Multiple Personality Disorder and Transference

Cornelia B. Wilbur, M.D.

ABSTRACT

The appreciation, interpretation, and management of transference constitutes a crucial dimension in the treatment of multiple personality disorder. The author offers remarks and observations based on a considerable body of direct clinical experience and consultations to colleagues. The most commonly encountered problematic transferences in work with MPD, the hostile, erotic, and dependent, are illustrated and discussed.

In his first mention of transference, in the seminal *STUDIES ON HYSTERIA* (Breuer and Freud, 1895), Freud described this phenomenon as the "transferring on to the figure of the physician the distressing ideas which arise from the content of the analysis. . . Transference on to the physician takes place through a *FALSE CONNECTION* (p. 302)." He further observed that "It is impossible to carry any analysis to a conclusion unless we know how to meet the resistance arising from personal estrangement between analyst and patient, fears of dependency, and the transference (p.303)." Although the concept of transference has been elaborated and studied by generations of analysts, Freud's first observations defined its essence, and a detailed discussion is not of immediate relevance to the main thrust of this article. A useful synopsis of contemporary analytic understanding of the transference was offered by Sandler, Dare, and Holder in 1973.

In multiple personality disorder (MPD) each individual alter within the complex develops its own transferential relationship with the therapist. Each transference relationship can become extremely complicated because it may include admixtures of many forms of transference. For example, one of many ways of classifying transference is to describe it by its positive and negative components. Positive transference includes tender, affectionate, and warm feelings as well as erotic and sexual ones. Negative transference includes feelings of rage, hostility, hatred, annoyance, and distaste. Any and all of these may be reflected onto the therapist in the course of the treatment.

Person (1985) noted that the phenomenon of transference has two different levels, the manifest content and the motivational source. Any given transference, be it positive or negative, erotic, paranoid, or idealizing, etc., can be named in terms of its manifest content. However, to complete its description, the source or motivational structure should be specified; i.e., maternal or paternal, Oedipal or pre-Oedipal, etc. For example, a very profound manifest negative transference may be linked with a very needy maternal or paternal transference. A common experience in work with MPD is to have an alter enraged at the therapist in connection with a covert wish for nurture from the therapist.

In the following remarks I will share a selection of observations on the transference in MPD patients. I cannot hope to be comprehensive or exhaustive; instead I will offer some observations based on decades of direct clinical work with MPD patients and consultations on the treatment of such patients undertaken for numerous colleagues.

The importance of negative transferences cannot be overestimated. They constitute one of the most common reasons for the interruption or stalemate of therapy. If, for example, an angry alter experiences a hostile paternal transference toward a male therapist, the alter may become so intensely antagonistic, critical, fault-finding, and irritating that the beleaguered therapist may respond to the alter in an angry way, bringing treatment to a jarring halt. Countertransferential rage is not uncommon when an angry alter has placed the therapist in the position of a hostile father and refused to communicate or carry on treatment with him. At times other alters will disrupt treatment for fear that the angry alter will assault the therapist. Such constellations constitute one of the most extreme resistances in the treatment of MPD. A keen appreciation of the centrality of the transference and its potency as a resistance is necessary to the successful resolution of the symptoms of this condition.

Although hostile transferences are most commonly discussed in work with MPD, erotic transferences can generate equally intense resistance. For example, a not infrequent but rarely discussed dilemma occurs when a flirtatious and coy alter may try to seduce the therapist into believing that all is well and that certain areas need not be investigated. If successful, crucial problems may be bypassed, and, in effect, the therapy is scuttled. It is, unfortunately, not uncommon for an alter to attempt to seduce the therapist sexually, and succeed in arousing sufficient countertransferential sexual desire to reduce the therapist's effectiveness, even if an actual sexual contact is averted. I concur with Person (1985)

Address reprint requests to: Cornelia B. Wilbur, M.D., 408 Bristol Road, Lexington, Kentucky 40502

that there persists within analytic thinking a tendency to perceive certain transferences as Oedipal when they may have pre-Oedipal dimensions as well. Erotic transferences are often assumed to be exclusively Oedipal, when they may have significant earlier determinants that must not be overlooked.

As Person (1985) observed, the manifest or surface similarities of transferences may obscure the fact that they have totally different motivational bases. This may be regarded as similar in many respects to the familiar analytic concept of overdetermination; i.e., several dynamics may play a role in a common symptomatic expression. Therefore, the analysis of any single transference dynamic leaves the work incomplete. An unsophisticated therapist may believe that "the problem of hostility" is resolved if extensive work has been done with the transferences and resistances that seem to stem from the relationship of the patient and an abusive father, only to find the hostile negative transference remains vigorous, motivated by as yet untouched transferences toward maternal figures based on still unrecovered or unmentioned events. Once these are appreciated, still further negativity may have an origin in yet other difficult relationships.

Kluft (1988) further observes that the unsophisticated therapist may not appreciate that although some alters may appear to demonstrate some transferences prominently, the same transferences may be present in less overt forms in other alters as well, and failures to analyze them may prove an impediment to treatment. To remain with the example of a hostile paternal transference, he cites an instance in which the openly acknowledged angry feelings of some alters were less problematic than the deeply denied and passive-aggressively expressed rancor of those who, on a conscious level, stoutly maintained their admiration and affection for the therapist. He also addresses the problems encountered when an alter's expression is combined with that or influenced by that of another alter whose feelings the first cannot allow himself to own.

Many younger therapists have been trained without an emphasis on psychoanalytic concepts, and, in their "use of themselves," are relatively unaccustomed to acknowledge the potency of transference/countertransference phenomena. Such therapists are quite prone to personalize their patients' transference expressions, and may have difficulty maintaining objectivity. It becomes important to allow and accept the patient's attribution to the therapist of abusive intent as well as almost magical nurturing capacities without responding with outrage or withdrawal in the face of what, if taken at face value, are unwarranted character assassinations and excessive demands for care and reassurance. The therapeutic task is to avoid the personalization of the patient's expressions, however intense and outrageous, and instead to point out to the patient what is happening in the process of treatment. Such interpretations should be kept "cool." The patient must not come to feel that he or she is being criticized or condemned for attempting to resist further movement in treatment.

In my experience consulting with therapists across the country, the most recurrent transference/countertransference problems brought to my attention in work with MPD are those that involve very bright angry alters' persistent needlings and criticisms that provoke an angry response from the therapist. Therefore, such situations have dominated the examples I have shared thus far. However, on occasion miscarriages of erotic transference/countertransference situations are shared with me, unfortunately, long after the fact. It would be naive for me to assume that such incidents would be brought to my attention with as ready openness as other difficulties and misadventures. It is insufficient to remark that therapists should never do anything that would embarass either themselves or their patients under any circumstances. In general, therapists bed their patients more frequently than the professions would like to acknowledge. In MPD, however, one often finds that therapists have persuaded themselves, often with the patient's manifest collusion, that this is what the patient "needs" and "wants" because the patient has been so deprived. Such therapists forget that MPD patients, like many abused populations, may have attuned themselves to offer whatever a person of power appears to want, lest they be mistreated, or have come to confuse sex and love. Kluft's materials (1988) include the instructive example of an MPD patient who was so affected by her background of profound neglect, brutalization, and sexual exploitation that the only form of acceptance with which she was familiar was gentle rather than violent sexual activity. In several alters she became convinced that her therapist disliked her because he interpreted rather than acted upon her offers of sexual favors. She threatened to drop out of treatment unless he "proved he cared for her." It took several months to work through this issue, at the end of which process the patient spontaneously integrated over 40 of her approximately 50 alters, and began to make rapid gains in treatment.

Transference can prove a most potent resistance. Reich (1949) correctly remarked that the accurate comprehension and management of the first transference resistance is essential for the logical development of the treatment. In treating MPD it is important to be alert to the first manifestations of transferential attitudes on the part of any alter or the birth personality, and assess both their potential to act as a resistance to the treatment and to stimulate countertransference. A transference resistance and a countertransference response can develop a pathological synergy that leads to their mutual intensification.

The analyst who is in a supervisory situation that studies transference and countertransference may be more clearly aware of such difficulties than the therapist who either is without supervision or who is supervised without specific attention to these phenomena. Szaz

(1963) believed that Freud first understood transference in the context of his colleague Breuer's experiences with Anna O.; i.e., the theoretical formulation of this phenomenon was made by someone other than the therapist.

Although my previous remarks focused on the hostile and erotic transferences, and the erotic transference is the one most widely discussed in the analytic literature, it is important to realize that these transferences do not develop to the same degree in all therapeutic situations, nor do they develop to the same degree with each of the several alters in MPD. It is a common error to misinterpret many nurture-and dependency-seeking transferences as erotic. Both positive and negative maternal and paternal transferences will emerge, and emphasis must be placed on their resolution. In this almost invariably highly abused population, transferences toward past abusers often include elements of hostility that coexist with wishes for love and dependency needs toward the same individuals. These must be disentangled in the course of treatment, lest the patient repetitively seek out love objects who resemble the past abusers.

Person's (1985) observations that traditional formulations regarding transference are often oversimplified cannot be overemphasized with regard to MPD. For example, classic descriptions of the erotic transference were based on feelings expressed by heterosexual female patients toward male doctors. In MPD the erotic transference may be expressed through many alters of different genders and sexual orientations. For example, it would not be uncommon for a female psychiatrist to be the object of overt heterosexual erotic feelings from the male alters of a female patient and overt homosexual erotic feelings from the female alters. However, the situation is far more complex. Few individuals, or alters, are without some degree of conscious or unconscious bisexuality, and this influences the transference as well. Also, while the female psychiatrist is consciously understood to be female, the transference toward her may be based on a relationship with an important male figure. All of these considerations must be kept in mind.

The same concerns apply to other types of transference as well. The unsophisticated female therapist may assume that hostility directed toward her reflects a negative maternal transference, when, in fact, she is perceived unconsciously as the recreation of an abusive male figure. She may also erroneously conclude that such anger is an indication that the mother was abusive, when, in fact, the anger may stem from the fact that mother did not recognize or acknowlege the abuse, or act to protect the patient.

Work with the transference in MPD is complicated by the fact that transference projections and accusations often are directed toward the therapist's areas of personal vulnerability. MPD patients can be exquisitely sensitive people. They pick up a great many cues about their therapist's attitudes and feelings. They certainly can find areas of vulnerability that hostile alters will attack in connection with transference resistances. In a similar vein, Kluft (1988) has observed that the therapists of MPD patients often so extend themselves to be kind, welcoming, and giving that they reveal a great deal more of themselves than they do with many other types of patients. He also has noted that MPD patients can be quite intrusively curious about their therapists. Consequently, the transferences may become sufficiently enmeshed with reality components that they are experienced by the therapist with the discomfort associated with an intrusion into one's own "personal space" and with the intensity of a vigorous personal attack, and are difficult to interpret because they are engrafted upon known reality components.

The therapist must strive to create a situation in which the best possible communication is encouraged. Optimally, the sharing of whatever affect, even rage, should be possible without incurring a hostile response on the part of the therapist, who, even under the harshest of verbal assaults or the most erotic provocations, recalls that he or she is the therapist and only a "stand-in" for "X","Y", or "Z."

Likewise, the therapist should be aware that hostility toward other individuals in the MPD patient's life may have transferential components. For example, one MPD patient dated a man who humiliated her. She spent four days in a complete rage with a migraine, spells of vomiting, and a plethora of other symptoms. She believed this man had produced this reaction in her. It was clear to the therapist (and so interpreted to the patient) that the man had behaved much like her father had acted toward her for years, and had awakened not only her anger toward this man, but her long-disowned hostility toward her father as well. Until this interpretation was made, the patient could neither "settle down" nor understand how a single episode could have produced such an intense rage reaction.

The dependency shown by MPD patients can prove unsettling to many therapists. It is useful to reflect that when one carefully examines the life of the patient who develops MPD, one usually recognizes that normal dependency was not permitted. No support was given to allow the patient to build the strength that is necessary to become independent. Therefore, these patients come to us with intense dependency problems and considerable conflict about them because dependency is both craved and perceived as a severe threat. For example, if one becomes dependent upon a hostile parent, one perforce becomes the victim of continuous abuse. This adaptation and coping style may be carried over into marriage and other relationships after the MPD patient becomes an adult, and may aggravate the burden the alters are obliged to handle for the birth personality.

The complex of personalities within an MPD

patient usually includes very youthful alters; it is expectable that those up to adolescence will express an understandable dependency toward the therapist. The therapist must create a therapeutic situation in which these alters can gain strength and begin to mature. These matters are often better managed than interpreted in a classic manner. There are many ways to encourage maturity. When a three year old alter states that she now is four years of age, she may be congratulated heartily and assured that this is the direction that she should take. Infant and child alters need to be reassured that their needs and desires are normal for them and their age. Often this can be addressed without major life disruption or the encouragement of regression. For example, a very young alter, aged three, requested a furry animal that she had seen in a store to sleep with. However, the more mature alter who did the shopping was extremely heasitant to buy this object because she was afraid that she would look foolish. It was pointed out that unless she assisted the younger alter to feel secure the younger alter would have difficulty in maturing. The therapist took the side of the younger alter and explained to the more mature one that she could pretend it was for her "little sister." The object was bought. The younger alter was very happy; within a few days she reported that she had grown up a lot and now experienced herself as five years of age.

Therapists who fear "excessive dependency" may have difficulty in dealing with the dependency of the various alters because they do not appreciate that the "excessive dependency" will persist until some resolution of whatever propels its perpetuation is achieved. Their stance may be rationalized as an avoidance of unnecessary regression, but this is a problematic countertransferential attitude that overlooks the nature of these patients' areas of difficulty. Some colleagues have spoken of their beliefs that the younger alters should receive reparenting. In fact, the crucial issues are addressed in the process of working through the dependency concerns that are inherent in most MPD patients. Again, I want to emphasize that the normal dependencies of childhood have not been resolved for these patients, and must be addressed therapeutically in the course of the therapy.

It is useful to underscore, in closing, that the therapist who hopes to succeed in working with MPD patients cannot be misled by assuming that the manifest content and motivational source of a given transference is completely revealed in the course of its most florid expression in the verbalizations and actions of an alter who appears to embody its most dominant attitudes. We often are confronted with hostile alters who always express hostility. Therefore, if they try to provoke an altercation with the therapist, the fact that they are using hostility as a defense against resolving whatever problem has created their hostility or instigated its contemporary expression is fairly self-evident. Likewise, because we appreciate that MPD patients usually have suffered severe abuse, the motivation and the source of the transference may be readily apparent. However, it must not be assumed that such instances reveal the full dimensions of transference in a given MPD patient. Most transferences are considerably more complex in their structure and dimensions. For example, in this article I have used the terms erotic and hostile transference as if they were self-sufficient and mutually exclusive. This represents an oversimplification in the service of my didactic purposes. However, sexual seductiveness may disguise the underlying rageful intent of a woman who is furious with men and wishes to degrade them, but, due to her history of sexual brutalization, has come to eroticize her hostility.

The therapist who hopes to help the MPD patient resolve his or her difficulties must become familiar with the literature on transference, even if he or she is not analytic in orientation. The illustrations that I have chosen to use are rather simple; what I have been able to express in this brief communication only scratches the surface of a phenomenon that inevitably intrudes itself into virtually every aspect of every therapy. It behooves us to watch carefully for transference as a resistance, and to monitor and be informed by, rather than act upon, our countertransference responses. Our MPD patients are intelligent people. They may mobilize their intelligence in the service of resistance. However, the correct appreciation and the appropriate interpretation and management of transference phenomena will facilitate their increased understanding of themselves and the therapeutic process, and minimize the risk of therapeutic stalemates, failures, and misadventures.

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