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Multiple Personality Disorder

A Psychoanalytic Perspective

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Multiple personality disorder (MPD) is a syndrome of defense.[58,83] The MPD patient has used splitting and dissociative defenses to preserve the good self and the good object. As with so many of the terms used with MPD, *splitting* and *dissociation* seem to lend themselves to a "multiple meanings disorder." There are a variety of uses for these terms, but simply put, both splitting and dissociation involve the separation of incompatible mental content. This can entail the separation of an idea from its affect, as in isolation, or it can mean either the passive or the active separation of or division of the image of a person into a good version and a bad version.[49] This separation also can mean the removal of some aspect of sensation or knowing, or it can mean the change in state of consciousness so as to remove the person consciously from an event or circumstance. The literature on object relations[28,41] and on borderline disorders[37] favors the term *splitting* and emphasizes the separation of good and bad images of self and object. The literature on neurosis[6-8] prefers the term *repression* to signify the removal of unpleasant mental content from conscious awareness and the term *isolation* to indicate the separation of sensation or affect. The MPD literature favors the term *dissociation*[31] to describe the processes used by a person to escape mentally from danger,[22,43,73] or to shift from one state of consciousness to another. Each of these terms is used less precisely than one would wish if clarity and consistency were goals. Each term also carries with it implicit connotations and associations, which further dilute clarity and precision.

In this article, the term dissociation will be used. If the word splitting is used, it is meant more in the sense of different states of consciousness and organization of self and less in Klein's[44] and Kernberg's[38,40,41] sense of dividing mental content according to whether it is

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deemed to be good or bad. Thus, somewhat akin to a family entering a war zone or a concentration death camp, that splits up into as many parts as possible in order to increase the chances of survival of at least someone, the MPD patient exists in as many parts as is necessary to survive. The literature generally emphasizes the traumatic experiences* that necessitate this internal division. I wish to emphasize here that internal conflicts and tensions can also contribute to the creation and maintenance of MPD. In this respect, MPD presents similarly to other disorders, with various blends of conflict, deficiency, and trauma; and with varying degrees of nature, nurture, and fate. Clearly, the trauma elements in MPD are nearly always decisive, but conflict and deficiency should not be overlooked.

From this perspective, defenses have to be respected. Treatment demands an appreciation of the methods the patient uses for survival; real in the past, psychological in the treatment present. In this respect, the operation of the defenses is just as important as the discovery of what is being defended against. Mapping the personalities, pursuing the anamnesis, or documenting the history must not be allowed to dominate the exploration of what the dissociative process achieves for the patient. As Schafer[64,65] points out, defenses are not merely mechanisms but elaborated fantasies in their own right. The paranoid patient may have fantasies of spitting on or hurling things at others, whereas the obsessional patient may have fantasies of touch and contamination. The dissociative patient has fantasies of disappearing, of being someone else or somewhere else, or of living in a world governed more by primary than secondary process. What the patient fantasizes by means of dissociation is an important part of a psychoanalytically based treatment.

Bion[2] and Rosenfeld[60–62] focus on an aspect of the process of dissociation that they call "confusional states," or "attacks on linking." In their understanding, it is not just that certain things must not be known and are therefore sequestered in the form of alters, it is also that ways of knowing and thinking are blurred or rubbed out to protect against annihilation. The very way in which perception, thought, and memory work with each other is under attack in MPD. Selective default into primary process overemphasizes condensation, displacement, and symbolization; permits time to flow in all directions; and allows contradictory information to coexist. Confusion itself becomes part of the process of dissociation. Working with the confusional states as a ubiquitous process rather than a specific phenomenon helps both patient and therapist view MPD as a total system. If the typically healthy person operates on the premise, "I think, therefore I am," then the patient with MPD, having been faced with the threat of overwhelming trauma, is not able to think in the usual ways: "If I face not being, therefore I cannot think."

Trauma, conflict, and deficiency all play a contributing role in the genesis of MPD. The blend of each of these ingredients may account, in

*References 3, 9, 13, 22, 25, 30, 45, 57–59, 63, 72, 73, 78, 81.

part, for different levels of function from one patient to another, as well as among alters within a particular patient. When trauma alone, without much conflict or deficiency, is the causal factor for a patient, there is greater likelihood of higher function, greater chance of well-functioning internal self-helpers, and more health to work with in the integration process.

Most patients also have conflict, which can include internal division over sexuality and aggression and guilt over collusion with abusers. This conflict may have arisen out of trauma, but it is not understood merely on the basis of trauma. To leave out issues of conflict deletes from therapy key aspects of the patient's dynamic organization necessary for therapeutic resolution.

This is even more true with respect to deficiency. Kluft[45] recognized this in his Four Factor theory of etiology of MPD. His fourth factor, notable in this context, is lack of soothers. Some MPD patients benefit from the good mirroring of a nonabusive relative, or even from the nurturing behavior of an abuser. Those patients who had major deprivation are least likely to have internal self-helpers, least likely to have effective aggressive protector alters, and are most likely to view integration as leading to loss and emptiness. For these patients, the same careful and tedious work required in treating severely narcissistic patients is demanded. This lengthens the course of the treatment considerably and may require working very slowly with certain alters to permit them to build the inner structure needed to begin integration.

Trauma, conflict, and deficiency are not confined to MPD patients alone. In fact, the childhoods of patients with borderline personality organization[30,34–37,75,76,82] and many alcoholics resemble those with MPD. All three groups seem to come out of similarly dysfunctional families, and many are likely to have been affected particularly during the Rapprochement Phase of development.[26,38,42,49–55,68,70,80] Indeed, it is possible that some patients merit more than one diagnosis.

There is particular confusion over the differences between MPD and borderline personality organization. Whereas some work has been done to differentiate these two diagnoses,[1,5,12,30,32,33,75] the literature still lacks a clearly worked out explanation of all the distinctions. Briefly, in MPD the self is split more than the objects are, whereas in borderline personality organization the object appears to be more split, with greater swings of idealization and devaluation. This suggestion is in line with Armstrong's thought (Armstrong, J: personal communication, 1991) that MPD patients divide in order to maintain relatedness, whereas borderline patients split to create distance.

Another distinction supported at present only by initial clinical intuition may be the relatively greater freedom to express aggression overtly in the borderline patient as compared with the MPD patient.[56] MPD patients may be forced to compartmentalize their aggression more than those suffering from borderline personality organization. It remains to be seen whether this is an accurate observation, and if it also applies to MPD patients with a history of violence or abusiveness to others or a history of forced perpetration while being abused. Attention

to these matters by clinicians will enhance our understanding of this confusing area.

TRANSITIONAL PHENOMENA

Lack of soothers and deficiency of good objects create a special dilemma for the MPD patient. It is my view that one aspect of the creation of alters is the need for transitional objects. As with Winnicott's[84] original notion of transitional objects, what starts as something concrete can later become more abstract, operating more as a process and less as an object. Transitional phenomena and transitional processes aid us in dealing with separation, disconnectedness, insignificance, emptiness, and deficiency. Perhaps the "cohesive self"[48,79] of Kohut is itself the ultimate successful transitional object.

For MPD patients, alters are soothing, even in the act of being disturbing and disruptive. In therapy, the therapist has a chance to become a transitional object for each of the alters.[27] In the general psychotherapy literature, the therapist is sometimes described as serving as an auxiliary ego for the patient. In the treatment of MPD patients, the therapist serves a multifaceted role as transitional object. Typically, the therapist is the first outsider to have knowledge and contact with each and every part of the patient. The therapist carries the narrative for the patient in the early phases of treatment. For the patient, the knowledge of the therapist and the experience in therapy may be the first event shared by all the alters. In the fact that every alter develops a therapeutic alliance with the therapist lies the leverage of common experience that can lead to integration.

As this process proceeds, many patients find the therapist serving as a transitional integrated self. For the therapist the patient is one, even though the alters are many. Thus, a split patient is relating in a split way to a therapist who is having experiences with a single person who is split. The therapist's working alliance constitutes the matrix for a provisional integration that exists first as a construct in the mind of the therapist but then becomes the model for the patient's ultimate integration.

The therapist becomes crucially important at this phase. The self-object demands of the patient are multiplied by the transitional-object neediness of the patient, thus creating powerful stresses for both patient and therapist. Maintaining an optimal balance of closeness and distance during this stage of the work is as critical as it is difficult. It is at this stage that many initially successful treatments come apart. Sometimes the patient is able to force the therapist to get too close. This closeness can consist of hugging, intervention in the patient's life, intrusion into situations with other important figures for the patient, and even may lead occasionally to new abuse experiences. More often it leads to therapist burn-out. At other times, the therapist, perhaps through the mechanism of projective identification[28,44], starts to dissociate the patient. This can manifest itself by a tendency to play favorites

among the alters; to over-use friendly, charming, or helpful alters, to avoid contact with difficult or troublesome alters; and to maintain splits covertly by becoming overly fascinated with and enamored by the complexity of the dissociation. All of these factors interfere with integration. Another disruptive variation is the withdrawal of the therapist from the patient.

Whatever the particular variation, at such times, consultation is extremely useful. These sorts of difficulties precipitate the largest number of consultation requests to me from therapists in the community. Unfortunately, in all its many cases, consultation commences after the point when the treatment has been irrevocably disturbed. Many cases could have been saved with earlier consultative intervention. Too many therapists vow never to treat a patient with MPD after such an experience, thereby missing both the knowledge and the satisfaction that comes from following treatment to its conclusion.

It is here too that the therapist must again rethink the matter of dissociation as a fantasy and a defense, both within the patient and within the therapist. It is useful to conceptualize the treatment setting as a dramatic transferential reenactment in which the therapist sometimes plays the part of a figure in the patient's past; sometimes plays the patient while the patient plays the part of a past figure; sometimes plays the patient while the patient plays the therapist; and sometimes experiences dissociation and confusional states as the patient evokes in the therapist what the patient has experienced.

INTEGRATION

The terms *integration* and *fusion* can be added to the list of those words that suffer from multiple meaning disorder. For some authors the terms are interchangeable; for others fusion constitutes a preliminary, temporary, or partial integration, or a phenomenon that takes place at a particular point in time. For still others, integration is a process that occurs in the treatment of all patients, whereas fusion is unique to MPD. For purposes of this article, Kluft's[47] distinction between tactical integration and strategic integration is useful.

Many therapists who come for consultation or supervision seem to have the impression that integration proceeds one personality at a time, with merger occurring in a serial way with clear-cut signs. Recently, a consultee became confused over just this issue, expecting personality A to merge with personality A′ before moving on to merge with personality B, and so on. This kind of integration may be useful for tactical purposes,[10] as when an aggressive personality lends its ability to defend itself to a shy and self-effacing personality, or an intellectual alter assists a charming but uneducated alter to succeed in a job. Brilliant clinical intervention[46] can make use of spontaneous or contrived tactical integrations of this sort. Perhaps many patients integrate systematically in this manner.

From the psychoanalytic perspective, strategic integration is more

likely to proceed as a by-product of therapy rather than as its preliminary goal. As defenses are understood and revised, the alters have fewer needs to preserve their differences. Memories, functions, feelings, even dreams become shared and separateness blurs. Clinical signs of greater difficulty in telling the alters apart alert the therapist to this.[24]

In this respect, psychoanalytic psychotherapy of MPD patients is similar to therapy of "single personality disorders" in that less attention can be paid to the merger of specific alters and more attention can go to the process of free flow of information and affect. As the patient increases in the ability to use secondary process thinking, divisions lose their raison d'être.

In other respects, treatment of MPD patients presents special challenges. As integration proceeds, a previous equilibrium, however inefficient, is disturbed. This has consequences for patient and therapist. It is common for alters to have a vested interest in their own separateness; many do not want to lose their sense of a separate identity. Some alters believe that the entire system would collapse if their separate functions were not kept sacrosanct. The force of previously unrecognized affects and memories can engender intolerable anxiety or depression. The whole patient can be threatened, and sometimes the therapist can feel it too. Suicidal feelings can overflow, or abuser alters previously held in check can appear to gain the upper hand, and brief hospitalization may be required. In some respects, this is the other side of the therapist's feelings of dissociating the patient. Here the integrating patient wants to redissociate. At the same time the patient is feeling personal annihilation, the therapist can feel despair and lose confidence in the therapeutic process in general or in the prospects of this particular patient.

This annihilating force is similar to the way these patients as children experienced their parents and their lives. In childhood, many of these patients experienced a parent who was good at one time changing into a parent who was unspeakably bad at another time. They survived this change in the parent by changing themselves. At such a time, the extreme method of dissociation is like a mini-annihilation from which it is possible to return. Out of this comes the belief that one can be annihilated, as well as die, and then return to life again. Confusion between the two concepts may develop. How many reports of deaths, disappearances, and killings, both internal and external, partake of this confusion is a matter to be carefully worked out in each case.

Patients are also likely to feel guilt for having survived. This is especially true if, to survive, the patient had to collude with abusers or had to create a state of apparent enjoyment of the trauma or sharing of the abuse. When one is small, he or she is helpless in a world of powerful others. Under such circumstances it is preferable for the patient to think that he or she is bad and that the others are good, for otherwise the patient would be at the mercy of a malevolent universe. When one is bigger, it is tolerable to think of oneself as good in a world populated by a combination of good and bad others. Reconciling these two competing views can be very painful for the patient.

It is difficult yet important to linger in this state so as to understand it, rather than trying to wash it away too soon. This is especially true when, as a result of this process, enormous amounts of aggression are aimed at the therapist and the self. Both patient and therapist can feel suicidal at such a stage of the therapy. Forcing tactical integration or fusion to reduce the anxiety of the patient or the therapist can render treatment more superficial.

Here it can be especially helpful to understand the therapy of MPD patients unfolding as a reverberating drama of shifting identifications. Patient and therapist alternate roles of victim, abuser, observer, inadequate comforter, and so forth. Hateful countertransference is understandable, as the dread of annihilation is evoked in the therapist or as unattainable demands are felt by both patient and therapist in turn. This can also express itself as terror of the patient on the part of the therapist. This, too, is a point at which previously successful treatment can fall apart.

IDENTITY, DEVELOPMENT, AND THE DEATH INSTINCT

This section is the most theoretical and metapsychological, and the least directly relevant to the clinical setting. Nevertheless, three areas where psychoanalysis may make a contribution to a deeper understanding of how MPD unfolds and where MPD may shed light on how the mind works in all of us are addressed.

Many have noticed that patients with MPD can go into trance states, or can show degrees of numbness, amnesia, or alexithymia.[77] We also know that aggressive alters are among the most common. We know, too, that MPD patients relive their traumatic memories or their experiences with traumatic figures in particularly vivid ways; this is most obvious during abreactions but can also be seen in flashbacks, alters, internally reenacted abusers, and in repetitive behavior and relationships. Is there any way to account for this characteristic triad of phenomena? Are aggression, dissociation, and repetition related?

In *Beyond the Pleasure Principle*,[15] Freud described what can happen when a person's stimulus barrier is overwhelmed. Usually it is the case that trauma evokes anxiety, and based on prior experience, anxiety can serve as a useful signal function.[16,19] In other cases, notably relevant for our understanding of MPD, the stimulus barrier is breached, and anxiety is either absent or insufficient. Instead of experiencing anxiety in a way that permits its use as a signal, the patient is overwhelmed. The vigilant guardian alter is created to become the signal rather than the anxiety. Subtle and slower acting defenses are not available or are ineffective. The only sufficient defense left to the individual is to dissociate, to become quiescent, to become as nearly dead as possible so as to remain alive, to "play possum." Thus the person ceases to exist as a whole entity in order to avoid complete annihilation.

Freud noted that whenever this extreme of quiescence is found,

the other elements of repetition and aggression are also found. His explanation was that there had to be a fundamental motivating factor other than the seeking of pleasure to account for these three phenomena. It made no sense that a person would repeatedly relive terrifying affect or would dream about or recall painful memories. It also made no sense that some individuals displayed far more aggression toward others than simple mastery required, or far more aggression toward themselves than guilt commanded. There was also no apparent reason why individuals would seek to obliterate their consciousness of themselves, the world, or the boundary between them. To explain this, Freud went "beyond the pleasure principle," to another principle that he called the Nirvana Principle. Just as sexual instincts formed the motivational basis for the pleasure principle, Freud posited the unfortunately named "death instinct" as the motivational basis for the Nirvana Principle.

Our MPD population offers us a chance to study this interesting triad of repetition, aggression, and quiescence generated in individuals whose stimulus barriers were overwhelmed often and severely. The tenacity with which our patients seek quiescence through dissociation is matched by the intense and relentless pressure to repeat in the form of certain alters. The unalloyed aggression found in some alters is rarely rivaled by any other clinical experience with other patients. The increase in suicidal risk during certain phases of treatment, particularly during early phases of integration, and the quest for and dread of obliteration also suggest that these three phenomena are related. Through the study of MPD, we may begin to get a better understanding that can supplant the concept of the death instinct[29] without ignoring its clinical value.

MPD is regarded typically as a disorder of dissociation or a quasi-permanent chronic posttraumatic stress disorder. Relatively neglected in MPD theory are concepts of identity. This is true for the anthropology scholars who compare shamanism to MPD, as well as the psychiatric scholars who take MPD too concretely, expecting on the one hand to find a homunculus equivalent in the patient or believing on the other hand that the dissociated patient actually *is* a child in the office, rather than an adult in a dissociated state.

Actually, MPD may have a lot more in common with other identity disturbances than has been credited to date. For example, although some patients with transsexual disorder actually turn out to have MPD,[67] most patients with primary transsexualism do not. Yet the two conditions have important features in common. In both cases there is a strong identity contrary to the one assigned by the parents. In both cases, the superficial conclusion is that the identities are so contrary to observable fact as to be practically delusional. In both syndromes, the conviction on the part of patients is to the authenticity of their self-perception and their inner sense of identity. Overt physical or sexual trauma is often missing in the histories of patients with primary transsexualism. Examining the process of identification may reveal additional paths to identity multiplicity besides the well-established one of dissociation in the face of trauma.

Exploring the process of identification and the nature of identity formation[17] also can help us to learn how there can be alters who are "replicas" of abusers and other important figures, as well as to learn about the process by which alter identities are created. In effect, these identifications can become substrates or building blocks for the creation of future alters. The distinctive feature of monochrome or single affect alters also needs more understanding.

In the course of development, methods of identification change, culminating in what Kernberg[38-41] calls the "depersonification" of identifications, which enables the individual to transfer characteristics of important others into attributes of the self. Why and how is this interfered with in MPD?

Less flagrant examples of individuals who maintain different identities include actors, spies and double agents, law enforcement officers required to go deep undercover, and impostors. One can add to this list malingerers, those suffering from factitial illness, and perhaps, Munchausen's syndrome (some of whom may have MPD).[23] Studying how and why these persons resemble and differ from those with MPD is as important as pursuing the distinctions between MPD and borderline personality organization.

Certain "normal" processes alert us to the power of nondissociated identity changes in our lives. A colleague (Hornstein, N: personal communication, 1991) recently related a story of how a physician friend had unexpectedly come across an accident scene and left his car to help. He was surprised at the revulsion he felt at seeing a maimed body and at how powerful an autonomic reaction he had. He was able to master this initial reaction and be of assistance. The physician then compared this sudden experience with the different reaction he had after going through the "ritual" of scrubbing in and dressing for surgery. By performing certain rituals, he was able to transform his identity and modify his physiologic responses. The same can be true for participants at religious ceremonies during which identities can be altered by means of ritual, but with only limited amounts of dissociation. Serial identity shifts over the course of life also can teach us about MPD. How does the somnolent infant become the curious observer, then the anxious and wary 8-month-old fearful of strangers, then the happy and appropriately hypomanic 12-month-old seemingly impervious to pain and disappointment, then the cautious 18-month-old, supplanted by the defiant 2-year-old, the depressive then delightful preschooler, and so forth? In this way, the study of identity disorders leads to a closer examination of development.[11,74]

It has long been my view that the window between approximately 18 months and 4 to 5 years of age represents the period of greatest vulnerability for the development of MPD. During this phase,* the distinction between self and object is still cloudy, and there is a tendency to use defense mechanisms that are in the "splitting hierarchy" rather than in the "repression hierarchy."[38-41] The cognitive ability to

*References 4, 9, 20, 26, 42, 49–55, 68, 70, 79, 80.

conjure different identities is not present prior to this vulnerability window, and the ability to use more advanced defenses commences at the end of this vulnerability window.

It is possible that the onset, timing, and sequence of abusive experiences, matched with the defensive tools available at the time, are as important as the degree and persistence of the trauma. It may also be that different alters, developing at different stages, may be capable of different repertoires of skills, accounting for internal structural differences. Assessing the different characteristic defensive strategies and the different cognitive styles of each alter thus becomes extremely useful.

It may also be the case that girls possess a different mix of defensive skills and cognitive abilities during this vulnerable period, accounting in some measure for their apparent disproportionate representation in the MPD population. Of course, other factors such as the different incidence and prevalence of abuse among boys and girls may also account for this phenomenon.

WORKING THROUGH

Working through[19] requires many skills on the part of the patient and the therapist and in some ways remains as mysterious as the capacity to develop MPD in the first place. Simple logic would have it that the patient devised ingenious and heroic measures to survive hideous traumatic experiences and that these measures have served the patient with variable success. When the patient enters treatment, the inefficiency of such extreme measures can be appreciated, and previously unacceptable or overwhelming memories and affects can be faced, making the existence of separate personalities unnecessary. This makes sense and resembles early psychoanalytic understanding about the liberation of "strangulated affect," the recovery of "mnemic images," and the idea of "making the unconscious conscious." It is also too sensible for the patient to absorb and overlooks the process nature of dissociation and the fantasy nature of defenses. Such an approach tempts us to move the treatment along too quickly or makes us succumb to frustration or despair when the patient takes longer than expected to improve. We would do well to heed the wise words of one of my former MPD patients, "We have to go as fast as we can and as slow as we can, at the same time."

Creating a safe environment, developing a therapeutic alliance with all parts of the patient, establishing intersystem communication and cooperation, and getting to know the various aspects of the patient (whether through formal "mapping" or not) are all ingredients in the first phases of treatment. As the therapeutic alliance is firmly established and the therapist assumes the role of transitional object for more and more parts of the patient, deeper anamnesis can occur, and the tendency toward coconsciousness and copresence increases. Under-

standing the developmental differences among alters and tracking the transference and countertransference differences displayed in the presence of different alters add dimension and nuance to earlier mapping and contribute to the self-knowledge of the patient. During this phase, alters may begin to make gradual forays into affective territory previously assigned to separate parts.

It is here that the deficiencies of the patient's life are exposed more clearly, and the capacity of the patient to absorb previously dissociated feeling and thought is stressed greatly. These are some of the rough spots at which treatment can get off track.

Just what happens in the working-through phase? Freud[15] made the useful observation that what we do not remember does not disappear but instead is repeated in disguised forms. Generally, the best way to reduce the repetition is to remember, but it is not always the case that remembering solves the matter.[18] This is certainly true in MPD, in which, as we know only too well, mere abreaction and anamnesis do not guarantee either fusion or integration, let alone full recovery. Some patterns have an unusual adhesiveness or stickiness that causes them to persist despite remembering and despite insight. It is this stickiness that the concept of working through addresses.

What makes people change? Many theories abound, but none is completely satisfying. Under the nineteenth century theory that intrinsic vulnerability of the patient set up the preconditions by which trauma would be forgotten and transformed into hysterical symptoms, change was thought to come about by developing awareness of the forgotten trauma. When Freud concluded that it was not a linear reaction to trauma but the defenses against recalling the memory of the trauma that was central in neurosis, the analysis of defense became the path for change and cure. When dynamic and conflictual affects, desires, wishes, and forbidden ideas were seen as the salient feature of emotional disorder, making the unconscious conscious was the path to health. When maladaptation was seen as the residual of misshapen mental structures, the amelioration of an overly harsh superego was crucial, and "where id was, so shall ego be." When deficits in development were identified as causative in adult emotional disorder, various methods to make up for deficits were devised. The sadly ill-reputed "corrective emotional experience" still contains elements of truth that have unfortunately become too tainted to be subjects of serious psychoanalytic study today.

Aspects of the "real relationship" and the "therapeutic alliance" were seen as curative, standing alongside insight with special power, the so-called "mutative interpretation." Special transferences designed to reinstate development that had gone off track were discovered, and we learned the value of "mirroring" and "twinning," with their associated "transmuting internalizations." Infant research enlightened us to "affective attunement" and altered us to the manifestations of separation and individuation in the treatment setting.

There are specific and nonspecific aspects to working through. The environment of safety, the freedom to disclose previously forbidden

secrets without punishment, and the presence of a witness to the patient's pain are some of the nonspecific factors. Without any sense of manipulation, they themselves constitute a field of corrective emotional experience. In all psychoanalytic psychotherapy, but especially with MPD patients, the temptation to want to fix defects in the patient's life must be resisted by the therapist. The hug that may reassure one alter may feel like an assault to another; the act of declining a hug that provides a reassuring boundary to one alter may seem like a heartless rejection to another. At all times it is important to allow the patient the opportunity to express thoughts and feelings with a minimum of prejudgment or censorship, on whatever level the patient feels capable of, while at the same time remembering that the patient is a single person who may be experiencing things in a dissociated manner. The adult regressed MPD patient is just that and must not be confused with an actual child the age of the regressed alter.

I belabor these points somewhat, because we are reaching the end of the twentieth century and are seeing a revival of nineteenth century concepts. MPD patients nearly universally experienced trauma in childhood, and most probably had special talents or vulnerabilites that allowed them to develop MPD. The simple remembering of the traumatic events is not sufficient to bring about lasting change, nor will making the unconscious conscious suffice. Most of all, we cannot redo or undo the injuries of a lifetime. Yet if we cannot change facts, we do have it in our therapeutic ability to change meanings.

It is in this sense that we can turn around the usual notion that the past causes the future and say that by means of changing meaning and context, the future can "cause" the past. The hermaneutic school of Schafer[66] and Spence[71] teaches us that one of the ways therapy changes people is to rewrite their autobiographies. For example, the patient's response to a devastating event that shattered his or her sense of worth may be reframed as the only possible if not an ingenious path to survival. We are powerless to change the historical truth of the patient's traumatic past, but we are capable, together with the patient, of writing a narrative truth that transforms the meaning of the unchangeable events. The actual trauma history is not lessened or diminished by this emphasis on narrative, but the context for eliciting the history and mapping the personalities does change.[21]

A final point about working through is to highlight the difference between secondary gain and primary gain. Secondary gain refers to the real world benefits a patient attains from the continuation of being afflicted. Sometimes this can be conscious, as in malingering or in equivocal compensation cases. More often it is not conscious, as in the extra attention or exemptions from demands one may get when one is ill. The primary gain, however, has to do with the conviction that only by maintaining the status quo of the illness can the patient hold on to what remains of sanity or of continuing existence. To be successful, working through must address this crucial area of primary gain by exploring the process aspects of the illness, as well as mapping out its

content, and then by giving patients new hermaneutic tools to reshape the meaning of their lives.

INTEGRATING MPD WITH PSYCHIATRY AND PSYCHOANALYSIS

The metamessage of this article is to make a plea for all serious workers in the field of dissociation and MPD to integrate our work with the rich body of knowledge offered by psychiatry and psychoanalysis, and by research into development, cognition, and other cultures in which dissociation and identity may develop differently from our own. I am grateful to my colleagues at UCLA, especially Dr. Nancy Hornstein, for sharing this perspective; and to others across the country, particularly Drs. Richard J. Loewenstein, Richard P. Kluft, Frank W. Putnam, Catherine G. Fine, and Judith G. Armstrong who contribute to this integrated vision. For our field to grow, we must forge links; that is the reason why I so comprehensively referenced a basically clinical paper.

Our MPD patients are very similar to the ones whose illnesses provided the database for dynamic psychiatry 100 to 200 years ago. They hold the potential to show us how the mind functions in all of us thanks to the peculiar transparency of many of their symptoms. Let us begin to integrate our art and our science as we integrate our patients.

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