requests that the author received.*

## INTRODUCTION

Clinicians confronted with patients suffering multiple personality disorder (MPD) often find themselves in need of consultation with regard to the issues raised in the diagnosis and treatment of the complex and chronic dissociative psychopathology. Although it is quite common for mental health professionals to seek consultation about such patients, the literature has been fairly silent with respect to this topic. Kluft (1982h, 1988a), Marmer (1985), and Feldman (1986) have discussed consultation to therapists treating MPD in presentations at scientific conferences, and Greaves (1988) has described a number of consultations in the course of describing common errors in therapy, but the subject has yet to be addressed within the literature other than incidentally or in passing.

I reviewed my recollections of my unrecorded experiences and the records of over 450 consultations I had undertaken with respect to MPD over the fifteen year period 1973-1988. This review disclosed that although certain themes were recurrent, other concerns changed markedly over time. These changes seemed to occur both after certain major publications in 1980, and again after the publication of still further contributions in 1984. Hence, the discussion of each major consultation issue was subdivided to address the periods 1973-1980, 1981-1984, and 1985-1988 separately.

The first part of this two-part communication addressed issues arising in connection with consultations regarding diagnosis and treatment in general. This portion explores consultations undertaken with respect to the "surround" of treatment, forensics, hypnosis, and patient-initiated requests.

## CONSULTATIONS REGARDING THE "SURROUND" OF THE TREATMENT

Those who work with MPD frequently observe that the actual treatment of the condition, however demanding, often proves less onerous than the strain of dealing with the reactions of colleagues, hospital staffs, and administrators. The prevalence of this type of problem was given quantitative expression by Dell in 1986. In his survey study, Dell found that the vast majority of practitioners working with MPD had experienced skepticism and ridicule from other mental health professionals, and that a sizeable percentage had had their therapeutic efforts interfered with and their patients subjected to indignities or efforts to undermine or alter the treatment. It is a rare week in which I do not both receive a telephone call or letter from a colleague under duress and hear from one of my patients, students, or colleagues that the credibility of my work has been challenged or disparaged to them. My observation is that any geographical area or clinical facility's first few encounters with MPD are attended with high casualty rates for all concerned. In sum, my experience (1984) is consistent with Dell's findings, that when a person or facility first experiences the impact of working with MPD, there often is a loss of the expected and customary sense of mastery and competence. This is experienced as a hurt, often narcissistic in nature, and begets anxiety, confusion, and anger. This usually occurs as the therapist of the MPD patient is going through a phase of fascination with MPD, a normative response to encountering the condition (Kluft, 1988b), so that the conflicts have great potential for rapid and painful polarization. Two common responses are pressures to treat the MPD patient without regard to the MPD (or as if he or she could be treated as something else), or, to rid one's self of the problem by invalidating the reality of the condition or the credibility of the practitioner who has inflicted the patient

upon the consciousness of a group of colleagues or the resources of a unit or clinic. The first approach is self-deceptive because patients who are not treated with regard to their MPD do not fare well (Mull, 1985); the second replicates the dynamics of an abusive family in which the victim is redefined as the wrong-doer (Kluft, Braun, and Sachs, 1984).

1973-1980. I received few consultations about such matters, but I requested many. A consensus seemed to emerge among those working in the field and those who were sympathetic but not personally involved that a militant or conversion oriented approach to colleagues was generally ineffective, generating more heat than light. It seemed best to practice at a high level of competence, to share knowledge when it was requested, to inform those concerned of our treatment plans and strategies, and to keep low-key and low-profile. It seemed particularly important to build bridges from mainstream knowledge to MPD, and vice-versa, and to avoid using MPD as the vehicle for "demonstrating" one's unique theories aetiology. Those who did not behave with such restraint fared poorly.

1981-1984. As more practitioners diagnosed MPD and encountered difficulties in its management, I began to receive consultations from individuals and institutions distressed and overwhelmed by their experiences with MPD. Often such requests followed administrators' and supervisors' complaints about the amount of time, effort, crises, staff protests, anxiety, and miscellaneous tumult that ofttimes surrounds these patients' management. MPD patients seemed to require or at least profess their need for interventions that tnarked them as different_ Administrators and supervisors often insisted upon interventions that my experience had taught me were counterproductive. In units that prioritized rapid mobilization and symptomatic remission, MPD patients who were regressing and having massive abreactions had lengths of stay that were discordant with the philosophies and practices of those units. For example, I received over 100 calls asking for confirmation that a practitioner was in error for addressing the personalities by name. In each case the patient felt disbelieved and hurt by staff who did not acknowledge their MPD, and their distress took the form of crises. Very few such callers were pleased with my advice that the alters should be addressed by whatever name they wanted, but made to realize that staff was not responsible for recognizing and accurately addressing each alter. The usual result of such an approach is that the patient feels acknowledged and the alters rapidly stop needing to demonstrate and prove their separateness; in contrast, the militant "one name only" approach generates messy dramatic efforts on the personalities' parts to prove that they are "real," or drives the patient into a counterproductive masochistic submission. I also got over 100 calls from persons who wanted a second opinion about the usefulness of major tranquilizers in MPD, or who wanted me to persuade a "recalcitrant" colleague to prescribe them. I received so many such calls that I wrote an article summarizing my observations on crises, inpatient management, and the use of medications (Kluft, 1984), to which I could refer the callers. In a small number of instances 1 was called after clinicians had lost or were threatened by the loss of admission privileges or their salaried positions in connection with such disputes.

1985-1988. The previous period's trends continued, but with a new addition. Clinicians who had suddenly become aware of MPD from courses, articles, or their first MPD patient, were suddenly finding large numbers of such allegedly rare patients. Often these clinicians encountered tremendous resistance and hostility. I was called for support and confirmation by such clinicians, and for clarification by their hospitals' or clinics' administrators or supervisory staffs. This phenomenon occurred as across the country an increasing number of clinicians were identifying themselves as having special interest in MPD, and rapidly acquiring practices with many such patients. It became important to work with such callers to share state-of-the-art awareness, to acknowledge ongoing areas of controversy, and to help all involved move toward collaboration rather than antagonism.

## CONSULTATIONS REGARDING FORENSIC MATTERS

I have always found that appearing as a forensic expert unduly disrupts my practice, and have taken active measures to avoid encouraging such consultations. Aspect of my forensic experience have been reported elsewhere (1987a, 1987b).

1973-1980. On ten occasions in 1979 and 1980 I was called in connection with proposals to undertake the hypnotic assessment of MPD of defendants in criminal matters. In each case my preliminary conversations indicated that the guidelines deemed necessary to safeguard the use of forensic hypnosis (Orne, 1979) had already been violated, and so informed the attorneys who had asked my opinion.

1981-1984. I received occasional consultation requests and helped the callers find other experts. I did help several more involved experts by providing insights based on my ongoing but as yet unpublished research on the natural history of MPD (1985) and its simulation and dissimulation (1987a), and because of still other research (1987h), found myself unable to decline to become involved in a small number of cases involving decisions on the termination of parental rights. I succeeded in unmasking a small number of simulators, dissimulators, and patients coached to present themselves as having MPD. I also helped a number of colleagues who had contrived "logical tests" for identifying "true MPD" realize that these "capricious rules" tests were inconsistent with the realities of clinical MPD. Efforts to resolve some of these common false assumptions were usually rather uncomplicated, although often affectively charged.

1985-1988. A small number of parental fitness consultations were undertaken, and help was rendered to a number of forensic specialists. However, the nature of the requests I received most frequently changed quite abruptly in an unexpected manner. In these newer cases the defendant was no longer the MPD patient - it was the mental health professional accused of the misdiagnosis and/or the mismanagement of a patient alleged to suffer MPD. I was asked to confirm or disconfirm a diagnosis and/or to comment on aspects of a treatment. These matters are still in litigation,

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and cannot be discussed further. Only the phenomenon and the trend can he noted.

## CONSULTATIONS REGARDING THE USE OF HYPNOSIS

The use of hypnosis in the treatment of MPD is a subject that continues to be controversial, despite the fact that the majority of successful contemporary treatments have been facilitated by hypnosis (Kluft, 1986a; Putnam, 1986), and the majority of therapists worki ng with M PI) find it useful (Coons, 1986). Polarized opinions and all shades of intermediate viewpoints can be heard whenever clinicians who use hypnosis gather together. Many scientific investigators are impressed with the demonstrated effectiveness of therapies that employ hypnosis to treat MPD. This stance is sufficiently well articulated for therapists encountering their first case to turn to the literature and apply these methods with noteworthy success (e.g., Marcum, Wright, & Bissell, 1986). On the other hand, many, aware of the potential for hypnosis and suggestions and cues given in the course of hypnotic procedures and inquires to distort memory and alter perception in ways that often prove to be rather unshakable thereafter, are extremely concerned that MPD may he created by hypnotic interventions, and that memories retrieved may he encouraged confabulations, without intrinsic veracity, but which become, in effect, baptized as truth by the concretizing potential of the hypnotic experience. Not surprisingly, these concerns are voiced most eloquently by those who have studied the vicissitudes of forensic hypnosis. This is a most complex area discussed in detail elsewhere (Braun, 1984a; Kluft, 1982, 1987a, 1987h; Kline, 1984; Orne, 1979; Orne, Dinges, and Orne, 1984).

As Beahrs (1982, 1986) has observed, it is somewhat simplistic to assume that either polarized stance can completely exclude or discredit the other. Both Kluft (1982) and Braun (1984a, 1984b) have taken pains to emphasize this. Kluft (1982) wrote that hypnotic procedures "should not be used haphazardly in the mistaken notion that 'hypnosis' in and of itself may be helpful. Complications which occur in situations involving hypnosis are more likely to result from either the misuse of hypnosis or its inappropriate inclusion in an ill-considered therapy rather than from any characteristic of hypnosis in and of itself.... Hypnosis is relatively innocuous, but those who use it may not he" (p. 238).

1973-1980. Many consultees were relatively naive about both hypnosis and MPD, and either they or the patients they referred made it clear that unrealistic and magical expectations had contributed to the consultation. Accustomed to the use of hypnosis in brief, time-limited treatments, and/or misunderstanding hypnosis as a treatment rather than a facilitator of treatment, some consultees and their patients were surprised to learn that I could not "take care of the multiple personality part of the patent's problem in a few sessions," nor could I "suggest the MPD away." The consultees often were unaware of the extensive traumata such patients often have experienced, and failed to comprehend the nature of the patients' overall therapeutic needs. Several hoped that after a few hypnotherapeutic interventions, the patient could be returned to them for more conventional treatments. Usually I succeeded in clarifying misperceptions, and encouraged the therapist to get appropriate training in the use of hypnosis. In a few instances, I became a collaborating therapist and/or ongoing consultant.

1981-1984. Naive consultations were encountered in diminishing numbers, and requests from clinicians who were uncomfortable with the use of hypnosis increased. Many analytically-oriented practitioners with strong negative feelings about hypnosis sought consultation as to whether MPI) could be treated without it. These consultations began shortly after the publication of an article (Kluft, 1982) in which I described 70 successful treatments, 1 in a classic psychoanalysis, and 69 that involved at least one use of hype osis. There were a great number of requests that I use hypnosis to clarify the diagnosis of a particular patient, usually someone who, by their own report or the report of other observers, showed classic signs of MPD (reviewed in Kluft, 1987c). Some were quite sophisticated about the concerns that surround such efforts, but felt the highest priority was enhancing their ability to help a suffering patient. It is instructive to note that 50% of the patients referred for an hypnotic evaluation who later proved to have classic MPD did not reveal their MPD at the time of their first such assessment. An MPD patient trying to conceal his or her condition often can dissimulate sufficiently to leave the diagnostic picture uncertain. Longer evaluation sessions without the use of hypnosis usually resolved the issues (Kluft, 1987a).

Increasingly, I was consulted by practitioners uncertain about how to use particular techniques. Most came with their patient, and watched me demonstrate certain basic approaches, tried them under my observation, and continued their treatment efforts thereafter. I began to notice a disturbing trend toward the end of this period. Clinicians were calling about problems in their use of hypnosis, and, in the course of the conversation, I learned that they were without adequate training in hypnosis, and/or were using techniques prematurely and without regard for the natural process of therapy. A frequently-encountered and particularly distressing example was when a therapist made the MPD diagnosis, read one of the recent articles on the use of hypnotic techniques (Braun, 1984b; Kluft, 1982), and attempted to begin fusing the patient's personalities within weeks of discovering the MPD, long before any meaningful therapeutic work had been accomplished. Their urgent need to "do something" had outpaced their clinical judgement, and they had employed the techniques described in the literature without employing any of the cautions recommended. A small number of such patients had been harmed to the point that their transfer became necessary.

1985-1988. Many consultation calls concerned issues of clinical judgement as to whether a particular intervention should be attempted, how to manage strong abreactions, and whether certain provedures having to do with potentially disruptive material should be undertaken in a hospital setting. As more practitioners struggled with their first MPD patients and called for advice, I encountered many individuals who hoped to be able to treat MPD with their usual

methods augmented by hypnosis. A major problem was their press to use hypnosis out of context, rather than as a well-planned intervention in the course of thoughtful therapeutic plan. The most frequent situation involved a clinician's wish to achieve some integration or fusion by hypnotic means without having done the necessary basic therapeutic work. Many called after several failures had discouraged both them and their patients. I also had to deal for the first time with consultees from the many divergent schools of thought or orientations within hypnosis. Practitioners with their roots in Ericksonian thinking or the theories of neuro-linguistic programming often described their efforts to bypass, suppress, or change the MPD condition with their favorite techniques, and questioned my slow and gradual methods, disputing their necessity. Their prime concern was whether they really had to deal with past traumata, rather than alter the patient's perceptions of them or management of their impact. A good percentage appeared very dissatisfied with the experience-based observations that I shared. Other new phenomena were side effects of the new awareness of MPD and the recent literature. In the past, a consultee who had gained his or her first familiarity with MPD through the recent literature was not only a rarity, but a near-impossibility, as was one who had learned about MPD in discussions with colleagues and teachers. I was asked for help by several clinicians who had absorbed rather idiosyncratic notions of how to use hypnosis to treat MPD from colleagues, and, assuming the information they received was mainstream and accurate, did not consult the literature, which would have disconfirmed what they had been told. I also found consultees who had read extensively, but had never taken a course on MPD, and were unable to put what they had learned into the context of clinical practice.

## CONSULTATIONS INITIATED BY PATIENTS

Thigpen and Cleckley (1984) reported receiving many communications from people who represented themselves as having MPD, and described encountering many individuals who believed they had the disorder "and who apparently made the `pilgrimage' to us to acquire our sanction" (p. 63). No such persons received it. My own experience includes similar incidents, all but four of which occurred prior to 1981.

1973-1980. During the first part of this period my work with MPD was publicized largely by collegial denigration, and in the second by a combination of this form of acclaim, some more positive recognition, and a television appearance with "Eve" (Chris Sizemore), who had co-authored I'M *EVE* (Sizemore & Pittillo, 1977). This exposure brought many people to me who claimed to have MPD, and generated scores of telephone contacts that never led to actual evaluations. Clearly, in the minds of many callers, I was perceived as rather far from the mainstream. Well over 200 telephone and mail inquiries went no further when the callers realized that I could say nothing without a full clinical evaluation, would insist on fees for my professional services, and was not interested in collaboration on a book.

Of those seen in person, most did not suffer MPD. A

number hoped to use the diagnosis to sue a practitioner with whom they had a grievance, and behaved as if to indicate that they thought my opinion could be bought or easily swayed. Some hoped to use the diagnosis to evade responsibility, often for an affair. Some were self dramatizing and voiced plans to exploit their circumstances. These patients generally withdrew their self-proclaimed diagnosis once they realized the connection of MPD and child abuse. As the evaluation proceeded stolidly, their contact with the sordid realities of MPD dispelled its apparent glamor. None agreed to a second appointment. Some were very unfortunate chronic patients who were very ill, and hoped that their failure to respond to previous treatment was due to their having been misdiagnosed.

The patients who did have MPD in my clinical judgement were usually of that small subgroup of exhibitionistic and poorly motivated florid subjects who are easily diagnosed and differentially overrepresented in the caseloads of clinicians with relatively little experience with MPD. This is a major reason why few neophytes can match the treatment results of the more experienced hands, who generally work with more motivated patients. Only one of these patients had sufficient motivation to endure the rigors of treatment, and she enjoyed an excellent result.

Therefore, my 1973-1980 experience with self-referred patients had some congruence with the Thigpen and Cleckley account (1984).

1981-1984. Within months of the publication of the 1980 articles noted above, the types of self referred patients without MPD noted above virtually ceased to appear in my office. I have seen only four such cases since. Now I began to see primarily patients who had learned of my work, often by the disparaging remarks of a colleague to whom the patient broached the idea that he or she suffered MPD, and, increasingly, from supportive colleagues or successfully-treated former MPD patients. Many had seen many prior therapists and had extensive and unhappy treatment histories. They deeply resented their having been disbelieved and often mistreated by prior therapists. Most were correct in their self-diagnosis. Most requested therapy, either with myself or a colleague closer to their home. All of those whom I treated, whether they had MPD or not, proved highly motivated. All prospered in therapy. Those with MPD integrated, terminated, and were well on follow-up. Those without MPD either had less developed ego state phenomena, or had fastened on the metaphor of MPD to express their inner turmoil. Interestingly, they did very well also, and none clung to an insistence that they had MPD. I infer that their prior therapists had, in their hostile and unsympathetic responses, failed to hear the patients' talk about MPD as a communication about their inner turmoil, and, by responding to the manifest communication, lost the opportunity to hear and interpret their latent messages.

1985-1988. The 1984 publications included several articles of my own. The most motivated self-referred patients often said that they had called because my articles convinced them of my expertise, or were like those seen in 1981-1984. However, I began to encounter a number of frank "doctor shoppers," many of whom had legitimate MPD, but severe

narcissistic psychopathology as well. A good number had seen other experts, and several challenged inc to prove I was better than a colleague and more suited to undertake their care. I usually spent considerable effort attempting to educate such patients as to the nature and importance of a therapeutic alliance, and declined to take any into my care until they had given careful thought to what meaningful therapy involved, and were prepared to make a commitment.. The most common form of self-referral, however, was of the correctly self diagnosed mental health professional or mental health discipline student with MPD, a group I had begun to discuss at workshops in the early 1980's. Marry had attended many workshops and lectures and thoroughly researched my publications before calling for an appointment. I have described the treatment of such patients elsewhere (Kluft, 1986b). The next most common variety of sell referral was of patients who hoped that I would disconfirm a colleague's diagnosis of MPD. In most cases the colleague had been correct; in a few cases the patient's determination to show no signs of MPD led to interactions from which no clear conclusion could be drawn. Nearly as common were MPD patients who described severe misalliances with a prior therapist. These included situations in which the therapists conveyed the impression that they were unable to accept the MPD condition, unknowledgeable about its treatment, or pointedly skeptical about the patient's account. On several occasions therapists alluded to by such patients later sought consultation for a second MPD case, and told me that they had had an unsuccessful experience with their first MPD patient and, based on that experience, felt a need to seek consultation on the second MPD case thew encountered.

## DISCUSSION

This paper offers an overview of my consultation experiences with respect to MPD over a period of fifteen years. My conversations with other experienced scientific investigators suggest that most of them, discounting certain unique aspects of their practices or circumstances, have noted analogous trends and phenomena. Despite the controversy that continues to surround MPD, the experiences shared in this article indicate that clinicians are becoming increasingly aware of this disorder, and responding to the newer literature and its findings. Notwithstanding the efforts of many dedicated individuals, contributions to the scientific literature appear to be the most powerful source of forward-moving change in the last decade. The sequence of experiences recounted here suggests that clinicians who continue to work with MPD become increasingly more sophisticated diagnosticians and healers. The treatment of MPD is no longer the province of the few. hi some locations, work with MPD has become routine. However, these findings also suggest that this progress is by no means a universal or uniform process. Instead, each clinician who discovers that he or she is among the first in his or her area to diagnose and treat an MPD patient can expect to encounter many of the same problems that other inadvertent pioneers have endured. Hopefully, as the years go by and MPD moves increasingly into the mainstream of the mental health sciences, these problems will pale. Perhaps in a generation, students will receive extensive education about the dissociative disorders throughout their training, and, if a professor describes to them the controversy and contention that once surrounded MPD and similar disorders, they will have to resort to an article such as this to recapture a taste of a less well-informed, if no less well-intentioned, era. ∎

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