DIAGNOSIS OF COVERT AND SUBTLE FORMS OF MULTIPLE PERSONALITY DISORDER

Through Dissociative Signs

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ABSTRACT

There are different forms of multiple personality disorder (MPD) that vary on a dissociative continuum from subtle forms in which the alters are not very distinct or elaborated and often influence each other without assuming full control, to patients with fully developed MPD, whose alters are distinct, elaborated, assume full control, and emerge overtly. Most MPD patients present covertly, and some patients with covert presentations will later show overt classic symptoms, while those with subtle forms will often remain mild and subdued. Most MPD patients hide or disguise their condition, while their alters express their thoughts and feelings through subtle dissociative signs that occur when the alters influence each other, partly emerge, or subtly shift. These signs consist of frequent, sometimes sudden, fluctuations in affects, thoughts and behaviors, transferences, developmental levels, and psychiatric symptoms, and marked discrepancies in memories, viewpoint, and attitudes, which may indicate the possible presence of alters and of MPD or Dissociative Disorder Not Otherwise Specified: variants of MPD. The case of a subtle form of MPD is presented which illustrates some of the subtle signs of dissociation and other dissociative symptoms often seen in these patients.

It is becoming increasingly clear that overt presentations of multiple personality disorder (MPD) are more uncommon than other presentations. MPD is difficult to recognize and diagnose, because it is a condition of hiddeness (Gutheil, cited in Kluft, 1985b). Most MPD patients do not present with classic symptoms like those of Sybil (Schreiber, 1974) or Eve (Thigpen & Cleckley, 1957), who had fully developed personalities that emerged clearly and assumed full control. Instead, most present covertly, suppressing or hiding their symptoms (Kluft, 1985a, 1985b), or are unaware of them, and many present with a subtle form of the disorder in which the personalities are difficult to distinguish. Patients with both covert and subtle forms of MPD often present with subdued dissociative signs, which, if recognized, make it possible to suspect the diagnosis early in therapy (Franklin, 1985).

MPD patients are also difficult to diagnose, because many of them present with symptoms of other disorders (see reviews: Bliss, 1984, 1986; Coons, 1980, 1984; Kluft, 1984, 1985a, 1987b; Solomon & Solomon, 1982). They are polysymptomatic (Bliss, 1984, 1986; Coons, 1984), and on the average, have received three or four other diagnoses (Putnam, Guroff, Silberman, Barban, & Post, 1986). They often present with symptoms of depression (Coryell, 1983; Kluft, 1985a, 1985b; Putnam, et al., 1986; Putnam, Loewenstein, Silberman, and Post, 1984), borderline personality disorder (Greaves, 1980; Gruenewald, 1977; Horevitz & Braun, 1984; Solomon & Solomon, 1982), schizophrenia (Bliss, 1980, 1984, 1986; Bliss, Larson & Nakashima, 1983; Kluft, 1985b, 1987a; Rosenbaum, 1980), somatic symptoms (Bliss, 1980; Coons, 1984, 1986,1988; Kluft, 1985b), drug abuse, or antisocial behavior (Coons, 1984).

Almost all MPD patients (about 97%) have experienced severe, repeated sexual, physical or psychological abuse or other traumas in early childhood (Coons & Milstein, 1984; Putnam, 1985; Putnam, et al., 1986; Spiegel, 1986; Wilbur, 1984a, 1985). They use dissociation as a defense against their traumas (Braun, 1986; Kluft, 1985b; Spiegel, 1984; Young, 1988), and different identities are formed to deal with the traumas and to preserve and handle other personality functions.

Most MPD patients hide or disguise their condition, because: (1) they may have been threatened or punished about revealing their abuse, or blamed for their abuse and feel ashamed, or punished when their personalities emerged; (2) they have strong fears associated with their traumas; (3) they may be afraid they would be considered "crazy" or accused of lying if they revealed their symptoms (Coons, 1984; Kluft, 1984, 1985a, 1987b); and (4) if their personalities came out clearly, they would expose their dissociative defense, thus obviating its usefulness. Sometimes they are not aware of their multiplicity and are amnestic for their traumas (Putnam et al., 1986).

Some patients hide their personalities by suppressing them, or their personalities disguise themselves by passing for one another (Kluft, 1987b), by blending their characteristics, by transferring personality elements to one another, or by funneling them through the presenting personality (Kluft, 1985a, 1985b). Their personalities are difficult to distinguish when they are suppressed or disguised, when they influence each other without emerging or when they are similar.

CONCEPTS OF A DISSOCIATIVE CONTINUUM

Several workers in the field have proposed concepts of dissociative continua that range from normal or less pathological dissociation to MPD. Ross (1985) has proposed a continuum of increasingly large amounts of dissociated ego which ranges from transient psychogenic amnesia to fugue states and depersonalization to partial MPD to fully developed MPD. O'Brien's (1985) continuum ranges from isolated traumatic experiences and ego states to dissociative state syndromes to multiplicity syndromes, which include overt, covert, and latent forms of MPD.

The dissociative continuum described by the Watkinses (H.

H. Watkins, 1984a, 1984b; J. G. Watkins, 1978; Watkins & Watkins, 1979-80, 1984) ranges from normal ego states (Federn, 1952) to covert ego states (Hilgard, 1977) which influence the executive state (J. G. Watkins, 1984) to overt multiple personalities. Their continuum is quantitatively scaled by their definitions. They define an ego state as "an organized system of behavior and experience whose elements are bound together by some common principle" and separated by more or less permeable boundaries (H. H. Watkins, 1984a). The personalities in MPD have rigid, impermeable boundaries and are independent of and often unaware of other personalities (H. H. Watkins, 1984b). According to J.G. Watkins (1984), the diagnosis of multiple personality should be given *only* if these states emerge spontaneously without any hypnotic induction.

Beahrs' dissociative continuum ranges from fluctuations in moods to roles and ego states, to MPD, in which there are alter personalities that have more impermeable boundaries and are beyond voluntary control (Beahrs, 1982). He believes that everyone has multiple levels of consciousness and multiple entities similar to Hilgard's hidden observers (Hilgard, 1977). Normally, there are various trains of simultaneous consciousness that are kept somewhat separate from each other, that is, there is a healthy co-consciousness. The degree of awareness and voluntary control of the different entities decreases from normals to patients with MPD, in whom the various entities are kept separate by dissociative barriers (Hilgard, 1977). A continuum of forms of MPD is reflected in Beahrs' description of patients with *ego state disorder* (Watkins & Watkins,1979-80) who have less rigid dissociative boundaries than MPD patients.

Kluft's view of a dissociative continuum is qualitative, in that he believes that "what is essential to multiple personality across its many presentations is no more than the presence within the individual of more than one structured entity with a sense of its own existence" (Kluft, 1985b), and the "personalities' overt differences and self concepts can range from minimal divergence to extreme polarity" (Kluft, 1985a). He has said that "overtness is not basic to the condition" (Kluft, 1985a), because the personalities influence each other without assuming full control and that their distinctness and elaboration can be minimal, as they often are in childhood cases. He has observed that there may be some personalities "which, were they the only other personality, would not have sufficient definition to qualify the patient for a [DSM-III] diagnosis of MPD" (Kluft, 1984). In his view, the term *personality state* could be used to include both *personality* and *personality state*, which are seen as varying only in degree of definition.

Braun's continuum (Braun, 1986, 1988), formulated under DSM-III, includes other dissociative disorders as well as several categories of MPD, described in terms of his definitions of personality and fragment. He defines a *personality* as having a consistent, ongoing set of response patterns to given stimuli, a significant history, a range of emotions and a range of intensity of affect for each emotion. This definition is a quantitative one, based on specific, recurrently observable criteria that are discrete and qualify as a *full* personality. A *fragment* is an entity smaller than a personality, that has a consistent, ongoing set of response patterns to given stimuli and either a significant history or a range of emotions but not both to the same degree.

His continuum goes from normal to dissociative episode, dissociative disorder, atypical dissociative disorder to atypical MPD to MPD to polyfragmented MPD. His MPD categories also are quantitatively scaled by his definitions. *Atypical dissociative disorder* includes patients who dissociate frequently, but the dissociative episodes, though linked, do not qualify as personalities. In *atypical MPD*, the patients' alters exchange factual information, so they have knowledge of their life history but lack the affective component of memory. In *MPD*, patients have two or more personalities and may have some fragments. In *polyfragmented MPD*, they have some personalities and numerous fragments.

DIAGNOSTIC CRITERIA FOR MPD

In DSM-III-R (American Psychiatric Association, 1987), the criteria for MPD are that patients must have "two or more distinct personalities or personality states (each with its own relatively enduring patterns of perceiving, relating to and thinking about the environment and self)" and "at least two of these personalities or personality states recurrently take full control of the person's behavior." A personality is a "relatively enduring pattern of perceiving, relating to, and thinking about the environment and one's self that is exhibited in a wide range of contexts. Personality states differ only in that the pattern is not exhibited in as wide a range of contexts." In the present paper, the term *alter* will be used to mean either a personality or a personality state.

The use of the terms personality and personality state represents an attempt to incorporate the quantitative and qualitative concepts of the dissociative continuum into DSM-III-R definitions. The term personality is quantitative by definition, whereas personality state is a qualitative, fluid concept. Thus, both quantitative and qualitative views of the dissociative continuum form the theoretical basis for DSM-III-R.

Those patients who show some of the symptoms of MPD but do not meet all the criteria for this diagnosis are classified in DSM-III-R as one form of "Dissociative Disorder Not Otherwise Specified" or DDNOS: variants of MPD (American Psychiatric Association, 1987). In DDNOS, there is "more than one personality state capable of assuming executive control of the individual, but not more than one personality state is sufficiently distinct to meet the full criteria for Multiple Personality Disorder, or cases in which a second personality never assumes complete executive control." This definition allows for the removal of the quantitative criterion of distinctness or of assuming executive control, again introducing the concept of a qualitative continuum. If the childhood form has what is essential to the condition (Kluft, 1985b), this means that patients diagnosed as DDNOS: variants of MPD have the basic psychic structure of MPD. Thus, MPD can be viewed as on a continuum including a range of forms: from those resembling the childhood forms, that are more subtle, to the full-blown classic forms with two or more fully developed, distinct personalities that take full control of the person's behavior.

FORMS OF MPD

The criteria for MPD in DSM-III-R have been broadened from DSM-III (American Psychiatric Association, 1980), and with the inclusion of DDNOS: variants of MPD, now include a range of forms of MPD: from overt classic forms to covert, subdued and subtle forms. Most patients present covertly (Kluft, 1985b, 1987b), appearing in subdued forms with signs and

symptoms that are reduced in intensity or degree.

In covert presentations, the alters hide by suppressing or disguising themselves or by influencing each other, but during certain periods of their lives, some of these patients show overt symptoms of classic MPD (Kluft, 1985b). Patients with subtle forms of MPD may also hide at times, but sometimes may only appear to be hiding, because many of their alters are similar and not very distinct and are difficult to perceive or distinguish. The signs and symptoms of these patients tend to remain more mild and subdued.

Compared to subtle forms of MPD, patients who present covertly but later show symptoms of classic MPD have a greater degree of dissociation among many of their alters, which have more impermeable amnestic boundaries and more separate memories and distinct behavior patterns. Their alters are more substantial and divergent and more distinct when they emerge. Their divergence often leads to more conflict and pressure to emerge as one alter tries to express itself. Often their alters are strongly suppressed or disguised and operate by influencing one another.

Patients with subtle forms of MPD have less dissociation among many of their alters, which have more permeable boundaries and share more memories and behavior patterns. Their alters are, in general, less distinct and substantial. Some are barely elaborated and have only enough intrapsychic dissociation to separate out their traumas and give them a sense of separate existence (Kluft, 1985b). Their alters are not very distinct, and usually influence each other without taking full control, and because they are less divergent, they have less conflict and less need to emerge. Subtle cases have used intrapsychic dissociative defenses in childhood and have continued to use them to maintain their amnesia for their traumas but have not elaborated their alters as they moved into adulthood.

Forms of MPD can be understood in terms of Kluft's concept of a range of personality states that vary in degree of definition. On this continuum, subtle forms would range from DDNOS: variants of MPD at the low end of the continuum through some forms of DSM-III-R multiple personality disorder, but would not reach classic forms at the high end of the continuum. Patients with subtle forms of MPD would at first be diagnosed as DDNOS, and some will eventually be diagnosed as DSM-III-R MPD. Patients who present covertly would at first be diagnosed as DDNOS: variants of MPD, but as they become more overt, their diagnosis could fall anywhere on the continuum.

The personality system of patients with classic forms of MPD would generally include relatively more substantial personalities and fewer personality states, while patients with subtle forms would usually have more personality states and fewer personalities, or perhaps only personality states. Some multiples with subtle forms could be *complex* multiples with 26 or more personalities and personality states (Kluft, 1988) or *polyfragmented* multiples (Braun, 1986).

SUBTLE SIGNS OF DISSOCIATION

Patients with covert and subtle presentations do not show overt symptoms of MPD, but often show a number of subtle signs of dissociation which suggest the presence of alters or their dissociated elements such as behaviors, thoughts and feelings. These subtle signs may be observed when the alters express themselves by influencing each other, partly emerging, subtly switching, and fluctuating in and out.

MPD patients need to express the memories and feelings connected to their traumas, but are afraid to, because of the fear, pain, anger, and shame connected to them, of which they may not even be conscious. This conflict between expression and hiding leads to a compromise in which the memories and feelings are expressed through subtle signs of dissociation. This process can be viewed as similar to the compromise leading to neurotic symptoms, except that in MPD, the subtle signs are a return of the dissociated rather than a return of the repressed. In addition, internal or external stresses may serve as triggers which activate memories of past events and the alters who contain them (Loewenstein, Hamilton, Alagna, Reid, & DeVries, 1987).

The presence of different identities may cause patients to show subtle signs of dissociation in any of the following ways: as subdued, sometimes sudden changes in affects, behaviors, thoughts, moods, and memories that are incongruous or disconnected from each other, or as sudden discrepant changes in social relatedness, transferences, developmental levels and psychiatric symptoms. They may show many inconsistencies and contradictions that are expressions of alters who have different attitudes and viewpoints about the same person or problem area. They may also show other dissociative symptoms which may or may not indicate the presence of alters, but which can lead one to suspect the presence of a dissociative disorder.

A case of multiple personality whose personality system was basically covert and subtle will be presented, and excerpts from her therapy will be used to illustrate the subtle signs of dissociation and other dissociative symptoms observed in MPD patients.

CASE HISTORY

The patient, Margaret (and M. or *"she"* will be used to refer to any of her personalities or personality states) was a 21-year-old college student, the youngest of six children. When M. was two, her mother was hospitalized for depression for some months, and M. was cared for during the day by a woman who left when the mother returned. The father drank, and sometimes abused the mother at night, which M. must have overheard, as her bedroom was next to theirs. The parents divorced when M. was six, and the father remarried and rarely visited.

M. was severely teased, bullied, and depreciated by her siblings. She was not protected from these abuses and often hid in closets to feel safe. She remembered pretending to throw her stuffed animals and dolls into "a moat of boiling water around her bed and rescuing them in a macerated condition." She ran away from home when she was five and was found by the police several miles away. She was frequently scolded for losing and forgetting things.

Her mother depreciated and dominated her by telling her what to do and how she should feel and think, and M. would "space out" to shut her out. M. said, "My mother puts her own thoughts and feelings onto me and totally wipes mine out." When she was 12, M. found her mother so difficult to live with that she attempted suicide by taking an overdose of aspirin. Then, on her own, she saw a series of seven psychotherapists over eight years with no improvement.

After high school, she went to New York to study art, lived alone, and was depressed and dysfunctional. She saw a young woman therapist, but presented her family as ideal, and the

therapist did not recognize her dissociative symptoms, such as "blank outs" during sessions, which could have led her to suspect MPD and early traumas.

The next year, M. entered college, and in her junior year began therapy with me. She presented with depression, anxiety, bulimia, headaches, blank outs, and memory problems. She did well in her courses, but found it hard to complete her work and worried about failing.

Though M. felt socially inept, she had several girl friends who were socially skillful and helpful. She was attractive and well-groomed, but felt panic around men and did not date and avoided talking about men or sex. Her extreme attitude made me suspect that she might have been sexually abused as a child. She once said in a low voice, "Maybe my mother and father raped me when I was four, but I don't know if this is true."

Early in therapy, her transference feelings were that the therapist was projecting her own ideas onto her or was not helping her, because she did not tell her what to do or say. She used her college work to shut out feelings, and at these times denied anything was wrong with her, because she felt "normal". At other times, she was overwhelmed with despair, low self-esteem, and feelings of non-existence and failure. Her earliest expression of affect in the transference was anger, which was later directed at her mother. She alternated between accepting therapy and scornfully rejecting, depreciating and sabotaging it. When I used hypnosis, she broke trance twice and then refused further attempts.

During a year of therapy, her dissociative condition gradually unfolded. She showed many changes in mood, attitude, voice quality, and facial expression between and during sessions. She alternated between tentative trust and deep mistrust, but eventually was able to express more of her feelings.

Although I suspected MPD in the first interview and told her then that she had a dissociative condition, most of her alters showed minimal divergence and did not emerge clearly. M. described herself as being like a collage in shades of brown, with a little gray and black, rather than in reds, blues and yellows like Sybil or Eve. Her dissociated states did not appear to be highly elaborated; most were not distinct; and she did not refer to them by names other than her true name and its diminuitive form, "Peggy". Eventually, I could distinguish four personalities which were similar in external appearance and only slightly different in voice and facial expression, but were more substantial than her other dissociative states, in that they had a more distinct psychic structure in terms of attitudes, affects and functions and were more stably present.

They were: (1) Her presenting personality, who was depleted, depressed, anxious, confused, subdued and had a soft, low-pitched voice; (2) a hostile personality, who was angry because her parents did not love or care for her properly; (3) a self-assertive, autonomous personality, who allowed her to get her work done; (4) an efficient personality, who had a slightly higher-pitched, brisk and clipped voice and who made definite plans for the future. These personalities sometimes influenced and blended into one another before emerging.

She also had a number of personality states that emerged recurrently, but briefly. These states had certain functions or represented identifications or sides of conflicts or embodied certain defenses. A few showed distinct differences in body appearance and facial expression and switched clearly, such as the child states and the mannequin state. The states were (1) a superficial, conventional state, (2) a numb state, (3) a paranoid state, (4) an identification with the abuser state, (5) a hated, rejected state, (6) a superior, snobbish state, (7) a hopeful, positive young adult state, (8) a robot or mannequin state, (9) a defiant, rebellious state, and (10) several child states: a child with positive feelings, a fearful, unloved abandoned child, and a dependent child.

M.'s behaviors and affects fluctuated as she changed states. Her states did not seem to be connected to each other, and when she was in one state, she sometimes seemed unaware of the others, but at other times she was co-conscious for more than one state. She was often not aware of her conflicts when each side was expressed by a different alter. Her personality states led her to show many subdued and subtle signs of dissociation throughout her therapy.

CASE ILLUSTRATIONS OF THE SUBTLE SIGNS OF DISSOCIATION

FLUCTUATIONS IN AFFECTS AND TRANSFERENCES

In MPD, each personality or personality state has a specific transference arising out of its needs, functions and developmental level (Wilbur, 1984b, 1986, 1988). The influences, subtle switches, or partial emergence of the alters cause these patients to show marked fluctuations in their transferences and affects, within or between sessions, that may be the first evidence of the presence of alters.

M. showed many such fluctuations. In one early session, when she was feeling dependent and helpless and that everything was out of her control, her hostile state influenced her, and she suddenly turned her head away and said angrily, "Therapy is a waste of my valuable time," and got up and started to leave. Just before college graduation, her hopeful, positive young adult alter came in, saying that she had decided to go to New York to live with her friends and find an interesting job and was sure she could make it with the support and help of her friends. Two days later, her efficient, realistic alter, influenced by her dependent child alter, called, saying she could not count on her friends and should continue in therapy a while longer.

FLUCTUATIONS IN DEVELOPMENTAL LEVELS

MPD patients often show sudden changes in facial expression, voice and vocabulary and level of emotional expression. Many may behave at times in ways suggestive of a young child, or show magical or polarized thought typical of young children. M.'s facial expression sometimes changed to that of a frightened child, or she would hang her head in shame like a small child. Her dependent demands to be told what to do and say alternated with expressions of autonomy, willful defiance, and anger.

FLUCTUATIONS IN PSYCHIATRIC SYMPTOMS

The psychiatric symptoms of MPD patients sometimes vary markedly from day to day (Coons, 1988; Kluft, 1985a, 1985b, 1987b; Putnam, et al., 1984); for example, they may change from depression to acting out or to psychosomatic symptoms, and sometimes these variations may indicate a change to a different alter. M. would suddenly become depressed or bulimic when she visited her mother or felt that her friends did

not pay enough attention to her, but these symptoms would suddenly disappear when she changed to another state, such as her autonomous state.

INCONSISTENCIES AND CONTRADICTIONS IN VIEWPOINTS AND ATTITUDES

M. often showed striking inconsistencies and contradictions in her viewpoints and attitudes between and within sessions. When she was beginning to open up in therapy, she said, "Therapy is making me feel worse. I can't work. Everything is hopeless. No one ever helped me."A few days later, she said, "I've been more stable in this therapy than I've been in my whole life." She was fearful about sex and associated it with sadism, yet said she was looking forward to having pleasurable sexual relations. She alternated between saying she loved and hated her mother and her mother loved and hated her. She once said in a normal voice, "I've got to stop seeing my mother," and then in a muted, younger voice, "but I'm not sure I can do it."

EVIDENCE OF SWITCHING

Patients with covert and subtle forms of MPD usually show subtle switches rather than the obvious switches seen in classic multiples in which a distinct personality emerges and takes full control. In a subtle switch, one alter may influence and mix into another before it emerges. Subtle switches are smooth transitions that may pass unnoticed if one is not looking for them; for example, one facial expression may blend into another. Before they occur, a patient may pause, look blank, or turn away, or there may be no sign. M. often turned her head away so that her transitions were hard to see. They could be inferred from subtle changes in her voice and facial expression or from incongruous changes in her viewpoints, attitudes, and feelings.

INFLUENCES OF ALTERS ON EACH OTHER

The personalities and personality states of patients with covert and subtle forms of MPD usually influence each other rather than emerging overtly. They may influence each other by talking to or transferring thoughts and feelings to one another or by imposing themselves on, dominating or suppressing each other.

These influences take the form of *co-presence, co-consciousness* and *passive* influence, which often overlap. In co-presence, an alter influences the behavior or affective state of another without assuming control (Kluft, 1984). In co-consciousness (Prince, 1906), an alter is aware of the feelings, actions and thoughts of another. In passive influence, patients feel that impulses, acts and affects are imposed on them, that their body is influenced by some force, that thoughts are withdrawn from their mind, or that their mind is influenced by thoughts they ascribe to others (Kluft, 1985b, 1987a).

Co-presence leads some patients to say they are "possessed", and co-consciousness causes some to hear their alters' voices in their head. M. heard "murmurs" and received "signals about the pain of her childhood". She showedpassive influence when she felt helpless to control what happened to her and was like a "robot" or "mannequin". She once said, "When I talk, I don't know what's going to come out. It's like pulling something out of a hat."

ATYPICAL REFERENCES TO SELF ASPECTS AND DISSOCIATIVE EXPERIENCES

MPD patients often make atypical and metaphorical references to self aspects and dissociative experiences that are evidence of their dissociative condition. M. described herself as a "zombie" and said that a "ghost was buried in her". Some patients use descriptive terms for their alters or say that their states "take over" or "come out".

M. said many things that suggested multiplicity. She said, "Many years ago, there were a lot of little 'Peggys' that got put on the shelf and got dusty," and "I have two sets of eyes; inner eyes that see bad things and outer eyes that see what's happening outside." Early in therapy, she described her dissociation by saying, "Sometimes when I'm upset, I can block myself out totally."

SIGNS AND SYMPTOMS COMMON TO OTHER DISSOCIATIVE DISORDERS

Because they were traumatized, MPD patients often show other dissociative signs and symptoms. Like patients with posttraumatic stress disorder, they sometimes have flashbacks, sleep disturbances and out-of-body experiences (Spiegel, 1984, 1986). M. described an out-of-body experience by saying she felt like she was "floating in outer space." She described her trance-like states as being in a "twilight state." She had amnesia for most of her childhood and showed minor amnestic episodes (Franklin, 1985) or microamnesias (Kluft, 1985b), often forgetting what she or the therapist had said within or between sessions. She also showed depersonalization, once saying, "When I talk to people, sentences come out that don't mean anything. I come to a cliff - a big empty space. I can't think. I'm afraid all the bad things will come out. I lose a sense of myself."

CASE SUMMARY

I will now summarize how I suspected that M. had MPD from her history and from some of the dissociative signs I observed during the first interview. (1) The first thing M. did, was to look out the window and in a subdued voice and say: "I came to you for hurt," instead of saying "help". I saw this as possibly indicating leakage of feeling from a traumatized child alter to her presenting personality. (2) She asked me to repeat many of my questions, indicating microamnesia. (3) She kept her eyes focused on her key ring, apparently to keep herself in one steady state. (4) She kept her head lowered and talked in a very soft voice, behaviors Kluft (1985a) has found to be common in MPD patients trying to hide their condition. In addition, her presenting symptoms of depression, headaches, "blank outs", amnesia for her childhood and the fact that she had been treated by many psychotherapists with no improvement made me suspect the possibility of MPD (Kluft, 1985a; Putnam, et al., 1986).

M. continued to show many subtle signs of dissociation, and I could gradually distinguish different personalities and personality states. Sometimes, younger alters would suggest themselves by briefly coming out, but they did not speak, and when her presenting personality returned, she often seemed unaware of what had happened.

Later in therapy, M. had told me, "There were younger forms of me that got stunted in their growth, and that's when I

began to see psychiatrists." She described her intrapsychic dissociation by saying, "I have internalized 'hiding in the closet,' and now I can find a safe place in my mind to go to. I don't make connections that are relevant to each other. I have disparate minds, and that's why I'm so confused. Maybe I have over 100 pieces. I live in separate minds, and I don't know about it. I live multiple lives, and I'm not real."

Though she had made all these statements, she did not appear to have two or more personalities with sufficient definition "that were complex and integrated with unique behavior patterns and social relationships" as was then required by DSM-III for a diagnosis of MPD, and a certain vagueness remained. It did seem clear, however, that many alters were present in partial or full control, though without much distinctness or divergence among them. At that time, she would have met DSM-III-R criteria for MPD.

Eventually, in barbiturate-facilitated sessions, a child alter clearly emerged and recounted some of her early history, including a memory of sexual abuse. In a child voice filled with emotion, M. said, "I'm with my mother in front of the fireplace, and her boyfriend is there, and my mother poked me inside with her finger and showed the boyfriend how I was made." Then she paused, and in an adult voice said, "She made a specimen of me, and I was so mortified!" Although this child alter had appeared briefly several times before, this was the first time it had spoken and described a memory of sexual abuse.

CONCLUSION

In conclusion, it should be stressed that: (1) MPD patients do not have the internal cohesiveness and consistency one sees in other patients; (2) there is a range of forms of MPD with many different patterns and permutations of personalities and personality states ranging from overt classic forms to those that are more subtle; (3) the majority of MPD patients present covertly in a subdued form and hide or camouflage their symptoms; (4) although most conceal their condition, many will show subtle signs of dissociation that may be evidence of alters. Clinically, it is these dissociations which cause them to show frequent, sometimes rapid fluctuations in thoughts, moods, and behaviors and to have discrepant memories and feelings about the same situation or person. These fluctuations and inconsistencies are often the first suggestive evidence of MPD. It is the presence of intrapsychic dissociation, used to separate out mental entities and their associated traumas from awareness, that is the sine qua non for suspecting the existence of covert and subtle forms of MPD. What is essential to all forms of MPD is the intrapsychic dissociation that separates out and maintains multiple concepts of self, object, and the world within the same person.

While some fluctuations are observed during the therapy of most patients, the changes shown by M. were clearly beyond what is usually seen. If, as in her case, some dissociative symptoms such as amnesias, trance-like states, out-of-body experiences, and depersonalization are present in addition to the subtle signs of dissociation and evidence of traumas, the presence of MPD should be suspected. When one observes many dissociative signs that appear to indicate the presence of alters, but the alters do not emerge because of the strength of the resistances, and the diagnosis remains uncertain for long periods of time, hypnosis can be used (Braun, 1980, 1984a, 1984b; Kluft, 1982, 1985a). If there are major resistances to hypnosis, one can consider using barbiturates.

Several scales measuring dissociation, such as the Dissociative Experience Scale (DES) of Bernstein and Putnam (1986), the Structured Clinical Interview for Dissociative Disorders (SCID-D) of Steinberg, Howland, and Cicchetti (1986), and the Perceptual Alteration Scale (PAS) of Sanders (1986) are being developed and used to screen for dissociative symptoms and disorders and will help in suspecting the hidden forms of this condition.

Kluft (1985b) has observed that only about 6% of MPD patients present overtly. In a study of 73 cases (Kluft, 1984), he found that 40% showed subtle hints of dissociation, and 40% were highly disguised (Kluft, 1985a), which indicates that many more multiples exist than are now being diagnosed. In my own practice, an awareness of these subtle hints of dissociation has led me to suspect the possibility of MPD in seven previously undiagnosed patients, and the diagnosis was confirmed in six, by the exploration of what underlay the subtle signs, through uncovering techniques or hypnosis.

The structure and process of the intrapsychic dissociation described in the case of M. highlights the fact that the patient's use of intrapsychic dissociation as a defense is central in suspecting the diagnosis. The fluctuating presentations over time (Kluft, 1985a) and the variety of forms and structures of MPD make an openness in conceptualizing its diagnostic criteria necessary if some cases are not to be missed. DSM-III-R now allows for the recognition and inclusion of subtle, complex, and covert forms of MPD under MPD or DDNOS: variants of MPD.

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