THE PHENOMENOLOGY AND TREATMENT OF EXTREMELY COMPLEX MULTIPLE PERSONALITY DISORDER

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ABSTRACT

Cor temporary reports indicated that the average number of personalit.es in recently reported patients with multiple personality disorder (MPD) is larger than that reported in the older literature. A minority of tnese recent patients demonstrate extreme complexity. A group of 26 patients with 26 or more personalities and under observation for a n inimum of three years was studied. Their presentations, the rev ons that appeared to underlie their complexity, and their courses of / zeatment are reviewed. Findings indicate that this group of pat: ents is diverse, with some proving readily treatable, and others proving quite refractory. Observations that appear constructive for the 'reatment of such patients are offered. The concept of personality is d'scussed and an alternative description is explored. The usefulness of the paradigms and metaphors of splitting and division as heuristics for the understanding of MPD is challenged, and a paradigm/ metaphor of redoubling and reconfiguration is offered for fun her study.

In recent years multiple personality disorder (MPD) has been recognized, reported, and studied with increasing frequency. The recent DSM-III-R, (American Psychiatric Association, 1987) no longer describes MPD as rare. Cohorts of MPD patients have become available for study, and publisl-.ed collections of data from groups of MPD patients are slowly superseding the single case studies that had dominated the literature of the field for the majority of the twentieth century. One of the most consistent findings across the newer explorations of MPD is that the cases being encountered by con temporary clinicians and being reported in the modern scientific literature tend to have more personalities than those described prior to the 1970s.

Most cases in the older literature had relatively few personalities. Forty-eight of the 76 cases reviewed by Taylor and Martin in 1944 were dual personalities; another 12 had three personalities. Only one individual, a patient with 12 pe-sonalities, had more than 8. "Sybil, " with 16 personalities, reported in 1973 (Schreiber), was the first of the modern more complex cases to be described. Within the sar-te decade it was revealed that the celebrated "Eve" had 22 rather than 3 faces (Sizemore & Pittillo, 1977), and Billy Milligan, with 24 personalities, became *a cause celebre* in the media (Keyes, 1981).

As scientific investigators encountered increasing numbers of MPD patients, their estimates of the average number of personalities in such patients has increased. In 1979 I indicated that the number of alters in a series of 70 MPD patients clustered around a "modal range" of eight to thirteen alters; 55.7% had between two and ten, and 44.3 percent had eleven and more (Kluft, 1984b). In 1984 (a) I reported that a group of 33 successfully treated MPD patients had had an average of 13.9 alters. This group included nine patients with 20 or more alters; one had had 86. In 1985 a survey by Schultz, Braun, and Kluft (1989) of 355 MPD patients each reported by a different therapist, the patients had an average of 15.8 alters. Putnam, Guroff, Silberman, Barban, and Post (1986) found an average of 13.3 personalities per patient in their series of 100. In the same year I published an expanded series of 52 successfully treated MPD patients. This group averaged 15.4 alters. There were thirteen cases with over 20 alters, and patients with as many as 110 alters were included. Newer and unpublished additions to this research cohort include several successful treatments of patients with over 100 alters. Among the more recent series, Coons, Bowman, and Milstein (1988) are unique in reporting a mean of 6.3 personalities. They explain their findings by noting that their series was smaller than the others reported and that they sampled the number of alters "very early in therapy." In contrast, I (1979, 1984a, 1986) had included only enumerations of alters from the records of patients who had been treated to the point of stable integration.

My experience with very complex cases began in 1975. I was asked to see in consultation a woman who was believed to have three personalities. After a series of therapeutic misadventures she suddenly appeared to manifest 21 additional entities. My explorations convinced me that they were not conventional personalities, but were instead dramatic efforts to encapsulate the impact of imprudent therapeutic interventions. In essence, they were iatrogenic phenomena. A single hypnotic intervention reduced the complement of alters back to three. I had not anticipated any further contact with this patient, but, following several months of further therapeutic mishaps, she was transferred to my care. After a year during which she tested me extensively, a protector personality that had not emerged previously did so, told me that she decided I could be trusted and revealed a total roster of 33 alters. No outward sign had suggested such complexity.

She r ached integration in two and one-half years of treatment and retained her gains for five years, after which she reloc ted and was lost to follow-up.

I- 1976, while her treatment was proceeding, I discovered PD in a patient with a complex somatoform presentation (1984c). After meeting the second personality, which had :merged in a spontaneous switch, I invited any others that ight be present to come forward and introduce themselve . Four exhausting hours later, I had met 84 of the addit onal 86 separate and distinct alters who would ultimate be identified and integrated. Their rapid fluctuations and rattles for control had totally obscured the classic mani estations of MPD. This patient integrated after four years ork and remains stable on nine years' follow-up.

Alerted by these two patients and a third encountered a mont after the second, I began to appreciate that MPI) pale ts existed who were far more complex than those previ rusty reported. When I began to study my MPD patients as a g oup, I found that such cases were far from uncommon. In 19 9, I decided to collect information on this group. Som hat arbitrarily, I defined extreme complexity as the prese cc of at least twice as many alters as the upper limit of the dal range of 8-13, i.e., 26 or more. In 1983 I described findi gs in a series of 26 patients with 26 or more personalities t: the 26th Annual Scientific Meeting of the American Socie of Clinical Hypnosis; in 1984 I presented a series of 32 su h patients to the First International Conferences on Multi ile Personality/Dissociative States. These papers were not s i bmitted for publication at that time for two reasons. First, t was uncertain whether the field was moving toward a ne nomenclature, and I did not want my materials descr bed in a manner that would be confusing and inconsiste with an emerging set of definitions. Second, the contr.versy that surrounded MPD remained so intense that it see ed prudent to defer the publication of materials that migh well further inflame an already difficult situation. In the i ~ terim, however, no uniform terminology has been acce ' ted by consensus within the field, and MPD has succeed d in achieving more general recognition as a genuine clinical entity. Therefore it seems timely to communicate some initial findings with respect to highly complex cases of MPD

METHOD

The records of all MPD patients in my files were reviewe u. Those patients who both had over 25 alters and had been nder my clinical observation for a minimum of three years ere selected for inclusion in this study. The application f these inclusion criteria yielded a cohort of 26 MPD pane ts who were both extremely complex and very thorough y studied. They excluded over 100 such patients seen prim. rily in consultation or less extensively whose full com ' lexity was attested to only by self-report or by clinical obse 'ations made by others. It is of note that from my first obse ation of an extremely complex MPD patient until 1984, when several of my articles were published, extremely com ' lex MPD patients constituted approximately 15 to 20 percent of the MPD patients that I assessed. Subsequently, most of the MPD patients that I have seen were diagnosed by colleagues and referred for consultation. With each year more colleagues are more comfortable with the less complex cases, and the substantial majority of those that are referred to me are extremely complex.

Although the decision to report exclusively upon the best-studied group of such patients has the benefit of excluding information that was not tested and reconfirmed within a clinical context, it is acknowledged that if there exist any unwitting biases within the manner of my conduct of the therapy of these patients that might impact on the findings of this study, those biases remain uncorrected. Furthermore, the data of this study may not prove accurate if extended to that group of extremely complex patients that did not remain in treatment.

FINDINGS

The Patients

The sample consisted of 24 women (92%) and 2 men (8%); 94 percent were Caucasian. Both men were employed. Three of the women were homemakers by choice, eleven were disabled by their mental condition (and many described themselves as homemakers on this basis), and ten were employed. At the time of their entering treatment both men were married, ten women were divorced, six never had married, and eight were married. Six had been diagnosed and entered treatment with the author between ages 20 and 29, thirteen between 30 and 39, four between 40 and 49, two between 50 and 59, and one over 60. Twenty-four had had extensive previous therapy. They had been given a wide range of prior diagnoses. Fifteen had been in treatment over a decade before their MPD had been recognized, and all but two had been misdiagnosed for over five years. Nine received their MPD diagnosis from myself; the remainder had been referred with the diagnosis already established by a colleague. Of those referred already diagnosed, in only four or 23.5 percent had the patient's degree of complexity been suspected or established; in no case had the entire complement of alters been discovered.

The number of alters varied widely, from 26 to over 4,500. The complexities involved in defining a personality will be discussed below. For the purposes of this study, undertaken before DSM-III (1980) was published, all entities with consistent senses of themselves, consistent ways of behaving and interacting, personal memories, feelings, and patterns of function, and the capacity to assume executive control of the body, whether it was exercised routinely or not, were accepted as personalities. Phenomenologic and behavioral criteria were secondary. Ten patients, 40% (including both the males), had between 26 and 50 alters. One patient (4%) had between 51 and 75 alters, three (12%) between 76 and 100 alters, five (19%) between 101 and 200 alters, two (8%) between 201 and 300 alters, and five (20%) had more than 300 alters.

Despite these patients' degree of complexity, unless they were in the midst of an intense therapeutic process it was unusual for more than one to six of their alters, in

addition to the host, to play major ongoing roles in their interpersonal lives at any particular point in time. When this occurred, usually the patient became dysfunctional. Conversely, the number of alters playing ongoing active roles in a patient's private, inner world seemed unrelated to the patient's degree of dysfunction. With regard to this type of phenomenon, the alters' degree of conflict rather than their number seemed more correlated with problems in functioning effectively. Thus, even in patients with the most severe range of complexity (8-13), there are likely to be several personalities that, at a given moment in time, are less active, less manifest, and perhaps less powerful or apparently less important than others. The more alters that a patient has the higher the percentage of them that will appear less frequently or openly. To anticipate a point, the more alters that are both present and active, the less clearly is the patient likely to display the features expected to be found in the classic descriptions of MPD, which are based on the alternation of a small number of well-defined alters.

The Presentation of Extremely Complex MPD

As a group, these patients had proven difficult to diagnose. Of the eight (32%) whose MPD was first diagnosed by the author, three had presented essentially self=diagnosed, and five were in his practice for months or years before the MPD diagnosis was either first suspected or confirmed. None of these five had presented with signs that immediately suggested MPD, although in several cases this was due to the deliberate withholding of information or the provision of disinformation. Of the 18 (69%) referred with the diagnosis either already made or strongly suspected, the patients whose treatment careers could be documented had averages over ten years within the mental health care delivery system.

Although it is tempting to infer that the more multiple a patient would be, the more evident would be his or her MPD, this did not prove to be the case. Many of the more complex cases had a small number of alters handling most of their activities, and were no more obvious than other MPD patients. Those with many alters active presented such rapid fluctuations of appearance and behavior that the overall impression was one of confusion and chaos, and such disruption of their lives that poor ego strength was implied. Many functioned all activities through a beleaguered host, who, besieged with passive influence experiences and/or command hallucinations, was reduced to helplessness and despair. Interestingly, the patients who presented to me self-diagnosed had tried to tell previous therapists of their plight, but had been disbelieved. These therapists had used fallacious "casricious criteria" (Kluft, 1988) to discredit the diagnosis; e.g., that the patient could not possibly have MPD because she was aware of the other alters [sic!].

Another phenomenon that appears to have impacted on the manifest appearance of these patients, and thus upon their ability to be diagnosed, is order effect. First brought to the awareness of the MPD field by Frank W. Putnam, M.D., in a series of workshops and other presentations, this phenomenon relates to the fact that all alters are not the same all the time. Alter A may be somewhat different when it has been preceded by alter B than when it follows alter C. In situations in which many alters are switching with rapidity and facility, their appearance may not be as crisp and clear as when they are elicited in the clinical situation from a relatively placid baseline. In naturalistic circumstances, the alters of a highly complex and rapidly switching MPD patient may show few of the clear phenomena commonly associated with the condition.

In terms of prior diagnoses, virtually all had received an affective diagnosis with regard to their depression. Indeed, virtually all merited the diagnosis of depressive disorder not otherwise specified. Approximately two-thirds of the cases referred already diagnosed had received a borderline diagnosis, but their therapist almost universally withdrew this diagnosis after diagnosing the MPD. I considered seven (27%) to have a bona fide borderline diagnosis in addition to the MPD. This was made on the basis of borderline stigmata that could be distinguished from the manifestations of their dissociative and posttraumatic symptoms and signs and that had persisted for a long period of time and in a wide variety of circumstances and settings. Nine (36%) had been diagnosed as schizophrenic, mostly on the basis of hallucinations due to the inwardly-perceived voices of alters. None truly merited this diagnosis. Four had prior accurately diagnosed eating disorders; two had psychoactive substance abuse disorders.

Approximately half of the patients had had classic MPD diagnoses that simply had gone unrecognized for long periods. Most of the remainder had shown increasing signs of dissociative phenomena in the course of their treatments, and finally switched overtly in session. Four were accurately self-diagnosed. Two were found to have MPD (switched openly) in the course of investigating puzzling somatoform symptoms. Five were diagnosed with the help of hypnosis, four after much information had raised the suspicion of MPD. In one case I proceeded with no suggestive evidence other than the fact that the patient had come to me with a history of 38 years of unsuccessful therapy and, after a year, was not doing well with me either.

Pathways to Complexity

It may be difficult for many clinicians, even those quite conversant with dissociation in other contexts, either to believe that such complexity could exist or to conceive of why it would develop and be sustained. Although patients' retrospective reports are without external verification, they represent a useful source of information when this caveat is kept in mind. It is of interest that external corroboration of some aspects of alleged abuse was available in 12 cases (46%), including confessions by perpetrators, legal records, and the accounts of witnesses to the patients' mistreatment.

Based on the accounts available, the following factors, listed in order of decreasing frequency, were found in patients' material. Table 1 lists prominent factors in the given histories of these patients and the percentage of the 26 patients who gave such histories. It is self-evident that this was a highly abused cohort. As children they had been so bombarded with outrages that they had not been able to develop a cohesive and comprehensive system of alters within which

their further traumata could be managed. Instead, new alters were formed frequently on an ad hoc basis, and many persi; ted, some becoming major, some highly specialized, and same fairly inactive. Clearly their families were chaotic and unsafe, as evidenced by the high percentage of incest victims. Many formed a high percentage of their alters in direcr response to traumatic events; the more traumata, the more alters. These alters contained the memories of these evens and/or their associated perceptions and affects. They persi4ted as vehicles of memory, but rarely played major roles in day-to-day life unless events analogous to their uniq e experiences occurred. They were rarely invested in separateness and often integrated immediately or with little help ter being allowed to tell their stories. These patients had many years to respond to traumatic events, since 81 percent had continued to be abused well into adolescence and early adult life. Several had continued to be used even after establishing their own families; five (19%) were still being exploited well into their therapies.

Nearly three-fourths had rather vulnerable non-dissociative coping styles and defenses. Consequently, under stress they were readily overwhelmed forcing a resort to switching, and, should this fail, the precipitation of new alters One patient was so apprehensive about her consultation s ith me that no alter would agree to attend. A new alter was formed for the occasion. The weakness of the other available defenses also appeared to preclude the rapid "metabolism" of these ad hoc alters, which then tended to persist.

Over two-thirds had developed elaborate inner worlds, in which the personalities interacted among themselves to an extent that is far beyond the norm in MPD. These inner alters were quite crucial to these patients' psychological structure and could emerge and assume executive control. Often personalities formed ad hoc as noted above were incorporated into these systems, but in some cases alters appear to have been created to do no more than to fill roles in these inner worlds.

Almost two-thirds developed complex splitting patterns so that more than one new alter emerged on each occasion of the formation of new alters. Some developed separate lines of alters, each of which divided further on each occasion of new alter formation. Some had developed a pattern of generating new alters in clusters, such as groups each of whose members served different functions, or retained different aspects of a terrible experience.

All MPD patients were most unfortunate in their life experiences, but for many the abuse was unusual even by the norms of work with MPD patients. Wilbur has described some such instances, ironically, as "creative abuse."

Half of this MPD cohort demonstrated what might be called a pain-phobic orientation, by which is meant an intense preoccupation with avoiding dysphoria, and/or with protecting certain alters from dysphoria. Such patients spent considerable time in therapy arguing against the ideas of working with past traumata, and exposing particular personalities to painful material. But she can't take it/handle it" were common refrains. In many instances the alters being protected would be absent from the therapy sessions for prolonged periods, or be described as having died or gone away.

A substantial minority had developed a pattern of forming new alters in the face of trivial stressors and inconveniences, or whenever they felt cornered. They formed new alters to evade confrontations or responsibilities in therapy, and many, in the service of resistance, formed alters based on the therapist. Severe narcissistic traits and the deliberate abuse of autohypnosis was common in this group.

Ritualistic abuse was alleged by just over one third of these patients, and many of the most complex cases endorsed such experiences. A like number reported that others encouraged and/or manipulated their condition. Interestingly, since the personalities being manipulated perforce lost much of their defense capacities, the creation of still other alters to restore defensive balance or to propitiate the manipulator was encouraged.

Epochal divisions were common in most of this cohort as isolated phenomena, but played a major role in a substantial minority. With each major life change some or all of the alters were created anew, and their predecessors might either remain active or subside, and become covert or latent. The dynamics of such configurations usually reflect the wish to make a new start, rebirth fantasies, or anniversary phenomena. The often followed moving, changes in schools, changes in family constellations (such as the death of abusers or the birth of a child) , marriage, or great pressure to take

TABLE 1
Pathways to Complexity

Factor	%
1. Longstanding severe abuse	100
2. Ongoing alter formation	96
3. Incest	92
4. Event-based division	85
5. Ongoing severe abuse	81
6. Weak non-dissociative defenses	73
7. Inner world phenomena	69
8. Complex splitting patterns	65
9. Vicious torment	58
10. Pain-phobic orientation	50
11. Alloplastic evasiveness	42
12. Ritualistic abuse	35
13. Others exploit condition	35
14. Epochal division	35
15. Ego-syntonic splitting	31
16. Mythic elaboration	19
17. Massive introjection	15
18. Obsessional mechanisms	12
19. Symbolic splitting	4
20. latrogenic dividedness	4

flight. Obviously such a response pattern could either lead to sequential dual personality, with one line of splits and the nor-persistence of prior alters, or extreme complexity if several lines divide and alters persist.

A minority find the process of creating alters pleasurable or took narcissistic gratification in being complex. These patients constituted two-thirds of the 6 percent of MP a patients who flaunt their psychopathology openly and cultivate secondary gain from MPD (Kluft, 1985). Should this persist beyond the first few months of therapy, it is an ominous prognostic indicator.

Those few MPD patients who analogize their plights to kncwn myths or creative works (or who generate their own) ma) create a number of alters with little substance to fill in roles in their myth or reconfigure the present alters to par illel the personae of the myth/creative work. With such patients, it becomes crucial to understand the communicative function of the myth rather than to become enmeshed within its details. One patient reconfigured her alters after reading J.R.R. Tolkien's *Lord of the Rings,* and presented a complex cadre of alters based on hobbits, ores, and wizards; another used Shakespear s *I'empest,* a situation that became cle2r when I encountered an alter called Caliban.

Most MPD patients have alters based on identification, internalization, and introjection, but a small percentage havs formed a massive number of alters in this manner as a defense against object loss. These patients were rejected by large extended families, and introjected their members, forming alters based upon them. The role of obsessional phenomena in MPD is quite understudied, and more common than is generally understood. They lend themselves readily to serving as the nidus for alter formation. A small number of MPD patients have attributed special power to particular symbols or numbers, and these come to influence their manner of alter formation. One patient felt the number seven had special meaning to her. She wore a ring with seven stones, and her alters emerged in groups of seven. She spli off a first group of seven alters in a rather unremarkable manner, and then split off alters on 33 additional occasions, leading to 238 alters.

Finally, it is important to note that although there are many reasons for alters to emerge gradually over the course of therapy, implying to those who adopt post hoc propter hoc reasoning that they are of iatrogenic origin, a mismanaged therapy does have the potential to induce further alters (Kluft, 1982, 1989).

THOUGHTS ON THE CONCEPT OF PERSONALITY

Work with extremely complex MPD raises intriguing concerns as to the very nature of the personalities. Although this is a subject too broad to be addressed in depth in this article, an article that maintains that as many as thousands of the;e entities may exist within a given patient must attempt to ,hare the attitude such phenomena that informs its ob 1°rvations.

In the general psychiatric literature personality is taken to . can: "The characteristic way in which a person thinks, feels, and behaves; the ingrained pattern of behavior that each person evolves, both *consciously and unconsciously,* as the style or way of being in adapting to the environment" (Talbott, Hales, & Yodofsky, 1988, p. 1261). Generally, there are two trends in contemporary thinking about MPD as to the nature of personality. The stance taken by Coons (1984), hewing to the more general usage of the term, is that "It is a mistake to consider each personality totally separate, whole, or autonomous. . . . Only taken together can all of the personality states be considered a whole personality" (p.53). Braun (1986) attempts to define personality in a manner specific for use with MPD: "an entity that has the following: a) a consistent and ongoing set of response patterns to give stimuli; b) a significant confluent history; c) a range of emotions available . . .; and d) a range of intensity of affect for each emotion" (p. xii). He would describe less well-elaborated entities as fragments. Braun notes that using this definition may make MPD more acceptable if the number of personalities is "riot alleged to be so great" (p. xii).

I have never been pleased with the term multiple personality disorder because I endorse the conventional definition of personality and, therefore, regard the term as somewhat paradoxical. In my own thinking, I conceptualize the condition as disaggregate self state disorder (I have also used disaggregate structured self state disorder). I concur with Coons' (1984) stance, have encouraged the use of the term "alter" as a substitute for personality, and find the Braun (1986) definitions inconsistent with certain observations in my clinical experience (Kluft, 1985) and unduly defensive. Furthermore, they create a situation in which patients who quality for the DSM-Ill-R diagnosis of MPD may not have personalities as so defined.

I have tended to define a personality, alter, or disaggregate self state in a manner that stresses what such an entity does and how it behaves and functions rather than by emphasizing quantitative dimensions: A disaggregate self state (i.e., personality) is the mental address of a relatively stable and enduring particular pattern of selective mobilization of mental contents and functions, which may be behaviorally enacted with noteworthy role-taking and role-playing dimensions and sensitive to intrapsychic, interpersonal, and environmental stimuli. It is organized in and associated with a relatively stable (but order effect dependent) pattern of neuropsychophysiologic activation, and has crucial psychodynamic contents. It functions both as a recipient, processor, and storage center for perceptions, experiences, and the processing of such in connection with past events and thoughts, and/or present and anticipated ones as well. It has a sense of its own identity and ideation, and a capacity for initiating thought processes and actions.

Therefore, a personality as defined above and eligible for inclusion in this study might be a fragment in Braun's terminology; in fact, many extremely complex MPD patients have too many personalities for most of them to quality as such in this terminology. Braun uses the term polyfragmented MPD to describe such situations. Further remarks on the definition of personalities will be found in the *Treatment* and *Discussion* sections of the article.

ILLI STRATIVE EXAMPLES

n order to demonstrate the wide variety of phenomena enco mitered within this group of patients a series of illustrative s (etches will be offered.

ase 4. A woman of 34 had 27 known alters, of which 3 alwav s fulfilled Braun's (1986) definition of personality, a dozes of which did so for periods of at least a year in the cour e of therapy, and a dozen of which always fell short of this legree of definition. She was quite classical in her manifestations.

Case I9. A woman of 42 had over 1,600 separate entities. Virtually all were very minor entities, flickering briefly into action to influence the beleaguered host from behind the scenes. There was one additional very well articulated alter that never emerged unless requested to in the course of therapy. This patient exemplifies what Braun described as polyfragmented MPD. She did not appear to demonstrate classic MPD until she had unified down to three alters.

Case 6. A woman with 38 alters had about half a dozen

TABLE 2
Treatment Histories: 26 Cases

#	M/F	Age	Total Alters	Yrs Rx	Visits/Wk	Hosps. #/Mos.)	Current Alters
1.	F	37	>100	5	1-2	0/0	1
2.	F	39	238	3*	2	1/2	238
3.	F	55	33	3.5	1-2	0/0	1
4.	F	34	27	4*	1-3	3/7	?
5.	M	37	26	4	1	0/0	1
6.	F	27	38	5	1	0/0	5
7.	F	45	88	5	1	4/4	1
8.	F	32	>150	4	1	0/0	1
9.	F	39	>280	7**	1-2	7/18	>280
10.	F	51	409	7	1 (double)	0/0	<10%
11.	F	33	36	4***	1	1/1	36
12.	F	39	56	3*	1	3/5	3
13.	F	37	42	5	1	2/1.5	1
14.	F	42	86	5	1	0/0	1
15.	F	27	>100	3	1	0/0	<10%
16.	F	34	37	4	1-2	2/7	2
17.	F	26	36	4	1-2	1/1	1
18.	F	35	38	4	1-2	0/0	1
19.	F	42	>1600	3.5	1-2	0/0	3
20.	F	48	>150	5.5	2	3/14	1?
21.	F	39	685	8	1-2	7/24	7
22.	M	62	36	7	1	0/0	1
23.	F	39	82	8	2	12/30	1
24.	F	46	>4000	3	4	2/37	<5%
25.	F	40	143	7	1-2	4/12	1
26.	F	37	>_4500	7	4 (1 - 2 double)	3/52	1

Interrupted treatment against advice

** *Just returned after 3 year break of therapy*

*** *Transferred to another therapist for logistic reasons*

that were quite consistent, while the remainder were subject to frequent change and reconfiguration. The more she integrated, the more this tendency for reconfiguration became un.versal. The defensive power of the dissociative defenses and switching rather than the alters per se dominated her mental function.

Case 26. This patient, with over 4,500 alters, had only 300 that were as poorly defined as the alters in *Case 19.* They were remarkably full when they appeared, although many were quite similar to one another. It was as if the same "basic issue" types *of* alters could he reduplicated readily, and generated again and again over the course of the patient's life (epochal complexity). The sense of dealing with most was of dealing wit i a full personality that integrated more readily than a full personality because, despite their complexity, these alters had rather circumscribed bits of traumatic memories that were unique to them alone.

TREATMENT RESULTS

As of this writing, 13 of the patients (50%) are integrated, one appears integrated but 1 suspect there is more to be found, one is reduced to seven alters, one to six alters, two to three alters and one to two alters. Three very complex cases have integrated considerably, each alleging "over 90 percent," but none of these three patients can/will be specific. Two patients left treatment rather than deal with pailful material, and their state of integration is not assessable. One patient is essentially unimproved, and another, who left treatment for three years and is newly returned, in the interim redoubled all alters in a massive resistance.

In terms of general functioning, fifteen are fully employed and doing well, three are homemakers by choice, one is a student, and seven remain disabled. Two are currently hospitalized. Of the integrated patients, all are functioning well but those two whose integration is most recent, and one with medical problems. Some details of their treatment are summarized in Table 2.

The data *of* Table 2 are not accurate in detail, but in gestalt. Many patients refused to allow the precise details of their cases to be published lest they be identified or simply fee: uncomfortable. For similar reasons no effort has been made to link the particular historical antecedents (such as incest or ritual abuse) with specific patients. I anticipate that this concession of precise accuracy in deference to the sensitivities of the patients involved will be understandable and acceptable to those clinicians and scientific investigators fan-iliar with the treatment of MPD patients. The findings indicate that the extremely complex MPD patient can achieve anc sustain integration, although the therapy may be long, intense, and punctuated by hospitalizations, some of which ma, ' be quite prolonged. They also suggest that extremely complex MPD is a heterogeneous group, with some patients making rapid gains, and others struggling for many times as long to achieve comparable results. Members of the cohort tha=merited a borderline diagnosis did achieve integration, but the majority of those who broke treatment carried a concomitant borderline diagnosis. Five ritual abuse survivors are among the integrated and questionably integrated groups, indicating that this type of patient can be teated successfully.

The most salient prognostic features have proven to be neither complexity per se nor severity of traumatization. What appears most critical is the quality of the therapeutic alliance across the alters. When the alters are willing to work consistently, treatment proceeds regardless of all other difficulties. When the patients' primary gratifications are derived from their being MPD, treatment is problematic. One patient in this group who left treatment. with me presented herself to another experienced clinician in the field maintaining that she had ten times the number of alters that I had found, and requested free treatment due to the unusual nature of her case.

OBSERVATIONS ON THE TREATMENT OF EXTREMELY COMPLEX MPD

The general principles of the treatment of MPD as outlined elsewhere (Braun, 1986; Kluft, 1987) remain relevant with this more complex subgroup. Some observations based on clinical experience with these patients that bear upon their complexity per se may prove useful.

One must be vigilant to focus on the overall human being and avoid becoming entranced by the panoply of psychopathology. It is difficult to retain equanimity when confronted by materials which by their very nature raise the issue of their credibility. It is important to avoid making major decisions about therapeutic strategy before one understands why the complexity exists and what functions it serves. Certain interventions are contraindicated on the basis of the adverse responses of extremely complex MPD patients to such interventions in their prior psychotherapies: the expression of fascination, surprise, excitement, dismay, belief, disbelief, or the voicing of any opinion that could cause the alters to feel a need to demonstrate their authenticity. Likewise, the therapist's stating that he or she is overwhelmed or unable to cope with so many alters is counterproductive.

It is useful to make it clear that the number of alters is not important; that the critical issues are to understand how such a number came to be and to make sure that no aspects of the mind are neglected or lost in the shuffle in the course of the therapy. I tell the patients that if they are cooperative across the many alters, the complexity is not a problem. It is my experience that these patients are exquisitely sensitive to non-therapeutic interventions; the therapist who tells the patient that he or she only wants to deal with a few at a time, or does not want to hear about a newly discovered cohort, has severely complicated the treatment. The documentation of alters' differences in an intrusive way not related to evident therapeutic goals is deferred. If these patients come to feel that they are not being dealt with constructively, crises in the form or chaos, flight, pseudo-compliance, and self-destructive acts/suicidal behaviors are likely.

Evenhandedness to the alters must be demonstrated and demands for sustained attention soothed and confronted rather than gratified. In dealing with patients of this degree of complexity, it is extremely tempting to accord

atten ion and priority to the personalities in proportion to their initial apparent distinctness and importance. Nonethele s, such a course is fraught with peril, The true function and s gnificance of an alter cannot always be assessed early in tr: atment. Often many of the most crucial alters will emer e only after the therapy is well established and the thera 1st is trusted. In extremely complex cases layering (Klu 1984a), the emergence of additional groups of alters as th rapy addresses the issues raised by the first groups of alters that were encountered, may be anticipated. Some alters cannot emerge until those that block their coming forw d are mollified or integrated. Not unexpectedly, the thera fist's response to minor alters may be read as indicative of hi• or her overall concern for the patient, who usually exile fenced himself or herself as a minor figure in the famil of origin. For the reasons noted above and many other , clinical experience dictates that all alters be treated with qual respect and periodically accessed and inquired after, even if they have not emerged in session or have not appe. red to have any interest in the therapy process.

e following rather homely analogy may be useful. Rarel -encountered alters, alters described as insignificant, alters described or enumerated but which have not been met, nd alters that one can only suspect may be present, may e seen as the members of a football team or baseball team not currently on the field, but who may ultimately decid the outcome of the contest. I find it useful to assume that t+ ey are analogous to the team's substitutes, specialists, and c aching staff. Like field-goal kickers, third-string quarterba ks, bullpen catchers, relief pitchers called in only for left-h . nded power hitters, managers, and batting coaches, they re rarely on the field, infrequently noted, usually involl d in playing some role that is in no way apparent to the o tside observer, but may abruptly enter the play or influe ce it decisively from behind the scenes. Some appear to be hose who were so depleted that they enjoy an "injured rese " status, or are deliberately held in reserve (redshirte). Therefore the wise therapist always is aware of the likeli ood that when treating an extremely complex case of **MPD,** interventions are being responded to and assessed by alters whose roles and/or whose very existence remain hidde . These alters may prove to be the dominant forces in a sub• equent portion of the therapy, and will he easier to deal ith and less antagonistic if their presence has been antici ated and addressed.

T e amnestic barriers in extremely complex cases are intric. to and labyrinthine. It is useful to work toward maximizin co-consciousness and the sharing of contemporary aware ess and memory. I try to persuade as many alters as possi le to listen as often as is possible and tolerable. Once this is achieved, treatment has an impact far beyond the alters stensibly in charge at the time of the session. It is not unto mon to find considerable work occurs vicariously on the p rt of alters with concerns analogous to those who are "out" uring the sessions. Virtually all of these patients had alters which, when encountered, had rather abbreviated perio s of treatment before they integrated because of this antici atory vicarious therapy.

O ce a good number of alters are known to be listening, educative asides can be made to all, and comments that address the concerns of many alters at once can be successful. The personalities become accustomed to the virtues of co-consciousness and consistent contemporary memory within the benign environment of the therapist's office. In the course of this process, they usually begin to encourage one another and support the therapy process.

As a group, these patients are prone to propose numerous wishful plans and compromises which they advance as ways of furthering their recovery, but which prove to be evasions, conscious or unwitting, or variants of the flight into health. It is best to explore such proposals sympathetically, but to avoid colluding with them.

Unlike the more magical plans that such patients propose, the alters' requests to he treated somewhat differently with regard to the therapy often are productive. I had several patients who had alters that reclined on the couch, alters that sat in a chair, alters that insisted on different hypnotic procedures, etc. Unless unduly inconvenient, such flexibility often was rewarded by enhanced cooperation; such concessions often preempted more drastic demonstrations of the alters' needs to have their differences acknowledged. It frequently appeared that such token concessions sufficed to facilitate integration, and, in retrospect, proved to be rituals of farewell.

These patients are extremely hungry for reassurance, and request reassurance frequently. It is most useful to avoid offering false reassurance, and to give encouragement instead. What reassurance is offered should be based upon specific and tangible evidence. Global statements ofreassurance are most invariably experienced as pleasing lies or manipulations to "set up" the patient.

These patients are easily startled and upset, and do best with anticipatory socialization to upcoming work on painful issues. This "advance warning" may have to be undertaken at different levels of sophistication for the different groups of alters. Fearful of surprise, and, as therapy progresses, decreasingly able to block out pain, their responses to unanticipated dysphoria may include regression, alloplastic behaviors, obstructionism, or further splitting. Because of this, if the nature of the treatment at a given point in time is more focused on doing particular pieces of work rather than a more free-flowing process, I tend to anticipate for the patient the work to be clone in the next session, and to start the next session with a review of our potential agenda. I deal with potential objections and reservations, and am candid with regard to whether the session is likely to be painful. We either work out how to proceed and do so, or, if we cannot, move on to explore the resistances and reluctances, or some other subject that is either more pressing, more accessible, or more tolerable. This manner of proceeding reduces the number and frequency of sessions, and of crises.

It is the rule rather than the exception for additional previously unknown personalities to enter the treatment. Sometimes this is in the course of getting to know the patient more completely, and sometimes it reflects the presence of layering (Kluft, 1984a), in which as alters and conflicts that kept certain other groups of personalities covered over or hidden are addressed within the therapy, these other groups

eit er emerge or become more accessible. Since the discov- e of additional alters may be anticipated, and almost in ariably unsettles the patient, it is useful to socialize the pa ient in advance to the possibility that more alters may be fo nd and that such events are quite normal and without an im *act upon prognosis. In addition, since therapy is often ex.erienced as traumatic, and the patient *is* someone who re•ponded to trauma with the formation of alters, it is not un sual for new alters to be formed in the course of the trey tment.

Extremely complex MPD patients frequently rush Io- wa d fusion prematurely, either to please the therapist or to ev. de dealing with painful issues in the treatment (often eit er strong feelings in the transference or the anticipated pa n of the memories of other alters). Such apparent fusions fai nearly universally, and must be interpreted as indica- tio s for more work to be done rather than as proofs of a po s r prognosis.

Such patients integrate rather slowly and may remain un table for long periods. It is not rare for further alters to su face after many years of apparently stable integration. Ev n the most thorough therapy may leave areas untouched, *an some* alters are suppressed with such dedicated and int icate defenses that their appearance is postponed until ye. rs of a unified reconfiguration have loosened the forces th.t bound them so strongly.

Extremely complex cases have several pathways to inte- gr. Lion, and the several pathways may be encountered in a sin • le patient. It is not uncommon for large numbers of alt rs with similar concerns to coalesce rapidly, but, unfortu- na ely, this may happen before their unique memories have ben recovered and worked through. This may require ex ensive uncovering work within the alter that results from the integration.

Some patients work primarily in the context of a psy- ch ' dynamic uncovering therapy. The process of therapy ge ~s channelled through one or a small number of alters. Ern sion of the dissociative barriers gradually allows the alters to now more and more about one another, to empathize an . identify with one another, and to work on themes in co mon. Many may fuse at once or in rapid sequence. They m. fuse into a whole, into other alters, or coalesce. One pa ient had over 100 alters who worked in this manner for fo r years and then requested help in integrating com- pl:tely. They were joined in a single hypnotic procedure.

Other patients work in an obvious sequence, often from th most recent alters backward, or from the most venerable fo and in time. Patients who behave in this manner usually fu • - one alter at a time. This is an uncommon pattern in the m. st complex cases.

Many pursue treatment by working on one incident aft-r another. If a number of alters were related to a particu- lar event, they often coalesced together, simply ceased to ex st, or joined an emerging central alter after the incident wa. worked through.

The integration of alters who shared a related theme was qu to common. Those with similar concerns come together, an . as they do so, it is a curious phenomenon that the patient of - n begins to appear more classically multiple as the number of alters is reduced. For example, a patient with over ten alters who were concerned with themes of sexuality rarely showed overt signs of concern with sexual themes until they coalesced into a single powerful alter with sexual concerns that made her presence felt quite forcefully.

Closely related to the above is a variant found most commonly in psychodynamic psychotherapy, in which themes are not pursued in a structured manner, but rather emerge in the course of therapy, often as the feelings emerge in the transference. A common outcome is for the alters to remain separate in a depleted form, and require some more focused work to achieve fusion. If inquiry is not made, the therapy remains incomplete and the alters remain, ready to become active once again should stressors recur.

As more therapists and patients become involved in mapping the patients' systems of personalities (Braun, 1986), it becomes more common to encounter patients whose process of integration has been guided by strategies derived from the discovery of that mapping effort. No such procedure was employed with the patients in this series, but this pathway is mentioned for the sake of completeness.

As noted in a previous communication (Kluft, 1986), complex MPD patients arc more prone to the relapse into dividedness of apparently integrated alters than are relatively simple cases. This should be anticipated, and efforts made to educate the patient that such events are no more than indications of more work to be done.

On occasion, work with the extremely complex MPD patient requires some departure from the gentle and unpressured pace that is customary in work with this condition. The very complexity itself may serve the function of a character resistance that effectively precludes psychotherapy, and require confrontation and firm structuring. Generally the extremely complex MPD patient spends several months merely settling into the treatment, and is further disrupted by being pressured to address painful issues early in therapy. However, should it become clear that if a preoccupation with the MPD per se or a justification of the patient's particular sensitivities is dominating the sessions, it may be necessary to explore the defensive functions being served by such preoccupations, and attempt to move the treatment forward. This is not to diminish the importance of careful pacing, but to insist instead on the importance of dealing with resistance. A substantial majority of this group of MPD patients perceive that any attempt to deal with resistances constitutes an attack and a criticism from the therapist; their expressions of hurt and rejection may come to dominate the therapy. Of course, this too must be addressed.

ILLUSTRATIVE VIGNETTES

Case 8. Although she had suffered profound and prolonged abuse and had approximately 150 alters, this woman was ferociously motivated and prepared to be counterphobic to resolve her **MPD.** She was very pleased that I had not attempted to deny her MPD and talk her into behaving as if unified, as had a prior therapist. After she understood what therapy would require of her, she threw herself into treat-

ment hole-heartedly across all alters. Alters fused in clusters sp 7ntaneously after abreacting traumata. Although she was se n only one session per week on the average, and hypno is was only used on a few occasions, she worked with such i tensity that she achieved integration in under two years, nd has sustained integration for over four years. She was t ered to follow-up status after two years of integr [ion therapy.

se 6. Although she was highly motivated, a woman with 3 ' alters was mortified by what had befallen her, and both ecovered and shared information slowly and liesitan tly, with exquisite humiliation and overwhelming shame and p in. It required four years of two sessions per week and occasi nal three-hour sessions to allow her to share and work throu h her experiences, and finally to integrate. Although some naterial emerged in dreams, hypnosis was usually necess ry both to recover historical materials and to facilitate in egration. The treatment was gentle in the extreme.

Cr *se 26.* Ultrasensitive, pain-phobic, and readily distrade hy contemporary events, paralyzed by real or imagfined r jections, and prone to shed new alters in connection with t e pain of therapy, a woman with thousands of alters was so incapacitated by somatic and dissociative symptoms that s e required extensive hospital care. Seen for two douhl and two single sessions per week, she complained that e en therapy of this intensity was inadequate to her needs. Her pressure to evade painful material was intense, and, i her most characteristic alter, she maintained strong denial that she had ever been abused down to the last few integr. tions. Her therapy was characterized by innumerable crises nd complications. The inpatient staff and I were forced to impose stringent structure in the face of the patien s most anguished and persistent protests. Gradually the pa ient's alters began to work on painful materials and to coa esce along lines of commonalities of experience and attitu s e. All integrations were facilitated by hypnosis. As the patien achieved increasing integration she was astonished and a palled at her behavior over the course of treatment.

C se 7. A woman with 88 alters was so configured that all of the hers were very complex and very invested in separateness. he course of the treatment involved working with one or two hers and the host until those alters integrated or said they w uld integrate when they could join with an alter that had ni it yet been treated. In essence, each alter was treated relativ ly independently until it felt it had dealt with all that force ned it and was prepared to yield separateness.

C *se 21.* This highly complex woman with 685 known alters had an extremely intricate inner world dedicated to prote ting the host from pain. The host either withdrew immedia ely in the face of real or imagined stress or sat quiver ng, tearful, and ineffectual. After seven years of treatment he was completely unintegrated, continued to form new a ters, was self-mutilative and suicidal, and abused her childr n, despite energetic therapeutic efforts and many long ospital stays. Finally the impact of years of apparently ineffe tive treatment began to take hold, and the leaders of the in er world and the strongest protectors decided to integr = te. In the course of a year, with the use of many hypn is interventions, all known alters integrated down to four-the host, a protector, an alter that bore the worst hurt, and an alter that bore the anger. However, at this point, the patient felt she could absorb no more, and three new alters were created to further insulate the host from the pain of recovered traumata. She currently is attempting to stabilize at her present level of dividedness, and fighting off further memories, but the dissociative barriers are reduced in effectiveness, and all remaining alters are chronically flooded with memories of traumata that they feel unprepared to address directly in treatment. Her situation is unstable.

DISCUSSION

The above materials offer a description of some aspects of the presentation, phenomenology, and treatment of extremely complex MPD. Because the patients about whom this report is written were those who were studied most comprehensively, the findings are based on extensive experience with them. Therefore, the decided advantage of the wealth of the material in terms of depth must be qualified by acknowledging that the selection criteria may have generated findings that may not be applicable to all extremely complex MPD patients. Patients seen in consultation, unsuccessful treatments of under three years' duration, or relatively new in treatment may not prove to share the same characteristics found in this cohort. The requirement of being able to stay in treatment for three years or more may screen out certain subgroups of extremely complex MPD patients. Likewise, three years' exposure to me and my style of treatment may introduce some confounding systematic artifact that contaminates the objectivity of the observations. It is clear that extremely complex cases are being found by clinicians of all disciplines and theoretical leanings, and have been rioted throughout North America and elsewhere. Many of the findings of this study are self-evident and require no further elaboration and discussion. However, the issue of complexity itself raises profound questions about the basic nature of MPD, and the study of extremely complex cases offers a useful perspective from which to reconsider this condition.

Despite Young's (1988) useful corrective observations, there remains a tendency to conceptualize and describe MPD with the language of splitting and division. This proves very problematic in attempts to comprehend extremely complex MPD. If indeed one sees the mind as a unity that is torn asunder in MPD, it becomes very challenging to imagine that unity distributed among more than a small number of alters without straining credulity. How can one grapple with a "pie" represented as divided in a hundred or a thousand portions without the metaphor becoming absurd? This literal-minded approach to the problem of complexity naturally leaves both sympathizer and skeptic alike in a state of puzzlement, if not open disbelief.

However, if the language and metaphors of division and splitting are abandoned, this implicit reification and the difficulties that spring from it cease to be as vexing. It is clear that the alters in MPD are not so much polarized opposites, as was once believed to be the case, as different adaptational solutions to difficult circumstances, only some of which take

the form of being opposites (Kluft, 1987). The study of extremely complex cases with large numbers of alters, many of which have considerable similarities to one another, emphasizes that the alters are the vehicles of the patient's defensive and adaptational requirements, and the elaboration of their differences is a secondary phenomenon (Kluft, 1935). Alters may have their own relatively enduring patterns of perceiving, relating to, and thinking about the environment and themselves (American Psychiatric Association, 1987), but many alters *may* have virtually the same pa_tern, and be quite autonomous despite their similarity. One of the most efficient, effective, and difficult to detect ways of encapsulating the impact of trauma is to form isomorphic MPD (Kluft, in press); i.e., to form a virtual double of one's self as an alter. Such instances, found aplenty in extremely complex MPD, challenge the splitting and division paradigms and metaphors for the creation of alters, which are fragile vessels at best (Young, 1988). They suggest instead that the mind, rather than dividing itself, rather multiplies itself, recopies itself selectively, or rearranges a finite number of elements in patterns of great potential variety. It is the relatively consistent discontinuity, the relatively persistent dissociation of these copies and reconfigurations along the dimensions of memory and identity, that leads to the ongoing disaggregation of self states, which characterizes disaggregate self state disorder, i.e., multiple personality disorder.

If one understands the process of alter formation as one of defense reduplication and/or reconfiguration rather than division, the problem of wondering how the mind becomes divided into such complexity ceases to be relevant. The alters become different patterns of whole and/or partial copying and/or reconfiguring, which, when activated, may be more or less similar to one another, and inevitably will have a lot in common. This is more consistent with Putnam's unpublished findings on order effect than is the notion that the alters are discrete portions of some primal unity, and that any overlaps among them challenge the reality of the diagnosis of MPD (one of the "capricious criteria" [Kluft, 1988]). This line of reasoning may appear novel, but was in fact implicit in the work of Az.anr (1887). It. is also consistent with I.ifton's (1986) study of the process of doubling in adult adaptation to situations of extreme stress and conflict.

Another potential benefit of the reduplication/reconfiguration model is to avoid the use of a language that implicitly links the phenomena ofMPD with those of borderline personality disorder. Much unnecessary conceptual and clinical confusion has been generated by the utilization for MPD of terms that are so strongly associated with borderline personality disorder that they suggest an unnecessary and inaccurate connection between these two conditions, although they have been demonstrated to be discrete, although often coexisting, psychopathologies (Horevitz Rc Braun, 1984).

Perhaps the phenomenologic findings across extremely complex MPD patients and the fact that many of them are anomalous with regard to the paradigms of dividedness and splitting are indicators that these paradigms, however useful they have been, have exhausted their potential as heuristics for the study of MPD. If this proves to he the case, an important aspect of the study of MPD may be ready to undergo a revolution or paradigm shift (Kuhn, 1970). ■

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