THE INNER SELF HELPER AND CONCEPTS OF INNER GUIDANCE: HISTORICAL ANTECEDENTS, ITS ROLE WITHIN DISSOCIATION, AND CLINICAL UTILIZATION

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ABSTRACT

The Inner Self Helper (1SH), a specialized psychic structure said to be unique to Multiple Personality Disorder (MP)) and/or Dissociative Disorder (DD) patients, has its roots deep within traditional psychiatric and psychological heritage. This article examines some of the historical antecedents of the use of a source of inner guidance within the patient, a source that has been rolled the -unconscious mind, the obsenaing ego, and the higher self in addition to the LSH. This paper explores the ISH as it has been conceptualized in the past and as it presently is understood. Some clinical applications for the use of the ISH structure are also presented.

INTRODUCTION

Allison (1974) described the Internal Self Helper (ISI I) as a separate source ofwisdorn, perspective, and understanding within multiple personality disorder (MPD) patients, greater than is usually available to the conscious rnincl. He thought that working with the ISH was relevant and useful in the treatment of such patients. The concept of inner guidance is ancient; recent clinicians' describing the ISH as a form of inner guidance is consistent with a long tradition. This paper will review the debate which has surrounded the discussions of the IS11, describe some of the historical antecedents of the concept from psychiatry and psychology, discuss the concept of inner guidance in the context of dissociation, and conclude with a discussion of the clinical relevance of the 1SH. This review discusses areas and subjects that often are both untraditional and speculative. Its purpose is to organize and share observations about an important phenomenon that is more often the subject of informal discussion than scientific exploration within the dissociative disorders field.

CONTROVERSIES SURROUNDING THE ISH CONCEPT

Within the dissociative disorders field, the ISH became the focus of conflicting opinions. Proponents of the usefulness of the concept of the ISH hold that the utilization of inner guidance can aid both the therapeutic process and the development of the patient's ability to lead an autonomous, competent life. The ISH is thought not only to provide additional information concerning the patient's internal experience and make internal adjustments within the patient, but also is seen as able to develop the patient's ability to access a calm portion of his or her consciousness, removed from the intensity of the internal emotional storms. This latter ability is believed to provide stability, clarity, and a sense of peace. The patient's frequent. use of inner guidance is understood to begin to develop the patient's accurate self-understanding and self-directedness as a way of life.

Others who do not endorse the ISH concept argue that the existence of the ISH is unprovable, unnecessary, and probablyiatrogenic. Interestingly, many of these arguments are these same arguments which were originally directed against the existence of MPD as a separate diagnostic category.

The controversy surrounding inner guidance in the study of MPf) has been more intense in the past than it is at the present time. Early proponents of the Inner Self Helper described intensely vivid experiences beyond the realm of ordinary therapeutic encounters. They reported incidents in which an ISH would comment with great clarity and relevance about another patient seen only briefly in the waiting room; offer the therapist a cryptic and profound observation concerning a personal issue in the life of the therapist; or make reference to spiritual matters of great interest to the therapist. This was exciting to some therapists and unsettling to others. 11 seemed to result in a rift between those who held firmly to understanding interactions in traditional scientific psychiatric terms and those who seemed ready to embrace alternative explanations. Those who maintained a traditional understanding of patient/therapist interactions expressed concerns that 151-Is were compliant fabrications by the patient in response to the therapist's suggestions or difficulties. Whose ready to embrace alternative explanations viewed the ISH as a different and more spiritual manifestation of consciousness, perhaps even the portion of the person most closely related to and most closely identified with *God*.

As the debate continued, those who held different points of view tried to further their arguments by raising the issue of narcissism. Therapists' narcissism was advanced as the explanation of both encountering ISt I phenomena and failing to do so. The identification of an ISH as a potentially co-equal or even wiser part than the therapist within a special patient wilting to talk to a special therapists could be attribut-

ed to therapist narcissism. On the other hand, the assertion that there could be no ISH in a patient, no part wiser than the specially wise, trained, and gifted therapist could also be attributed to therapist narcissism.

Therapist sensitivity/naivete was another issue raised in the debate. Were those who accepted the ISH more sensitive to the spiritual nature of the human being, or were they naive (and perhaps highly hypnotizable, fantasy-prone) people engaged in *a folie a deux* (or more) with the patient?

Also, for a newly emerging field such as MPD, credibility in the face of the general scientific community was considered crucial. Many considered an interest in the ISH phenomenon as potentiallydamaging. Therefore, the unscientific generalization issue became another issue in the controversy. Therapists who were not personally aware of a source of inner guidance could he considered to be guilty of unscientific generalization in that they assumed their patients were constructed psychically just as they experienced themselves to be. Conversely, therapists who were personally aware of an inner source of guidance might he guilty of a similar preconception.

Inextricably woven among these controversies was the content of some of the ISHs messages and the reactions they evoked. Some ISHs claimed to have psychic abilities, an unproven claim which can neither be confirmed not dismissed peremptorily. As some 1SHs reported stories of reincarnation, miracles, spiritual encounters, special knowledge about the future, and instructions for their own care, and expressed with conviction obser'ations about other patients or the therapist, conservative eyebrows rose. On the other hand, ISHs did surprise many a therapist with the accuracy oftheir comments and observations. Therapists and patients who utilized the concept of the ISM in their work together believed (without confirmation or (lisconfirmatoryevidence) that they were having fewer crises with less need for patient hospitalization than would occur in comparable therapies in which there was no use of the ISH.

As with many other controversies in the field, this one has mellowed as proponents of both points of view have grown in clinical experience and sophistication. Presently, in my view, there seems to be an emerging consensus that .noteverything the identified ISH says is literal fact, but that there is a source of wisdom available within the patient.

A BRIEF OVERVIEW OF THE SUBJECT OF INNER GUIDANCE

The Unconscious as Inner Guidance

Jaynes (1976) theorized that early man had no conscious mind but rather had a bicameral mind composed of an executive portion which was perceived as a god, and a follower part which was perceived as a man. These parts, the wise part and the ordinary part, were dissociated horn each other.

Descriptions of sources of inner guidance or of ISH-like functions and instructions to utilize inner wisdom are not new phenomena. In 400, St. Augustine wrote, "Seek not abroad, turn back into thyself for in the inner man dwells the truth" (1972, p. 50). The *inner man* may have referred to a place similar to the concept of the *safe place* technique used in hypnosis (Kluft, 1989), or it might have referred to another aspect of consciousness such as the still, small voice within or to yet another, deeper aspect of the self.

As the concept of the unconscious became popular but remained obscure and poorly understood, it was credited with a multitude of different functions, Carus (Ellenberger, 1970), French physician and philosopher, described his perception of the source of the truth in the inner man in statements alluding to the abilities and gifts of the unconscious mind. His words are similar to those later applied to the ISH:

> ... the unconscious is indefatigable; it does not need periodic rest, whereas our conscious life needs rest and mental restoration ... the unconscious is basicallysound and does not know disease; ... the unconscious possesses its own inborn wisdom, in it there is no trial and error. (p. 208)

In 1886. psychologist Alfred Binet discussed the positive functioning of the unconscious mind and concluded that, "there is a permanent and automatic process of unconscious reasoning at the bottom of man 's psychic activity" (quoted in Ellenberger, 1970, p. 355).

Ross (1989) described Brewer 's patieiat, Anna O., and the portion of her personality which seemed similar to an ISH. "A *nna O.* had a third state as well, which today would be called a hidden observer, internal self helper, or center" (1989, p. 33). This state was, in Breuer 's (1895) words, "A clear-sighted and calm obser'er (who) sat, as she put it, in a corner of her brain and lookecl on all this mad business" (p. 101). Ross noted that this state could have been more useful to Breuer, and therefore to Anna O., had it been utilized more effectively. "If Breuer had been able to enlist this state as a co-therapist, he aright have uncovered earlier childhood trauma and provided a more effective treatment" (1989, p. 33).

In the late 1880s, Pierre Janet treated a patient, Justine, who either created an internal representation of Janet or had a part that utilized the representation of_ Janet to provide guidance. Justine raw her internalized Janet 's appearance and *heard* Janet's voice frequently. Ellenberger (1970) wrote:

> in a hallucinatory state she asked hire for advice, and he answered with good counsel which, interestingly enough, was more than a mere repetition of what he had actually said, but proved to he of a novel and wise nature. (p. Sh[y])

hr 1903, Myers (Ellenberg, 1970) posited three different functions of the unconscious mind: the inferior functions or the pathologically dissociative functions; the superior functions or the creative genius functions and the mythopoetic function or the unconscious tendency to weave fantasies (p. 314) Jung (1958) might view what Myers labeled "fantasies" as the unconscious mind's active presentation to

the conscious mind of archetypal images to represent or to compensate for the unbearable psychic tension of dissociation present in the collective conscious or in the personal unconscious.

Jung (1944/1954) conceptualized the unconscious as more than simply a repository for repressed drives, impulses, thoughts or wishes. 1le wrote:

> The unconscious is an autonomous psychic entity.... It is and remains beyond the reach of subjective arbitrary control, a realm where nature and her secrets can be neither improved upon nor perverted, where we can listen but may not meddle. (1944, p. 46)

Jung viewed the unconscious mind as an active source of wisdom, "the unconscious mind of man sees correctly even when conscious reason is blind and impotent" (1952, p. 24) . He listened to the unconscious through *the innervoice,* "the voice of a fuller life, of a wider, more comprehensive consciousness" (1954, p. 184). Jung believed that this wider, more comprehensive consciousness is a psychic richness that is available though not always claimed.

More recently, RobertLangs (1988) credited the unconscious mind of the patient with greater wisdom than the conscious mind of either the patient. or the therapist. He wrote, "... the deep unconscious system does not distort, but almost always perceives accurately and soundly" (p. 190).

Despite observations of the type noted above, interest in the unconscious itself as a potentially active participant in the therapy process has not been a major focus of interest. In an increasingly Freudian era, the unconscious was seen more as a somewhat unpredictable storage place for consciously unacceptable feelings,, thoughts or memories.

The Observing Ego as a Form of Inner Guidance

Many clinicians assume there is a healthy part of the patient, a heal t-beatofsanitvwith in the tumultuous labyrinths of the mind, that persists no matter how disturbed the patient seems to be. Freud (1940) described the situation as he observed it,

> Even in a state so far removed from the reality of the external world as one of hallucinatory confusion, one learns from patients after their recovery that at the time in some cannier of their mind (as they put it) there was a normal person hidden who, like a detached spectator, watched the hubbub of illusion go past him. (pp. 201-202)

Frankl (1963) wrote, "Indeed the innermost core of the patient's personality is not even touched by a psychosis" (p. 211). Ogden (1989) wrote:

> I conduct all phases of psychoanalysis and psychoanalytic therapy ... on the basis of the principle that there is always a facet of the personality ... capable of utilizing verbally symbolized interpretations (Ilion, 1957; Boyer and Giovacchini, 1967), .., an aspect of the patient flux tioning in a "non-psychotic part of the personality." (p. 39)

It is my understanding that the clinician who utilizes the concept of the ISH in an MPD or dissociative disorder (DD) patient is operating upon the same basic set of assumptions.

For years, psychoarralvsts have maintained that the existence of a functional observing ego was a desirable and even essential psychic structure within a patient (Sterha, 1934/1990; Greenson, 1967), something to he actively pursued or developed. The dissociation of the ego into observing and experiencing components is seen to be critical to the success of therapy.

> Hence, when we begin an analysis which can be carried to completion, the fate that inevitably awaits the ego is that of *dissociation.* A permanently unified ego, such as we meet within cases of excessive narcissists or in certain psychotic states where ego and id have become fused, is not susceptible of analysis. The therapeutic dissociation of the ego is a necessity. (Sterba, 1934/1990, p. 267)

Sterha (1934/1990) described a process of splitting of the ego so that a portion of the patient's ego can either form an alliance with or earl idcntif} with a portion of the therapist's ego, that portion being the analyst's analyzing ego. The therapeutic alliance is thus formed between the patient's observing ego and the analyst's analyzing ego.

Racker (1956) also employed this concept of a dissociated ego and requested his patient "to divide his ego into an irrational part that experiences and another rational part that observes the irrational part" (p. 176). This accurately describes many MPI) patients' reported experienceswith their own ISI Is. Greenson (1967) continued the focus on the necessity to have a dissociated, more neutral observing portion of the ego:

> Patients who cannot set apart_ a reasonable, observing ego will not he able to maintain a working relationship.... The patient is asked to split his ego so that one part of his ego can observe what the other part is experiencing. (p. 193)

NotonlvdidRacker (1968) insist that the patient develop an observing ego, he also advocated that the therapist either find or develop an observing ego of his or her own. Only in this way, he noted, can the therapist avoid becoming entrapped in unending a :ountertransfereuce responses. "Hence it is of the greatest importance that the analyst develop within himself an ego observer of his countertransference reactions...." (p. 138).

An observing ego developed within the context of a therapy relationship has not been labeled as iatrogenic or discounted as a compliantly-produced observing ego and therefore of questionable value. The observing ego devel-

oped during therapy is not thought to be any the less valuable or important than an observing ego produced in any other manner.

Hypnosis and Inner Guidance

The therapeutic utility of hypnosis in the treatment of MPD/DD is well known (e.g., Beahrs, 1982; Bliss, 1986; Caul, 1978; Kluft, 1989; Putnam, 1989; Ross, 1989). MPD patients move in and out of trance with relative ease and readily manifest classic trance phenomena when systematically tested (Bliss, 1986) . Most of the dissociative experiences MPD patients undergo spontaneously are experiences that can be replicated hypnotically, including the accessing of a specific source of inner guidance.

Two streams of thought in contemporary hypnosis are relevant to the ISH phenomenon. Hilgard (1977) performed extensive experiments in which he demonstrated the existence of what he called the hidden observer. He interpreted its meaning and implications cautiously and conservatively. Hilgard located the hidden observer within the conscious rather than the unconscious mind, and attributed to it a cognitive orientation. The hidden observer, he thought, ought not to he compared to a psychic structure with a will of its own:

> It should he rioted that the "hidden observer" is a metaphor for something occurring at an intellectual level.... It does not mean that there is a secondary personality with a life of its own-a kind of homunculus lurking in the shadows of the conscious person. (p. 188)

I-Iowever, the statements made by Hilgard's (1977) subjects seem to indicate they experienced their hidden observers as separate, active aspects of themselves:

1. The hidden observer is watching, mature, logical, has more information.... [p. 209]
2. The hidden observer was an extra, all-knowing part of me.... 1 p. 2091
3. The hidden observer is analytical, unemotional, businesslike. [p. 209]
4. He's like a guardian angel.... [p. 209]
5. He seems more mature than the rest ofine. More logical, and amused by the inc that couldn't hear. [p.2121

Among clinicians, Milton Erickson (1979, 1981) was a proponent of the wisdom of the unconscious mind. He perceived the unconscious as a positive hut not a perfect resource, and as an inner source ofwisdom. He would direct people to access their own internal resources when possible. If he found that their resources were insufficient, he would work to increase them. In much of his work, Erickson seemed to view the unconscious as if it were more creative, more subtle, and wiser than the patient (Hammond, 1984), an attitude some therapists have adopted towards the ISH.

The use of ideomotor signals to access information from a knowledgeable, although unspecified portion of consciousness, has been advocated by many therapists (e.g., Braun, 1984, 1986; Kluft, 1982, 1985a; Putnam, 1989; Sachs, unpublished workshop presentations) . Hilgard (1977) did not accept the proposition that one could communicate directly with the unconscious mind. He stated that although people believed they were in communication with the unconscious mind through finger-signalling, in his opinion this was absolutely not so.

INNER GUIDANCE IN THE CONTEXT OF MPD

Allison (1974) was the first to describe the ISH phenomenon in MPD patients and to represent the 1SH as an alter embodying wisdom and inner guidance. Allison had been influenced in his work by Assagioli (1965), the founder of the Psychosynthesis movement (Allison, personal communication, 1990). Psychosynthesis views the human being as composed of many subpersonalities, ego states, or parts. Each influences the behavior, cognitions, and/or affective response of the whole. Assagioli's conceptualizations stiggested a therapeutic style well suited to the treatment of MPD/DD and well suited to Allison's own belief system. Among the subpersonalities, Assagioli hypothesized the existence of, "a permanent center, of a true self situated beyond or above the [conscious self or ego] " (p. 35). He viewed this, which is termed the Higher Self, as The very core of the human psyche. " He was an enthusiast who advocated "the discovery rrrthe creation " of the Higher Self. Assagioli's Higher Self is obviously similar to Allison 's ISH.

Because a multiple dissociates affective and emotional states such as rage, sexuality, intense fear, and hopelessness, and traumatic experiences into separate and distinct personalities it is not unreasonable to suspect that this adaptive pattern extends t.o dissociating wisdom and insight into a separate alter. The ISH ' s attributes include its ability to function as an organizing force as well as to provide wisdom and insight.

The ISH as *Central Organizing Farce*

The existence of some unifying or central organizing force within an MPD patient may he inferred from his or her overall behavior, even though he or she subjectively may experience himself or herself as beingwithout internal cooperative abilities. The patient makes and keeps appointments over several different alters; finds her way to the office, school, or work, and then home again despite personality switching; remembers how to use the telephone and the bathroom, understands door knobs and shoe laces, and remembers the location of the elevator or stairs. Multiples have functioned for years with internal separateness but with sufficient cohesive functioning to enable them to hold jobs, to marry, to have children, and to have friends. This demonstrates some sort of internal communication, a fact which has one of two meanings: either the MPD patient is misrepresenting her

sense of herself as separate, or there is some central organizing force (unrecognized by the multiple) communicating across alters.

Beahrs (1986) credited the ISH as the central organizing force, "... these internal self-helpers or hidden observers may in some ways concretize that yet unknown organizing force that gives a normal person his sense of unity in the face of the multiple co-conscious ego states we all possess" (p. 107).

Fraser & Curtis (1984) and I (1984) developed comparable conceptual understandingsofsome structure or force within the multiple that was stronger, wiser, and connected to all parts of the person. Fraser and Curtis (1984) termed it the Central Subpersonality, and I termed it the Center. For purposes of consistency, Allison's term, ISI I, will be used to refer to the source, embodiment, or personification of inner guidance. Nonetheless, it is useful to note that Fraser, Curtis, and I originally believed that what we had found in our MPD patients was in some ways similar to Allison's ISH, but in other ways seemed so different that it warranted the use of a different terminology. Perhaps most importantly, the concepts of the central suhpersonality and the center were less mystical and. spiritual in orientation than is stated in Allison's original discussion of the ISH.

The ISH is neither the ideal form of the person, nor how she or he would have turned out had there been no trauma, nor the *real* self as contrasted with other alters *as* splits of a *falve self*. Allison (1980) described the ISH as "a dissociated part of the personality, not a spirit with a past life." Fraser (1987) characterized it as "the core of the person's consciousness... buffered by a characteristic interpersonal ego style or styles which we call personality" (p. 2). Putnam (1989) wrote of the ISH as, "an observing ego function that can comment accurately on the ongoing process, and provide advice and suggestions as to how to aid the patient in achieving some insight and control over his pathology" (p. 204). Beahrs (1986) described the ISH as "a healthy personification of the creative unconscious which we all share" (p. 106).

Affective Attributes of the ISH

Allison (1988) reported that the ISHs he met had a rather bland affective style. He remarked: "The ISH lacks eIllonons; it answers questions and conrrnunicates in the manner of a computer repeating programmed information. The ISH seems to be pure intellect" (p. 132). Putnam (1989) agreed, "Typically, they are physically passive and relatively emotionless personalities who provide information and insights into the inner workings ofthe system." Fraser (1990) commented, "I describe it as the Spock of *Star Trek*. *They* are logical and try to maintain a neutral position as observing ego. However, some do have a sense of humor and I have seen them laugh." I found that although [SI Is often present themselves as emotionally flat, they have the capacity for, and later often demonstrate, the full range of human feelings. They are oriented more toward task accomplishment and other alters than toward themselves, and they seem either to have a better ability to tolerate their feelings or a better ability to distance themselves from their feelings than do other alters.

Incidence

The question *of* whether the ISH is a universally occurring phenomenon or is a phenomenon restricted to pathologically dissociating individuals has probably been pondered by all therapistswho have seriously considered the ISH. Allison (1974, 1980), Beahrs (1986), Fraser & Curtis (1984) and 1 (Comstock, 1984) accept the premise that an ISH "is present in a normal person as well as in a multiple, although in a multiple personality, the ISII appears as a separate individual" (Allison, 1980, p. 13H. Beahrs (1986) thought they were universal: "I suspect are similar and present in everybody at all times" (p. 110). Putnam (1989) concluded that, "'Si 's appear to occur in at least 50-80% of MPD cases where they have been sought. One can often find this type of function in non-MPD patients as well as within one's own self" (p. 110).

Adams (1987) administered a survey to therapists on membership list of the International Society for the Study of Multiple Personality and Dissociation, concerning their experiences with and their beliefs about the ISH. Out of the forty participating therapists, 90% (36) had direct contact with at least one L5H in MPD clients. More than half of her respondents replied that they believed every MN) has an 1511.

The question of whether patients have one or several ISI Is also has been considered. Allison (1980) found many different ISlIs in his multiples. I-le described an upward spiraling group of ISI Is with ever-higher ones available if needed, some of which are beyond the body. He reserved the term ISI I for those within the body. Fraser and I recognize one ISH and the possibility of many other- helping alters. Certainly, the first identified apparent ISH within a multiple often is later revealed to have been a helping personality. It is not always clinically necessary to make a distinction between the ISH and a helping personality because information from the ISH can be communicated through helping.

As clinicians' experience with ISHs has broadened, it has become increasingly clear that there is no single way in which inner guidance is accessed or applied and no single way in which an ISH works. Some generalizations can be made concerning the potential activities of the ISH and possible methods of communication with the 1511, but each person is unique and develops a unique relationship among his or her own parts.

***Communication** with the ISH*

Communication between an NH and a therapist may take place verbally or non-verbally. A therapist can become aware of feelings that originate within the patient, visual or auditory representations of a patient's experience, or intuitions or *knowings* which the patient then later describes. Therapists have described experiences with MPD/DD patients during which they suddenly *know* something, understand something, or see something they could not reasonably be

expected to know, to understand, or to feel.

Projective identification (Klein, 1946) is one possible explanation. It is a primitive defense in which the patient splits off a feeling, an idea, and/or a portion of the patient's self or experience and then *passes it over, gives* it to or *puts* it in the therapist. The therapist then accepts and responds to the material the patient has passed to the therapist. Thereafter, the therapist either acts out his or her part of the projective identification or, preferably, works it internally himself or herself and then passes it back (in its reworked form) to the patient. This form of communication takes place forcefully and instantaneously, can happen on the telephone or at other times when the people are not in direct contact. Freud (1915) commented on such communication:

> It is a very remarkable thing that the Unc. of one human being can react upon that of another, without passing through the C's. This deser'es closer investigation... but, descriptively speaking, the fact is incontestable. (p. 194)

Ogden (1990) viewed projective identification as "predominately a communication between the unconscious of one person and that of another" (p. 79). Neither patient nor therapist can articulate the precise way in which the communication occurs. Projective identification, parallel processing, patient projection, therapist introjection, therapist projection, and patient introjection imply the actual passage of patient internal experience to the therapist on an unconscious level with whatever is transmitted from patient to therapist neither transmitted nor received on a conscious level.

Some therapists attempt to understand unconscious to unconscious communication as ISH-to-ISH communication. Such explanations, while admittedly not demonstrable, offer the possibility of working toward voluntary and intentional control over such communication, rather than abandoning it to the realm of the inaccessible, and responding to rather than directing this process. Admittedly, such thoughts are completely speculative.

Information Sharing

Because the 151-I is thought to have access to the memories of the person as a whole as well as to the memories of each alter individually, and because each alter knows a relatively small part of the real history of the patient, one of the most frequently requested clinical applications of work with the ISH involves its sharing information (Allison, 1980; Comstock, 1985, 1987, 1988, 1989; Fraser, 1985, 1986, 1987; Putnam, 1989; Ross, 1989).

Memory is not infallible (Loftus, 1991). Hypnosis does not add to the reliability of retrieved memories, but does increase the subject's confidence, rightly or wrongly, in their accuracy (Orne, 1959; Petinatti, 1988). Therefore, the reliability of recovered and abreacted memories remains an open question. It is not known for certain whether incidents reported by the ISH are more or less reliable than incident reports of any other person, but clinical experience indicates that the reliability of the ISH reports is likely to be a great deal higher than those of other types of individual alters.

Some types of statements made by MPD patients complicate the issue. Incidents from before or shortly following birth, from previous lifetimes, and/or involving encounters with spiritual entities have all been reported. These memories, whether simply recalled or abreacted, seem no more or less authentic to the patient than do memories or abreactions of any of more commonplace material. Simply put, we do not know how to differentiate between *a real* memory or an actual abreacted exogenous trauma, and a confabulated recollection or abreaction of a pseudomemory experienced within the therapeutic relationship for a different purpose. Strachey (1934) suggested that abreactions could be expressions of "an artificial neurosis in exchange for his original one" (p. 335), a discharge of affect and/or libidinal gratification.

The Spiritual Dimension of the ISH

Every major religion has referred to inner guidance in its teachings with its own referent identifying names (e.g., the Spirit of Christ, the Atman, God within, etc.). Most people do believe in the existence of God (Troll & Sheehan, 1989) and, therefore, therapists can assume that most people have a spiritual interest. With the notable exception of Bowman (1989), little has been published concerning the spiritual experiences of dissociative patients. The relative discomfort of therapists in addressing spiritual issues may have complicated, delayed, or prevented the acceptance of the concept of the ISH because early descriptions *of the ISH* so frequently included a spiritual dimension. In the early descriptions oflSHs, the aspects of inner wisdom and of spirituality seemed to have been dissociated into the same structure, the identified ISI I. Allison (1980) saw a strong connection between the ISH and God: "I see it (the ISH) as that part of the mind through which God is revealed to the individual" (p. 109). He continued, "They [ISHs) feel only love and express both awareness of and belief in God. They serve as a conduit for God's healing power and love" (p. 131).

Fraser (1989) found both *believers* and *non-believers* in the ISHs he met: "The center ego state has an ability to look at things philosophically as well as religiously, but I have known atheist ISH ego states ... religious beliefs are dependent on the background of the patient" (personal communication, 1989). Ross (1989) voiced a conservative view of the spiritual aspects and/or abilities of the ISI-I. "It is my experience that centers and inner self helpers can be excellent co-therapists, but they do not have transcendental abilities" (p. 35) .

I have observed some ISHs similar to Allison's ISHs and some ISHs who not only do not believe in God but are angered by the thought *of* the possible existence of a god who permitted them to suffer as they did. In many patients, the ISH does seem to be that part of the person most apt to deal with spirituality in a relatively undistorted manner (if any part in that patient is apt to do so).

Allison (1980) did *most of his* writing during his first years of work with MPD, and he may no longer subscribe to some of what he believed in those early years. He wrote:

> The challenge of formulating a methodology and the necessity of discarding it when it is no longer applicable is an integral part of such pioneering work. I have already found it necessary to revise some of my early theories and I'm sure this process will continue as long as my work continues. (p. 202)

Allison (1980) accepted his patients' statements of their experiences quite literally, as many originally tended to do. He had come to believe patients' reports of spirit possession as genuine, although he also considered the possibility that there was something about the psychic make-up of MPDs that made this particular explanation of their experience more plausible to them.

> Repeatedly, I encountered aspects or entities of their personalities that were not true alter personalities. It is, of course, possible that multiple personalities are particularly susceptible to such delusions. But in many of these cases, it was difficult to dismiss these unusual and bizarre occurrences as mere delusion. In the absence of any "logical" explanation, I have come to believe in the possibility of spirit possession. (p. 183)

Post-integration Experiences with the ISH

Because the ISH is conceptualized as a dissociated ego state, final integration changes both the expression of the ISH and the therapist's experience with the ISH. Allison described the integration process in psychological as well as spiritual terms. He viewed psychological fusion as the step in which the personalities are gradually merged until only a single personality and the ISH are left. Spiritual fusion, then, was the fusion between the remaining personality and the ISH, a process which could take place quietly and almost imperceptibly or could take place dramatically amidst visions and forceful spiritual experiences.

Following integration, both Allison and Fraser have communicated directly with the ISH. Fraser wrote, "Even after fusion, I have been able to contact the center ego state with hypnosis or guided imagery.. I believe it remains separate in its role as the observing ego" (personal communication, 1989).

I have not had contact directly with an ISH following integration. I see the abandonment of dissociative defenses as a gradual process, with separateness possibly recurring during stressful life episodes. Therefore, I would not be surprised to contact an ISH during a particularly stressful time after integration, nor would I expect the ISH to remain separate once the stressful time had passed. Those who are conservative in their understanding of the ISI-I would question whether an integration that left an ISH separate is a true integration, and would regard the re-emergence of an ISH as a simple relapse.

CLINICAL UTILIZATION OF THE ISH

The ISH cannot curethe patient, cannot control an individual alter's cognitive processing, or alter entrenched character pathology. However, the IStI's skills and talents can help the healing process, and the therapist can help the ISH learn to help the patient, just as non-dissociative patients utilize their observing egos.

Dissociation as a defense is only one portion of the difficulty the MP) patient presents. MPD originates in childhood, usually as a result of exogenous trauma (Braun, 1986; Coons, 1986; Ureaves, 1980; Kluft, 1984; 1985b; Putnam, 1989; Ross, 1989). It also has elements of Post-traumatic Stress Disorder, components of character pathology, and severe developmental gaps and disturbances. The ISH can be most helpful in addressing and facilitating the remediation of the dissociation and the PTSI) aspects of the disorder. The characterological aspects of the pathology must he treated in the usual therapeutic manner over the usual length of time with expectations of encountering even more than the usual difficulties. Although the ISH can make treatment easier, it cannot make it easy.

The following observations are drawn from clinical experience. The ISH is capable of making decisions, initiating actions, and implementing plans. Potential ISH actions include observing ego functions such as analyzing and evaluating, the provision of pertinent information to the therapist or to the patient, the offering of suggestions to solve a problem or to understand an alter, the orientation of an alter, the prevention and/or management of a crisis, the selection and implementation of a variety of internal adjustments to alter perception or experience, the management of abreactions, the education and management of the alters, and the blending of alters. Although the ISH cannot prevent denial, suppression, re-repression, or splitting (except for a brief time), the ISH can hold a picture, a phrase, a feeling, or a lesson in mind to make it more difficult for the alter to deny, suppress, or re-repress the experience. In addition, the ISH can hold affirmations or other positive thoughts or memories in mind to provide some positive feelings and/or thoughts. The 1Si-I can remove or block out certain thoughts fora time to allow development ofan alternative way of thinking.

The ISH can alter memories if requested, but substituting therapist-created illusion for patient-created illusion is not a reasonable therapy goal. The ISH is most apt to be involved and interested in the internal experience of the patient rather than in external life events. This can be disconcerting to a therapist who might expect an IS1-I to restrain an alter from prostitution or some other activity the ISH has long ignored. Familiar activity is not perceived as an immediate threat by the ISH.

The Use of the ISH as Organizing Force

The therapist's ongoing work with the ISH can begin to develop an organizing force within these chaotic patients to which the alters relate and around which they can coalesce. Therapists who remind the patient of the presence of the ISH by asking questions concerning the ISH's perception of a still mysterious feeling or perplexing situation encour-

ages the patient to appreciate that a portion of their minds is engaged in a rational, thoughtful analysis, no matter what their subjective perception is at that moment.

The ISH can act as a transitional object or an anchor, as a portion of internal reality to which the alters can cling when their newly emerging and quickly changing senses of self fluctuate. The 1S1-I's positive attitude towards each alter and towards the whole can begin to create an accepting internal atmosphere that will be ultimately productive for the patient. It may seem strange to a therapist who values introspection that MPD patients do not easily internalize the pattern of turning inward for answers or direction. This is not an easily learned process for the MPD patient.

Communication with the ISH

Obviously, one of the first tasks to be negotiated i▶r learning to work with an ISH is learning to *communicate* with it. During treatment, the therapist will want information and/or opinions from the ISH. However, itismore important for the patient to communicate with the ISH. The therapistcan set the stage for communication with a briefgereral statement describing the ISH or *a part* of the person with access to information which is not readily available to all alters. He or she can refer to that part. as the unconscious mind, a sort of inner guidance or observing ego, or a part that can communicate with all of the alters and may communicate directly with the therapist or may *communicate* through other alters. The therapist ought also to include the possibility that the ISH may not communicate at that time. Often, the system recognizes the ISH immediately *rom* the description *and* may refer to that part with a name, as a color, a sense, or even a shape. Caul (1978) advocated the energetic pursuit of the 1511:

> The Inner Self Helper (ISH) should be identified as quickly as possible. The therapist must not be afraid to *home tmdewith* the ISH, who will always he protective of the personalities and will see to it that therapy is provided and *that* the personalities will get the best deal possible. (Caul, p. 2)

In early t'eatment (when there is little co-consciousness among alters), the therapist's direct communication with the ISH may be more important than when the task of asking questions and listening for answers gradually has been turned over to the patient. Initial communication between patient and ISH need not include a dramatic presentation of the ISH. It may be dramatic, but more likely, the patient will *first* experience the presence of the 1SH as a hunch, a physical feeling, an ordinary voice, a sudden thought, a phrase of a song, poem, or prayer, a picture, a memory of a scene, or a pervasive feeling of peace or comfort.

In the early stages of communication between patient and ISH, the alteration in focus of attention from external to internal may result *in* the unintentional switching of alters. It may take practice before an alter can both remain present and *listen inside.* Communication by the ISH to other alters may take place in seemingly casual times. It is as if *haw* ing an alter distracted by a somewhat mindless activity such as showering or driving allows the ISH an opportunity to slip thoughts of ideas into the patient. Journal writing is another activity that affords the ISH a vehicle with which to communicate with all or with a part of the patient. The ISH may insert information or supportive statements into an ongoing journal.

At times, it may not he clear whether or not a message is coming from the *real* ISH or source of inner guidance. If the messages are practical and clear, it. probably does not matter if they are coming from the true center or another helper. If the messages do not evidence a positive and helpful attitude, distortion or misrepresentation is occurring.

Communication with the ISH can occur verbally, but can occur non-verbally through intuition, a hunch, a *felt* sense of knowing, projection, projective identification, parallel processing, or any other form of patient unconscious to therapist unconscious cornrnunication. From the perspective of those who find the ISH concept useful, the clinician who assumes that unconscious or ISH communication is random, arbitrary, and uncontrollable loses an opportunity to explore or develop this avenue oFcornmunication. The therapist who proposes that this process can be initiated or influenced by a portion of the patient utilizes an opportunity to encourage communicative efforts by the patient and an opportunity to make an unconscious process conscious. Making the process explicit can often provide enough heightened awareness and attention so that the 1Sf I can exercise more intentionality in the transmission or the withholding of communication.

***Response** of the Patient*

The response of the patient to the presentation of the concept of the ISH reveals a great deal about the patient's internal emotional world and also provides some pertinent clues concerning the possible form the resistances to its use will take. Patients' responses to the concept vary from comfortable, immediate recognition and acceptance to fear, anger, and refusal to consider such a possibility. Overly compliant patients may produce a representation of the ISH from a helping alter. Indicating that the ISM may not reveal himself or herself directly to the patient or to the therapist may help to minimize this possibility. Patients who are frightened by the ISH concept may experience the suggestion as a criticism of the way in which they are presently managing, as a demand to function beyond their abilities, as a hint there is something weird or foreign inside them, or as an indication/promise that the therapist can read their minds and will know there better than they need know themselves.

Patientswhovehernently resist the idea of *listenin.ginside* give clues to the ways they will express their resistances throughout therapy. They may he externalizing their present inability to resolve their struggle between two opposing desires: on the one hand, to be taken care of and, on the other hand, to learn to take care of themselves. Many patients enter treatment *with* the hope (often unconscious) that they can finally find someone who will take care of them. Intensely desiring to be cared for by the therapist, they energetically resist

any instructions or suggestions which would necessitate their taking active responsibility for their own progress. They *seem* to believe that if they can get someone to love them enough or care enough, the pain from having received inadequate love as children would *not* he as great (Krystal, 1988).

One aspect of the difficulties of MPD patients is their striking inability to either tolerate or modulate their feelings. Often a strong feeling (or even the merest beginning of a feeling) is a trigger to switch personalities, to *lose it* and fall into a flashback, to drink, to take drugs, to self-mutilate, to contemplate suicide, or to hurt someone. Patients traumatized as children were so overwhelmed with intolerable feelings *that* they responded either by numbing all their feelings, by becoming helplessly overwhelmed by them, or by alternating between these two responses. Children who have never learned self-soothing or self-nurturing skills perceive all control over their internal states as externally provided (Krystal, 1988) . Many remain dependent on external sources such as chemicals, food, sex, or self-mutilating behavior to alter their internal states. The use of music, relaxation tapes, and/or small transitional objects can provide an external permission to alter their internal state. The clinical use of the ISH as an interim separate-and-therefore-not-perceived-as-internal source of permission can begin to develop the natural self-regulating functions so long prohibited.

***The Orientation** of New Personalities*

The ISH can help to short-cut repetitive tasks that might be time-consuming and/or co-opted in the service of resistance, such as the orientation of new personalities. Some dissociative patients present. a seemingly never-ending supply of personalities who experience themselves as never having met or been aware of the therapist. When a new personality emerges during sessions, the 1SH can be asked to orient the personality to the office, to the therapist, and to the purpose of therapy. This may he cummunic:aled very rapidly and accepted far more readily than it might be from an external source, such as the therapist. Once this orientation process has been implemented a few limes, the IS11 can begin to orient an emergent alter or one that has been unaware of the therapy before she or he gets to the office. With ►umecessarily repetitive interactions avoided, alters can move more directly toward involvement in the therapeutic process. Here again, the use of the ISH to orient the alter encourages the patient to develop and then to rely on her own internal resources rather than to rely primarily on the therapist. A patient's inability or unwillingness to do this demonstrates either the internal strength of the patient 's prohibition against self-care, or the depth of the patient's determination to create a childlike dependence and make of the therapist a substitute parent (Barach, 1987).

Crisis Management and/or Prevention

[SI Is ma bernet more frequently (luring times of crises. Crises (in the patient's *eves)* include events, actions, impulses, memories, *upcoming* abreactions, or feelings experienced as overwhelming. Crises (ill the therapist's eyes) include potentially dangerous actions by the patient. Acting *out* the feelings behind crises does reduce the intensity of feelings for the patient by discharging the affect rather than containing it. Crises also provide a metaphorical way of communicating with the therapist concerning the patient's deep feelings or intentions. However, obviously, once the feelings are acted out, they are no longer available for exploring, resolving, or understanding. The 1S11 can clarify the underlying dynamics of approaching crises so that they can be talked about rather than acted out. Once the cause of or the purpose for the crisis is known, the immediate therapeutic issues are usually quite clear.

Personalities in crisis often are personalities disoriented in time and/or place. They may be having hallucinations, experiencing painful somatic sensations, acting out or re-experiencing portions of their pasts, and/or living in a flashback world (Loewenstein, in press). A personality threatening violence to self or others acts as if he or she assumes that the hostile, abusive, and dangerous past not only needs to be but also can be dealt with in the present time. The ISH can help to explain the situation to both patient and therapist and assist in re-orienting the personality to the present time, a time in which violent behavior is neither necessary not helpful. Although the personality may not be willing or able to recognize the past as past, the ISH at least can present a representation of today 's reality to the patient so that the patient will have two pictures in mind rather than one. The therapist can make suggestions to the ISH concerning phrases which could be repeated internally or relevant scenes which could he presented to begin to re-orient the personality. Conflicting realities sire an improvement over a non-existent reality.

Active therapist intervention can be more helpful at the beginning of treatment when the patient is beginning to learn the process of healing and integrating. As therapy progresses, the therapist may make fewer and fewer direct suggestions.

Internal Adjustments: Hypnotic Interventions

Therapists working with the ISI I offer many of the same suggestions, comments, and interpretations as do hypnotherapists who do not use the ISH construct. A major difference lies in the attributing of accomplishments to a part of the patient rather than to hypnosis or the therapist. There are many excellent compilations of hypnotic interventions useful in the treatment of MPD (Bliss, 1986; Braun, 1980, 1989, 1986; Klan 1982, 1983, 1985a, 1985c, 1989; Putnam, 1989; Ross, 1989). Kluft's (1989) article is a valuable compendium of suggestions to alter the affective experience of the patient. The reader is encouraged to study the hypnosis literature in order to understand the rationale behind the different types of hypnotic interventions possible. Most hypnotic interventions, designed to work quickly In resolve a specific problem, work best for short periods of time. Although they may not solve problems, that. they can postpone acting out until the problem can he solved is most helpful.

General hypnotic techniques can he easily altered to fit MPD patients. Common sense additions include the pro-

vision of internal safe places for individual alters and common areas designed to encourage closeness or visitingamong alters. The dual foci on separateness and togetherness addressed through the creative use of internal space makes explicit the process which is occurring implicitly. Common sense exclusions for MPD patients might include beds, basements, small spaces, and the avoidance of images such as candles or ropes which might be threatening for some alters.

The therapist can use the observations of the ISH to help determine what hypnotic interventions might help. The ISH is usually not aware of the wide range of possible solutions known to the therapist. Together, the ISH and the therapist may decide upon an appropriate course of action that the ISH can implement. Most of the steps successfully accomplished by the ISH involve self-suggestions that utilize extensions or alterations of naturally occurring phenomena in an intentional manner. The use of time distortion interventions for a system of alters that already exists in a time-distorted world is easily implemented. When it might he beneficial for an alter to age-regress or age-progress, the ISH can help. Altering the perception of affect in a person who has experienced both overwhelming affect and total numbness is similarly familiar and replicable in the source of a therapeutic intervention.

In the Ericksonian approach (Erickson,1965r/ 1983, 1979. 1981), it is assumed that somatic symptoms have a purpose. For example, pain may remind one to slow down, to remenr-bersomething, to learn or relearn something, to think about something, to attend to some parlor issue inside. Headaches may be signs of conflict between alters, between remembering or forgetting, between accepting or denying something, between remembering and re-enacting, and between containing and acting out. The 1SFI can help to translate the physical sensations into messages, meanings, or instructions for a part or the whole. The ISH can alter the perception of physical sensations in all the familiar ways; but even more importantly, the ISH can explain why the symptom is present and what needs to be done about it.

Abreaction

The use of the 1S1-I is particularly important in the abreactive process. Some therapists insist on knowing the content of upcoming abreactions before they permit the patient to begin the abreactive work. Such therapists can learn the contenteit her directly from the 1511 or from any alter through whom the 1SH speaks. Therapists may also utilize the ISH more extensively during the abreaction process to provide information, clarity, and modulation. During abreactions, the ISH can alter the personality's perception of the experience so that the personality will not become overwhelmed by the affect and re-repress the content of the abreaction in what becomes a re-traumatization rather than a learning experience.

During abreactions, the ISH can communicate with the therapist. Information can he given directly or non-directly in relatively non-threatening, non-intrusive, and non-disruptive ways through yes or no head movements, speaking through the alter, or having the alter speak enough for the therapist to understand. The working alter may not even notice that information has been shared.

The ISH can he employed to increase or decrease sensations so that the personality can continue moving through the memory. Although the ISH can make other changes in the experience, interventions are more useful once the per ¯ sonality has completed the abreaction and is free to attend to the whole picture.

Another effective ISH-facilitated alteration comes from the MPD patient's experience of observing an incident from several perceived-as-different points of view. During or after an abreaction, the ISII can superimpose a more realistic view of the situation on the personality's perception of the situation so the personality can observe the incident from two different points of view. This is particularly helpful for those personalities who allege they were ritually abused, involved with drugs, and/or subjected to the intentional creation of delusion or magic to confuse or dominate a child personality.

After an abreaction, the personality that abreacted can *check in,* uiewith the ISH to make certain that everything that needed to he seen has been seen, everything that needed to he felt has been felt, and that everything that needed to he learned has been learned so that. the personality does not need to abreact the incident further. Often I, the ISH, or the abreacting personality will restate the lesson so that we can be certain we have not missed anything significant.

Dreams

Often the ISH can create or influence dreams to offer a lesson in another, perhaps more palatable form, or to provide comforting experiences the patient neither is having nor has had. The ISH can provide one dream for one personality, many different dreams for many different personalities, or one dream for more than one personality to share. The ISII can stimulate the renremhering and/or the forgetting of such dreams. Freud's (1914) concept of the dream censor sounds remarkably similar to descriptions by MPD patients of experiences in which a portion of a dream seems to come close to the surface of consciousness, feels about to emerge into consciousness only t.o disappear again, almost as if something or someone had snatched it back down, away from consciousness. At times, an ISII reports intentionally doing this so that one or many personalities can have had the experience of the dream without the conscious recall of the dream. This prevents the personalities frorn consciously resisting or denying the experience of the dream.

Blending or Integrating Alters

The MPD patient with no control over his or her separateness and dissociation faces life with, at best, limited and often unavailable resources. Long before integration is near, it *may* be useful for alters to *pool* their *resources.* A model which permits the temporary blending or integrating of aspects of separated personalities has been described (Fine & Comstock, 1989). The clinician who works with the ISII perceives the ISH to have the ability to effect a temporary merger of separate parts, blending the emotions, the contents, anti the

energies of' those parts. Any blending images that appeal to the relevant alters can be used to facilitate this process. This can be helpful in a variety of situations including crisis management, learning experiences, calming, or re-orienting an alter, or offering additional energy to a depleted part in a process similar to Fine's tactical integration (Kluft, 1988). Obviously, each of the involved parts must be willing to participate in the blending, although it can be done when one part is too young or too disoriented to participate in an active fashion. Personalities who have blended and then separated again will have a different cognitive and emotional experience following the blending experience. It is as if they have been irrevocably influenced by another portion of themselves, and now share more of a common consciousness and common experience.

Post-integration

Following final integration, the experience of relating to the ISH will change, for both the patient and the therapist. The patient's experience of his or her self has changed. Communication with the ISH will still occur, but it will not he experienced as communication between two separate parts. It takes place more in the form of *felt* senses, answers, or hunches. An integrated patient may be able to speak from an ISH ego state in trance (Watkins, 1982), but this state does not remain obviously separate outside of the trance experience. An integrated multiple seems to experience an ISM in much the same way that other people experienced their own inner guidance. After integration, the therapist may leave the question of consultation with the ISII to the discretion of the individual to manage the communication within himself or herself in his or her own way.

CONCLUSION

As is true of any psychological assumption, the existence of the ISH can neither be proved nor disproveddefiriitively. However, there is sufficient and reasonable historical and clinical evidence to suggest that such a structure can exist and can he demonstrated t.o be of benefit. In the past, the concept of dissociation of the ego into the obser'ing and experiencing ego has been observed to he therapeutically beneficial to the patient.. The extension of the concept of inner guidance into the form of the ISH for MPf) patients seems logical and corresponds to the reported experience of MPD patients. In the opinions of many experienced clinicians, the phenomenon of a source of inner guidance as a separate presentation of a psychic structure can be a clinically helpful c once ptualization in the treatment of MPI)/DD patients. ■

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