Methods in the Treatment of Multiple Personality Disorder: Implications for Alternative Directions

By
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METHODS IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER: IMPLICATIONS FOR ALTERNATIVE DIRECTIONS

BY

JUDY A. HILL

A Thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF EDUCATION

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Abstract

Multiple Personality Disorder is being diagnosed with increasing frequency. Those seeking therapy for this disorder are appearing in alternative health care settings, often following non-productive treatment in the psychiatric system. Therapists in community health centres and private practices are attempting to work with a complex disorder traditionally thought to be treated most effectively in secure settings by psychiatrists trained in hypnotherapy. This study addresses the question of whether it is possible to offer effective and safe treatment to clients with Multiple Personality Disorder outside the medical, psychiatric community.

Three therapists working in alternative settings, each with several years' experience treating MPD, were interviewed about their interventions with clients diagnosed as having Multiple Personality Disorder. Interviews focused on particular aspects of their clinical experience with MPD, specifically: hospital admissions, hypnotherapy, safe rooms and restraints, psychotropic medications, and alternative interventions. The data from these interviews was categorized and analyzed to determine emerging themes. The results indicate that therapy with clients diagnosed with Multiple Personality Disorder is possible in alternative health care settings. These results also demonstrate that techniques employed by non-medical therapists to address issues of safety enhance therapy and challenge traditional beliefs about clinical practice with Multiple Personality Disorder.

Introduction

Close to fifteen years ago, in the late 1970's, I was doing crisis counselling in a community health centre in a major Canadian city. Clients seeking counselling included large numbers of adult women with suicidal ideation and histories of depression. I remember when I started hearing stories of sexual abuse and began to identify the underlying problem in these women's histories which explained the symptoms I was attempting to treat. This was new territory and there were many informal consultations, as counsellors in my and other centres shared what we were hearing for the first time. Clinicians more familiar with sexual abuse were brought in to educate and train crisis workers and counsellors. We learned to ask the questions that facilitated disclosure and we learned to identify symptoms that suggested a clinical picture of abuse. We came to understand that gender was not a safeguard against sexual abuse and began to identify this history in the lives of men. We developed clinical tools and a therapeutic perspective to help those clients heal and accommodate the trauma of their pasts in a way that was no longer self-destructive or self-compromising. But there were a few who didn't seem to get better, who continued to cycle through community and hospital settings, accumulating diagnoses and failing to respond positively to a variety of treatments. Those clients are now being diagnosed with dissociative disorders.

Just as the disclosure and discourse on sexual abuse helped explain the experiences of crisis clients years ago, the more recent identification and diagnosis of Multiple Personality Disorder explains the lack of resolution for some clients who have experienced severe childhood trauma. Multiple Personality Disorder, or MPD[1], has been classified as an extreme response to severe trauma that could not

[1] The initials MPD will be used throughout this paper to refer to Multiple Personality Disorder.

otherwise be accommodated. In numerous studies and clinical reports MPD has been directly linked to childhood sexual abuse. The debate that grew in the 70's regarding the reality and frequency of sexual abuse continues in the 90's, with conflicting opinion on both the degree of trauma and horror that abuse may include, and the validity and frequency of the coping strategy of MPD.

While the debate continues, the number of people presenting with a clinical profile of MPD is steadily increasing. These people are being seen not only in psychiatric units but in community health care settings and in the caseloads of therapists in private practice. In many cases they are high-functioning individuals with no psychiatric history who have avoided traditional medical settings and who have learned to mask the symptoms of dissociation. All too frequently they are also people who carry a litany of psychiatric diagnoses and have been treated unsuccessfully over a period of years by a variety of caregivers. It is incumbent on both the psychiatric and non-psychiatric therapeutic communities to develop treatment appropriate to these clients.

A possible outcome of this study may be evidence of interventions which could make the treatment of MPD more accessible both to clients and caregivers working outside the psychiatric community. A review of the literature will include the history, etiology and treatment of MPD. Through in-depth interviews the treatment techniques of therapists working with MPD clients will be elicited. These techniques will be reviewed to determine if there are models for this therapy that are not dependent on hospital or psychiatric care.

Statement of the Problem

Increasing numbers of clients with the clinical features of MPD are seeking treatment. In most reported cases these are women with a history of severe childhood abuse. While some find appropriate treatment in psychiatric care, many seek help from therapists and social workers in non-medical settings. Clients who seek counselling for MPD in alternative settings do so for a variety of reasons. Many have a long history of misdiagnoses and failed interventions, and have encountered a psychiatric system hostile to the diagnosis of MPD. Others have an established alliance with a particular caregiver who has been providing counselling for other issues when the presence of MPD surfaces. For each of these reasons, many therapists and social workers are finding MPD clients among their caseloads. This reality requires that treatment models for MPD are accessible and applicable to any health care setting.

The perception is that the complex nature of MPD requires treatment which includes hospitalization, the use of restraints and safe rooms, a clinician trained in hypnotherapy, and psychotropic drugs. Many therapists working with MPD do not operate in a hospital setting or have access to restraints and safe rooms, are not trained in hypnotherapy, and are not licensed to prescribe psychotropic drugs.

The question this study addresses is how does a therapist outside the medical, psychiatric community offer effective and safe interventions to MPD clients? Specifically:

a) How does the therapist manage acute crises?

b) How is communication established and maintained with the internal system of alter personalities?

c) How does the therapist ensure safety for the client and others when working with malevolent alters?

d) How does the therapist manage somatic symptoms?

Value of the Study

There is increasing evidence that childhood sexual abuse occurs with alarming frequency. A commitment to therapies which validate the external causes of internal anguish requires an openness to diagnoses and treatments which reflect the realities of clients. It is not a difficult or long leap from the belief that children "go away" when victimized in sadistic and traumatic ways, to a belief in the splitting off of both cognitive and affective memories into separate entities whose functions are to protect the child from pain and to ensure survival. It is a tragic and unnecessary reality that of MPD clients reported in the literature, an average of 6.8 years had been spent in unproductive treatments in the mental health system before diagnosis of MPD.

While many clinicians have contributed to the literature on treatment techniques for MPD, this author knows of no study which focuses specifically on therapies which occur outside the psychiatric medical community. Given the presence of MPD clients in alternative health care settings, a review of treatment outside the psychiatric system seems warranted. The possibility that aspects of these treatment approaches may form the basis for a treatment model which does not rely on hospitalization, hypnotherapy, the use of restraints or medication is exciting and potentially invaluable. The determination that no such treatment model could succeed will offer clarity to those attempting to do this work.

Finally, given the recent attention assigned MPD, this study will contribute to a growing body of literature on this topic.

Purpose and Objectives

The purpose of this study will be to examine the treatment techniques of therapists who have experience working with MPD clients to determine the viability of successful treatment outside a medical setting. The specific objectives of the study are:

1. To describe therapists' experience with the use of the following in the treatment of MPD:
   a) hospital admissions
   b) safe rooms and restraints
   c) hypnotherapy
   d) psychotropic drugs

2. To define therapists' alternative interventions in the following treatment areas with MPD clients:
   a) management of acute crises
   b) communication with alters
   c) safety in sessions
   d) management of somatic symptoms

Delimitations of the Study

While MPD is not exclusive to women, clients in therapy diagnosed with MPD are overwhelmingly female. The ratio of female to male clients reported in the literature is 9:1. Reasons for this may include the high incidence of sexual abuse in the histories of women and a greater proportion of women in the mental health system (Schafer, 1986).

This study reflects this gender ratio. Further study involving therapy with male clients is needed to determine the applicability of findings for female clients.

No research is created free of researcher bias. This researcher wishes to acknowledge her own experience counselling MPD clients outside of a medical setting. It is interest in this work and personal experience with difficult therapeutic issues which motivated this research.

Definition of Terms

The following terms are common in the description of MPD and clarification of each is useful.

Alters:

These are the separate personality states, each of which has its own history, memories, behaviours, and characteristics.

Host or Primary Personality:

The personality with the greatest degree of executive control over a period of time. This is the personality which often presents for treatment.

Birth or Core Personality:

The personality which began development after birth and from which the first alternate personality was created.

Switching:

The process of moving from one personality state to another.

Internal Self Helper:

A personality who has knowledge of the internal system and whose function is to assist in survival. These personalities can be helpful in the therapeutic process.

Fusion:

The blending or joining together of one or more personalities.

Integration:

The state where all personalities have blended into one. Many researchers and clinicians use fusion and integration interchangeably.

Iatrogenic:

The belief that a symptom is caused by a particular intervention. With MPD, this commonly results in a charge that dissociation is an artifact caused by hypnosis.

Literature Review

The History of Multiple Personality Disorder

Multiple Personality Disorder by its very name suggests a phenomenon that evokes strong reaction. The language used to describe this clinical entity -- "multiple personalities", "alters", "internal helpers", "switching" -- makes it all too easy to dismiss MPD as dramatic and unbelievable. After all, logic refutes the possibility of several different people inhabiting one body. MPD is not based on a belief that the impossible is possible; it is not a diagnosis which purports that some individuals are capable of physiological miracles. It is a diagnosis based in research and scientific study which attempts to define the dissociative process of the mind. First classified as a dissociative disorder in DSM III in 1980, MPD has its roots in history which spans centuries.

One has only to review the history of religious thought to find reference to transformations and possession. In some cases the transfiguration of one personality into another has been viewed with favour. Shamans, mediums and those possessed with the "spirit of God" are conferred status and power, their ability to take on another consciousness evidence of their connection to some spirit world beyond the grasp of ordinary persons. In other instances, dissociative behaviours are culturally condemned, viewed as evidence of invasion by an evil presence or demonic possession. One way of accommodating dissociative phenomena has been to place them in the realm of the spirit and to elevate or persecute the subjects of these experiences according to religious dogma.

References to dissociation as a psychological disorder date back centuries. Putnam traces MPD back to the mid 1600's (1984), Greaves to Eberhardt Gmelin in 1791 (1989), and Ross to the ancient Egyptians (1989). More general acknowledgment of the origins of MPD as a clinical diagnosis focuses on the nineteenth century and the work of Morton Prince, Pierre Janet and Alfred Binet (Horovitz and Braun,

1984; Kluft, 1984; Crabtree, 1985; Putnam, 1989; Ross, 1989). Morton Prince, co-founder of the *Journal of Abnormal Psychology*, was the first scientific researcher to investigate MPD. In the *Dissociation of a Personality*, he presented a case study of a client known as Miss Beauchamp and described his use of hypnosis in working with her. He introduced the phrase "co-consciousness" to describe the presence of what appeared to be separate selves. In his work, Prince advocated the ascendancy of one personality at the expense of all others (Ross, 1989).

Pierre Janet and Alfred Binet conducted important research with clients diagnosed as hysterics. Using hypnosis, they demonstrated the presence of a second self. Binet referred to this as a doubling of consciousness and published two works on dissociation: *On Double Consciousness* and *Alterations of Personality* (Ross, 1989). Binet also discovered that certain physical symptoms were manifested in one state of consciousness but not in another (Crabtree, 1985).

Janet is credited with establishing a link between MPD and past trauma. His treatment involved bringing split-off memories and emotions to consciousness, a clinical approach embraced by every contemporary treatment model for MPD. Janet also believed that, with the presence of real trauma, there existed in MPD clients a biological predisposition to dissociation. As Ross (1989) indicates, this is also a tenet of his and other contemporaries in the field, the difference being one of language. In Janet's work this predisposition was called " mental degeneracy" while Ross and other modern clinicians refer to this trait as "hypnotizability". In attempting to identify two predisposing factors of MPD -- a history of real trauma and high hypnotizability -- Janet, through his language, inadvertently pathologized those with this disorder.

One can already see the foundations of what is currently known as Multiple Personality Disorder. Through the research of clinicians like Prince, Janet and Binet, MPD emerged as a credible entity with identifiable origins and symptoms and a prescribed treatment based

on contact with separate selves and the retrieval of painful dissociated material. What happened to discredit this study and push MPD back into the realm of the paranormal?

The decline of MPD as a serious study began with Freud. Freud and Breuer in their published work *Studies on Hysteria* in 1895, described case histories of patients with dissociative disorders, most of whom also had histories of sexual abuse. Freud's original work with these clients was based on the reality of reported abuse and the use of hypnosis to aid in the retrieval of memory. Rather than expand on this work, Freud reversed his position shortly after the publication of these case studies. There are numerous theories on why Freud changed the direction of his work, most citing his shared social status with the extended families of his clients and the threat posed to that social fabric by exposed abuse. Whatever the reason, Freud's repudiation of the work he shared with Breuer led to the abandonment of both a belief in trauma-based disorders and the use of hypnosis. It also demanded an explanation for the experiences described by those clients and the symptoms presented in the case studies. This explanation came in the form of Freud's psychoanalytic theory. Like Janet before him, Freud pathologized his clients. Unlike Janet, he did so by distorting truth and developing theory that had little basis in the reality of his clients' lives.

With Freud's move away from hypnosis came a charge that those who used hypnosis created dissociative disorders in their clients (Horovitz and Braun, 1984; Putnam, 1989; Ross, 1989). This challenge that MPD is an artifact caused by the client-clinician relationship is the source of much continued controversy (Bliss, 1988; Dell, 1988a; Dell, 1988b; Hilgard, 1988, Kluft, 1987b; Spanos, Weekes, Menary, & Bertrand, 1986; Spiegel, 1988).

The discrediting of reports of sexual abuse and the use of hypnosis were only two factors in the decline of MPD as a valid diagnosis. The increase in the diagnosis of schizophrenia and the use of psychopharmacology generated a move away from talk therapy

toward the management of symptoms. Indeed, the symptoms which contribute to a diagnostic picture of MPD are in some cases the same as symptoms used to diagnose schizophrenia. Kluft (1987a), in a study of thirty clients with MPD, found that each had one or more symptoms on Schneider's assessment scale, an instrument designed in 1939 to determine the presence of schizophrenia according to first-rank symptoms. As a result of these findings, Kluft suggests that Schneider's first-rank symptoms may be an excellent tool for diagnosing MPD. This overlap, as well as the frequent prior diagnosis of schizophrenia in MPD clients, is noted by others (Horovitz & Braun, 1984; Putnam, 1989; Ross, 1989; Schafer, 1986) and would account for the discrediting of MPD in reaction to increased interest in organic brain disorders. Additionally, the development of psychotropic drugs in some cases displaced psychotherapy and, as Putnam (1989) notes, resulted in a decrease in the client-clinician relationship.

Thus, the practice and research in the 1800's which focused on dissociation as a response to trauma was replaced shortly after the turn of the century by a medical model which emphasized disease and chemical treatment. MPD once again was relegated to the fringe of respectability, the stuff of spiritualists and demons. One could more readily find a priest prepared to perform an exorcism than a psychiatrist prepared to diagnose MPD.

Prior to 1980, MPD retained its exotic status. While singular cases were reported, they were thought to be rare and abnormal. The most noted of these was Chris Sizemore, whose experience was reported in *The Three Faces of Eve* in 1957. At the time of publication of this book, written by her psychiatrists, Thigpen and Cleckley, "Eve" was considered to be the only living case of multiple personality (Horovitz & Braun, 1984; Ross, 1989). In fact, Thigpen and Cleckley lend their voices to those who challenge the increase in MPD diagnoses, reporting that of the hundreds of cases of assumed MPD

clients sent them in a twenty-five year period following their work with Eve, they have diagnosed only one (Hilgard, 1988).

Two more well-publicized cases in the 1970's gave increased visibility to MPD. Cornelia Wilbur, in her published account of her work with Sybil, described trauma-based dissociation and the internal world of alternate personalities. She used hypnosis to contact alters and worked toward fusion of all personalities. She was also consulted in the case of Billy Milligan, a man convicted of rape and other crimes allegedly committed by one or another of his alternate personalities. In *The Minds of Billy Milligan*, Daniel Keyes details the horrific abuse endured by Billy during childhood and the dissociative response to this abuse which resulted in twenty-four personalities. In her interviews with Billy Milligan, Dr. Wilbur was able to make contact with these personalities, including a "core" personality protected by others since the inception of the abuse (Crabtree, 1985; Keyes, 1981). Unlike Thigpen and Cleckley who believe MPD to be rare, Wilbur has contributed to a growing body of literature substantiating the prevalence of MPD and its connection to severe childhood trauma. She is noted as one of the pioneers of a growing movement beginning in the 1970's to reintroduce MPD as a viable clinical phenomenon.

The resurgence of interest in MPD since the 1970's is credited to several factors. The first of these is the reintroduction of hypnotism to clinical practice in psychotherapy. MPD patients most often present with subtle symptoms and those practitioners who look for florid evidence of dissociative episodes may conclude falsely that MPD is not present. Hypnosis has facilitated contact with alters, a basic criteria for diagnosis according to DSM-III (Caul, 1986; Curtis, 1988; Ross, 1989, Putnam, 1989). A second contributing factor is the growing attention paid to post-traumatic stress disorder (PTSD) as a result of the Vietnam War (Ross, 1989; Putnam, 1989). This diagnosis was developed to account for episodes of anxiety and violence which occurred as a result of flashbacks experienced by veterans of the war. It offered a context for behaviours that were not based in current

reality, but were also not the genesis of any organic disorder. It helped explain the complex survival mechanism of "splitting off" painful material and formed the basis of therapy which seeks to bring that material into consciousness for the purpose of integration.

Finally, MPD has received a revival largely through the efforts of the feminist movement and the consciousness it has engendered about the presence and prevalence of child sexual abuse (Blake-White & Kline, 1985; Gahan, 1987; Rivera, 1989; Putnam, 1989; Ross, 1989). The presence of severe trauma is a predisposing factor for MPD and, without the acknowledgement of the reality of that trauma in the lives of children in this society, a diagnosis of emotional distress based on social causes is impossible. With the reported evidence of sexual abuse estimated at one in three girls and one in ten boys, and with new information about the presence of ritual abuse (Kluft, 1988b; Mayer, 1991; Ross, 1989), it is not surprising that confirmed MPD cases are on the increase. Until 1980 the number of reported cases was estimated at 200 (Ross and Norton, 1989). Since 1980 and the classification of MPD as a dissociative disorder in DSM-III, reported cases have skyrocketed to 5,000 in North America (Ross and Fraser, 1987). What is important is that the work begun by Janet and his associates over a century ago is once again at the forefront of clinical thought: that the symptoms of dissociation are rooted in an external reality and that treatment requires the identification and assimilation of these traumatic experiences.

Etiology

In 1987 MPD was reclassified in DSM-III(R) in the following manner: (Appendix A)

1. The existence within the person of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
2. At least two of these personalities or personality states recurrently take full control of the person's behaviour (Braun, 1987).

There are three conditions seen as critical to the development of Multiple Personality Disorder. The first of these is a significant history of childhood trauma. In a vast majority of cases -- 83% to 97% reported in the literature -- this involves victimization through sexual or physical abuse (Gahan, 1988; Coons & Milstein, 1986; Putnam, 1984; Ross & Anderson, 1988; Chu, 1986; Kluft, 1984; Spiegel, 1988). In those few cases where physical and/or sexual abuse is absent, the trauma may result from witnessing a violent death or suffering some major disaster. Several researchers and clinicians cite the combined presence of both sexual and physical abuse as an important dynamic predisposing a victim to MPD (Bliss, 1988; Curtis, 1988; Ross, 1989; Vincent & Pickering, 1988; Putnam, Guroff & Silberman, 1986). This childhood abuse is severe and chronic and often contains bizarre elements such as satanic rituals, animal sacrifice and periods of being buried alive or other sensory deprivation.

A second necessary condition for the development of MPD is susceptibility to hypnotism or what is described as a biological predisposition to dissociation (Braun, 1986; Gahan, 1988; Kluft, 1985; Ross, 1987). Ross (1987) states that 10% of the general population is highly hypnotizable and it is this ability to "split off" in response to traumatic episodes that allows a person to separate memory and emotional responses such as pain and anger from an actual event. It

is common for MPD clients to form separate alters to hold exclusively the memory of a particular event, the pain associated with that event and the affect resulting from the abuse. The initial dissociative episode becomes a learned response to overwhelming trauma and similar incidents are linked in separate memory states. These memory states form individual identities, which, while initially formed as defensive coping strategies, develop autonomy with separate behaviours and social systems. (Bornn, 1988; Ross & Fraser, 1987). Ross describes this process as a basic survival strategy. "The fundamental etiology...is a maneuver designed, paradoxically, to maintain the integrity of the personality. To remain whole, the self must split" (Ross, 1984 p. 231).

The third criterion for MPD is the absence of normative and nurturing experiences. The unpredictability and inevitability of continuing abuse by parents and caretakers isolates the child from any restorative environment where consistency and trust are present. Marmer (1980b) explains that a child deprived of safe external objects necessary for ego identification, i.e. non-abusive adults, will be forced to develop internal self-objects to cope. Kluft (1984) incorporates these three criteria for the development of MPD in his four-factor theory, adding as a condition, the psychic transformation which results in the creation of alternate personalities. His theory describes the following etiology of MPD:

1. a biologic capacity to dissociate
2. the presence of overwhelming life experiences in childhood for which dissociation becomes a defense
3. the process by which this dissociative defense in linked to other psychic structures to create personalities
4. the absence of nurturing experiences

No one understands the process by which psychic structures referred to by Kluft are altered. That biological change does occur with MPD is suggested by research which documents differences across personalities in response to a variety of psychological tests and EEG's

(Braun, 1987; Putnam, 1984; Ross, 1989; Silberman, Putnam, Weingartner, Braun and Post, 1985).

These criteria explain why some persons who suffer severe abuse may develop MPD and others will not. If a person is not prone to dissociative episodes or self-hypnosis, she may still successfully block from memory traumatic experiences, but not form individual and separate identities to hold the cognitive and emotional responses associated with those experiences. She may effectively deny parts of her history but not harbour distinct personalities which are amnesic to each others' presence.

Treatment

Confirming a diagnosis of MPD is the first essential step in treatment. According to the American Psychiatric Association (1987), a diagnosis of MPD may only be made after contact has been established with at least one alter and it has been determined that that alter has occasional executive control of the client's behaviour (Putnam, 1989). Establishing contact with an alter personality may occur by the therapist's simply asking to meet another part of the client sitting in the room, or by asking the client to make room for another part who may be listening to become more present. Both Ross (1989) and Putnam (1989) describe successful communication with alters initiated in this manner, though also advise the use of hypnosis and, on occasion, drug-induced interviews. The use of hypnosis to contact an alter is a frequently cited technique, promoted by many clinicians as a facilitative tool which expedites the communication process, and is believed by some to be necessary to this aspect of therapy (Braun, 1984; Caul, 1986; Kluft, 1982; Kluft, 1988c; Mayer, 1991).

Once made, it is important to share the diagnosis with the client, at the same time outlining the course of treatment. Sharing the diagnosis involves educating the client about the nature of MPD. It is critical to explain MPD in the context of its etiology, that it is a survival mechanism developed to allow an individual to cope with overwhelming trauma. In receiving this information, the client often has, for the first time, a framework for a variety of symptoms that previously left them feeling crazy and alone. Some may have difficulty with the diagnosis and may even decide the therapist is crazy. Some may take a flight into health, reporting the resolution of symptoms which brought them into therapy. Working through this denial to acceptance of the diagnosis is assessed to be an essential first step to successful treatment. Putnam (1989) states that a basic rule in therapy is to be completely honest, and cautions therapists to assume that all alters are listening to everything that is said in therapy. This

is a reminder that the diagnosis must be made not only with the host personality presenting for therapy, but with all alters as they are contacted. In outlining treatment it is important to assure the client and each alter that no one will be lost or destroyed in the course of treatment, and that all are essential to the whole.

Once MPD is diagnosed, treatment recommendations include the development of trust to establish a strong treatment alliance, contact with alters for the purpose of history gathering and mapping the internal system, the dismantling of amnesia barriers to facilitate interpersonal communication, the recovery and integration of traumatic material, resolution of the dissociative process and the development of new coping skills. The goal of therapy recommended by many clinicians is integration, where all alters fuse to form a unified personality. Others acknowledge that individual clients may wish for a cooperative community of alter personalities with no amnesia.

Trust is a critical element in any therapy, but it receives special emphasis in working with MPD clients because of the abusive and unreliable authority figures in the client's history, as well as the extremely painful nature of the work required (Braun, 1987; Kluft, 1985; Putnam, 1989; Ross, 1989; Wilbur, 1984). Trust must be established with each alter, a difficult job considering the creation of this internal world was necessitated by betrayal. It is a slow process which may surface throughout the course of therapy, and the therapist should assume that the therapeutic relationship will be tested repeatedly (Braun, 1987; Wilbur, 1984). It is important to address clearly issues such as availability, limits and boundaries. The intense nature of this therapy is demanding for therapist and client alike and requires special attention to duration of sessions, frequency of sessions, emergency contact and additional resources. Kluft (1986a), for example, commenting on the need to restore equilibrium before the client leaves, recommends scheduling appointments which allow for longer sessions.

One of the frequent mistakes of therapists working with MPD is the assumption of trust (Chu, 1985). A simple statement by the therapist that she or he is trustworthy is not enough and must be accompanied by honesty, consistency and respect. It is helpful to acknowledge the protective function of alters whose job it is to mistrust, and to invite scrutiny. Remembering Putnam's (1989) assertion that all alters are listening to everything said in therapy, it is especially important not to promote secrets among alters or between the therapist and any particular alter. The therapist will be required to hear horrific material, the impact of which, as Mayer (1991) points out, will change forever her or his view of the world and what is possible. The ability to stay present and listen with empathy is a cornerstone of trust in MPD work.

Communication with each alter personality allows the therapist to gather history about the personality system and the events which necessitated its development. Each alter possesses its own thoughts, feelings and memories, which are often held in isolation. The function of treatment is to elicit information about these separate and autonomous memory states and then to plan for communication of dissociated material to the primary personality. Contact with alters is a facet of therapy that holds a great deal of fascination for therapists, as there is a dramatic and powerful alteration in the client's presentation. The client may regress or progress in age, taking on the appearance and vocabulary and tone of someone much younger or older. The affect of any alter may be in total contrast to that of the host personality and there may or may not be familiarity with the therapist or material previously discussed in therapy. Both Caul (1985) and Chu (1986) caution against fascination with the dissociative process, noting that some therapists may get stuck in endless history gathering.

The recommended treatment method for communicating with alter personalities is psychoanalytic psychotherapy assisted by hypnosis (Braun, 1987; Bornn, 1985; Caul, 1985; Kluft, 1986a; Frances

& Spiegel, 1987: Mayer, 1991; Ross, 1989; Putnam, 1989; Wilbur, 1984). Once contact has been established, the process of mapping begins. This describes the systematic charting of information about each alter. It is important to determine the identity of each alter, who they are and what name they use. This may include a physical description as to gender, age and appearance. Names may be alterations of the name of the birth personality, names borrowed from significant others or names that describe the function or affect of that personality, i.e. "the angry one" or "the one who cries". Additional information for mapping includes why each alter was created and why they are present now, how old the birth personality was when they were created and how old they were, where they exist in the power structure of the internal world, what they know and what function they serve, i.e. protector, helper, holding the pain, holding the anger. The client may or may not be aware of particular alters. Where possible it is helpful to have the client diagram the internal world as it is revealed to her. There may be one alter capable of identifying others and indicating the amnesiac barriers in the system. This mapping provides structure and order and gives a visual representation of change as it occurs in therapy. It is a process which evolves throughout treatment and continues into the post-unification phase (Ross & Gahan, 1986b).

Special procedures are recommended for communication with different alters. Because of differences in age, verbal and conceptual skills and physical abilities, different techniques are necessary. A sampling of these include art therapy, music therapy, occupational therapy, use of a sandbox and figures, dream analysis and journalling (Braun, 1987; Cohen & Cox, 1989; Marmer, 1980a; Ross, 1989; Putnam, 1989; Skinner, 1987).

It is important to contract with each alter around treatment issues such as the goals of therapy and safety for the client and others. Any proposed contract must be specific and clear and each alter must be made aware of its terms and individually agree to honour them.

This requires careful wording and frequent renegotiation. For example, an alter who believes the host personality is responsible for the abuse and deserves to die may agree to a no suicide contract but in no way feel restricted to make an attempt on the host's life, believing she or he exists separately and will survive violence inflicted on the host's body. In response to this particular dilemma, a contract advocated by Braun (1984, p. 25) states: " I will not hurt myself or kill myself nor anyone else, external or internal, accidentally or on purpose, at any time."

The protection of the client and therapist against attack by a malevolent alter personality is an issue of concern for anyone working with MPD clients. These alters are an integral part of the client's personality system and, though often maligned by the host and other alters, serve an essential protective role. Watkins & Watkins (1988) report that therapists must align with malevolent alters and work to facilitate the release of anger into the internal system where it becomes available to the primary personality. They propose that the best way to manage these potentially dangerous alter personalities is to enlist their help and acknowledge their protective function. There is agreement from practitioners that angry or malevolent alters need to be involved in therapy, yet pose a real threat. The recommendations for doing this work safely are to accompany contracts and the establishment of clear limits with the use of hypnosis, safe rooms and restraints (Braun, 1987; Caul, 1985; Mayer, 1991; Ross, 1987; Putnam, 1989; Young, 1986). Hypnosis is useful in facilitating the switching process and in creating an immediate trance state in a client who is exhibiting signs of violence. Some therapists recommend hospitalization specifically to make contact with a malevolent alter, and contract with the client around admission for this purpose. A hospital setting has the advantages of safe rooms, restraints and extra personnel. Though it may seem barbaric, the use of restraints and safe rooms are techniques used to ensure safety and are introduced with the consent of the client (Ross, 1987; Ross, 1989).

A dilemma exists for therapists outside a hospital setting who do not have access to these physical aids and who have no formal training in hypnotherapy.

In facilitating internal communication and breaking down amnesia barriers, it is recommended that neutral material be shared first among alters. The presence of internal helpers can be utilized to form a treatment alliance, with those on the inside advising the therapist about issues related to internal communication: who is ready to hear, who must be protected from painful material, who may pose a threat as amnesia barriers come down. The "internal self helpers" or "centers" exist within the system of all persons with MPD and are invaluable to the therapeutic process (Comstock, 1987; Adams, 1989; Ross, 1989, Wilbur, 1984, Caul, 1986). It is familiar for many individuals across cultures to envision an internal source of wisdom and counsel; in the MPD client this experience simply becomes personified in a separate psychological construct. Comstock (1987) likens these internal self helpers to an observer within the self which has an understanding of all the personalities and their readiness and abilities to work. As interpersonal communication occurs, alters become aware of each other and the functions that each serves.

Internal helpers are also useful in helping the client through abreactive experiences. They can help to intensify the experience or create distance from painful material, and can advise the therapist on the effect of the abreaction.

Abreactive experiences are the most difficult aspect of therapy with MPD clients. They differ from therapeutic experiences where clients recall past abuse or relive past experiences on a cognitive level while aware of their present condition. An abreaction is the past occurring in the present for the client. The energy discharged through an abreactive experience is a release of cognitive and emotional information previously inaccessible to the original personality and abreactions are the incidents which precipitated the development of separate personalities. During the abreaction the client experiences

the abuse as if it is occurring in the present and will suffer the physical as well as emotional trauma. A therapist's willingness to be with a client in her pain is tested in the face of abreactive episodes. They are, however, believed to be critical to the healing process for MPD clients. Comstock (1987) cites three purposes for abreactive experiences: to inform and allow the client to know what really happened, to educate and change the client's way of thinking which is inevitably distorted and self-blaming, and to complete an experience by integrating the discharge of feelings, somatic symptoms and content. Given the difficult nature of this work, Comstock's words are worth quoting: "It may seem cruel to permit a personality to remember such abuse. However the reality is that it is through the remembering, releasing and relearning that the healing is accomplished. Abreactive work is painful but the dramatic results as these people heal from their abuse do seem to prove that miracles can happen...Through your work, you are helping to transform years of pent-up anguish into health and you are freeing human spirits from the crippling effects of their abuse..." (Comstock, 1987, p.7).

During the course of therapy, the MPD client will experience many crisis situations. It is generally agreed that psychotropic drugs are not effective in addressing the core psychopathology of dissociation, but may be helpful in managing adjunctive symptoms such as anxiety, depression and sleeplessness. (Braun, 1987; Frances & Speigel, 1987; Kluft, 1985; Putnam, 1989; Ross & Gahan, 1987; Ross, 1989). The difficulties in using medications with MPD clients may outweigh the benefits. Different alters may respond differently to a particular drug or may sabotage the prescribed treatment regimen. As Putnam (1989) notes, compliance with medications is inevitably an issue in an individual for whom any consistency over time in thought or behaviour is difficult. There is also a danger of overdose in clients who are frequently self-destructive and suicidal. Despite those contraindications, clinical research advocates a controlled and carefully monitored program of psychopharmacology to ameliorate

symptoms which may interfere with the primary treatment of psychotherapy. The most frequently recommended medications are mild anti-depressant and anti-anxiety agents for depression and anxiety.

It is important to achieve as complete healing as possible with each of the personalities before integration. Each personality will have distortions in thinking, the result of a highly specialized function based on limited awareness. Cognitive therapy can be useful in challenging the misperceptions of alters and replacing them with new information (Ross & Gahan, 1988; Mayer, 1991). The process of integration may occur spontaneously or may require facilitation by the therapist through hypnosis. As power struggles are resolved and information is shared certain alters are blended throughout the process of therapy. Final integration involves the fusion of separate alters with those blended earlier in therapy. This joining together of personalities is often achieved through ritual in which all personalities are acknowledged and celebrated and then encouraged to blend into a whole. The therapist may use creative visualization to assist the personalities in imagining a whole in which none of the parts are lost.

Once integration is achieved, follow up is necessary to help the client develop new ways of coping with stress and to adjust to the new experience of conflicting thoughts and feelings. Since a predisposition for MPD is high hypnotizability, it is possible to teach autohypnosis to integrated clients to assist them in managing symptoms after integration. Autohypnosis can be useful in rehearsing a particular situation in fantasy or in relaxation (Kluft, 1988d; Braun, 1984).

Few follow up studies are available, but one study by Kluft (1985) on the continued unification of thirty-three MPD patients with an average of 13.9 personalities reports 94% had not relapsed into behavioural MPD after 27 months. In another study, Kluft (1986b) determines that age regression in 12 firmly integrated patients did not retrieve separate experiences of separate selves. Coons (1986) followed the treatment progress of 20 patients with MPD and, while

noting that outcome studies should extend to 10 to 15 years beyond integration, concludes that treatment is effective and rewarding. Ross, (1989) in reviewing treatment outcomes of 22 MPD patients in active treatment in the Dissociative Disorders Clinic in Winnipeg, Manitoba, estimates a 70% response rate and concludes that MPD is a treatable disorder.

Treatment for MPD is specific and, when compared with prior interventions in the histories of patients who spent an average of 6.8 years in the psychiatric system, is successful. It is a demanding and intense therapeutic process for both practitioner and client, but is highly rewarding in its outcome. Testimony to the success of MPD treatment may best be offered in a client's own words: "Is fusion worth striving for? Having viewed the situation both port and starboard, I am steadfast in my opinion. I've spent over 30 years as a multiple and nearly 6 years integrated. Although my inner distress was outwardly subtle, the difference between my intellectual and emotional functioning as a multiple and as a unified individual is vast and apparently unending. And I can think of no better way to render an abuser powerless...What am I most grateful for? I really don't know. Sometimes I think it is for the peacefulness within which allows me to revel in a glorious sunrise; sometimes for the ability to concentrate without an internal power struggle because 'someone' wanted to do something else; sometimes to regain my birthright (my intellect, feelings of worth - whatever was "me" before the trauma) and to have some years to use it. And sometimes I think that I am most grateful for a feeling of kinship with people..." (Braun, 1986).

Summary

Multiple Personality Disorder, once thought to be rare, has been diagnosed with increasing frequency since 1980. With its inclusion in DSM III and DSM III(R), it has come to be understood as a dissociative disorder developed in response to severe and overwhelming trauma. Three major criteria predisposing an individual to MPD are severe

childhood abuse, hypnotizability and the absence of nurturing and restorative experiences.

MPD patients have frequently been misdiagnosed and often have psychiatric histories which include diagnoses of schizophrenia and borderline personality disorder and other affective disorders. One reason for this misdiagnosis is the presence of symptoms which suggest other mental health issues. Controversy and disbelief contribute to a lack of education about MPD and its distinct phenomenology. Common features of MPD include: auditory hallucinations, amnesia for childhood and specific current events, headaches, chronic depression, episodes of self-mutilation and suicidal behaviours, mood swings, and a variety of unidentified somatic complaints. When these symptoms are present in an individual with a history of childhood abuse and a non-productive psychiatric history, MPD is a likely diagnosis. The confirmation of MPD is made only after contact with one or more alter personalities who, at times, have executive control of the client's behaviour.

Treatment recommendations for MPD are based on acknowledgement of past abuse as the origin of dissociative behaviours. Treatment involves the retrieval of information from separate memory states, the communication of this information across amnesia barriers and the assimilation and integration of fragmented experiences to form a cohesive whole. The recommended treatment method is psychoanalytic psychotherapy assisted by hypnotherapy. Psychopharmacology is not helpful in addressing the central problem of dissociation, but is recommended for the management of particular symptoms. Hospitalization and the use of safe rooms and restraints may be necessary for the protection of the client and therapist while working with angry or threatening alters.

While few follow-up studies are available, treatment outcomes indicate therapy is successful in resolving dissociative behaviour and improving the functioning of MPD clients.

Method

Participants

Participants for this study were therapists in Winnipeg, Manitoba whose current or past therapeutic experience involved counselling at least one MPD client. The criteria for identifying a client as having Multiple Personality Disorder were those outlined in DMS-III(R) (1987): the existence of two or more distinct personality states with at least two personality states in full control of the client's behaviour. All participants shared a professional association with the researcher and were selected for inclusion in this study because of their known clinical practice with MPD clients.

Demographics of Participants

Of the three therapists interviewed, two were in private practice and one was employed as a counsellor in a community health centre. All worked in settings where space was shared with other therapists. There were no physical designs to accommodate violent or threatening behaviours and no support staff designated to provide clinical back-up. All three participants were women. Academic backgrounds included undergraduate study in psychology and sociology with one participant's holding a post-graduate degree in social work. All participants emphasized the importance of their clinical experience over academic training, crediting professional supervision and consultation, and client contact for their expertise in the areas of abuse and MPD. As one participant put it, " I owe, I think, the bulk of my experience to my contact with victims of violence..." All three participants had attended numerous workshops and conferences, had experience as crisis line workers, and had been employed as counsellors in health centres.

All three participants had received training and education particular to clinical work with MPD clients. All had attended a number of workshops on Multiple Personality Disorder and had

participated in clinical consultation with Dr. Colin Ross, head of the former Dissociative Disorders clinic in Winnipeg, Manitoba. One participant was employed for ten years in a dissociative disorders clinic and had attended three conferences sponsored by the International Society for the Study of Multiple Personality and Dissociation. All three participants had been the primary therapist for MPD clients over a period ranging from seven to ten years. Their reports of the numbers of MPD clients with whom they had been involved were as follows: 4, with this therapist adding "(there were) probably others that I didn't know of at the time," 30, and 100. Two participants had only worked with female MPD clients. Of the 100 seen by the third participant, 2 had been men. This therapist offered a possible explanation for this ratio: "...in general, regarding any type of abuse history, I see very few males...I think it's hard for males in the first place. I think it's doubly hard to come into a practice where someone is describing herself as a feminist counsellor."

Design and Procedures

Each participant was asked to participate in an initial unstructured interview directed by an interview guide (Appendix B), and a second, follow-up interview. As Lofland (1971) notes, interviewing as a method of gathering information for qualitative analysis goes beyond an inflexible approach of seeking pre-formed answers to established questions. The unstructured interview invites subject participation in a meaningful dialogue which encourages the description of personal experience. It is described as "a guided conversation whose goal is to elicit from the interviewee rich, detailed materials that can be used in qualitative analysis" (Lofland and Lofland, 1984 p.12). Kirby and McKenna (1989) expand this methodology to include the interviewer as participant, advocating an egalitarian, interactive relationship. Both interviewer and participant shape the research in a dynamic exchange which requires a clear focus but allows for amendment. The interview is meant to be an

exploratory process which, while following a pattern of specific questions, goes through some transformation with each participant. It is " an instrument of data collection - but also a sharing of ideas and philosophy and experience and symbolic expressions...a sharing of self" (Kirby and McKenna, 1989, p.68).

The interview guide for this study was designed to focus participants on particular aspects of their counselling with MPD clients, and to elicit detailed descriptions of individual experience in each of these areas. The goal of this research was to record the realities of people in the front lines doing this very demanding work, and to determine from an analysis of this record what universal themes may emerge that suggest directions for the treatment of MPD. Kirby and McKenna (1989) write of doing "research from the margins", a conceptual framework that advocates seeking knowledge where it is traditionally and historically overlooked, to effect social change rather than to entrench the status quo. Their research methods are based on the following beliefs:

- Knowledge is socially constructed.
- Social interactions form the basis of social knowledge.
- Different people experience the world differently.
- Because they have different experience, people have different knowledge.
- Knowledge changes over time.
- Differences in power have resulted in the commodification of knowledge and a monopoly on knowledge production." (Kirby & McKenna, 1989, p.65)

Certainly therapists and social workers exist on the margins of a medical system and, all too often, theirs are the voices that are missing in a growing body of clinical research. A study which focuses specifically on non-psychiatric interventions may reveal an untapped body of experience which will advance knowledge of MPD.

Two in-depth 60-90 minute interviews were conducted with three participants. Participants were selected from the researcher's knowledge of their suitability through professional association. As noted above, participants were therapists and social workers in Winnipeg, Manitoba, whose current or past therapeutic experience includes counselling at least one MPD client. Initial contact with each participant was made by telephone, followed by an introductory letter (Appendix C) explaining the purpose of the research and the nature of the interviews. This letter was accompanied by a release form asking for the participant's consent (Appendix D) to have the interview tape recorded. No client names or information relating to client identity were solicited or included in this research. Participants were coded and no identifying information was included in the data analysis.

An interview guide was used to provide focus for the initial interview, but amendments to the process in response to material discussed were accommodated. The second interview provided an opportunity for clarification of initial responses. It was also scheduled to address participant fatigue and to allow for completion of material not covered in the first interview. Finally, the second interview was used to explore new directions which surfaced from a review of data gathered in the initial interview sessions. Any participant requesting a copy of the interview guide prior to the first scheduled interview received one. Questions for the interview guide came from the researcher's personal experience, dialogue with other professionals, and a review of the literature. The guide focused on these areas:

1. The demographics and professional data of the participants.
2. The participants' experience with the following interventions in the treatment of MPD: (a) hospital admissions, (b) the use of safe rooms and restraints, (c) hypnosis, and (d) pharmacology.
3. The participants' experience with alternative interventions in the following treatment areas with MPD

clients: (a) the management of acute crises,
(b) communication with alters, (c) safety in sessions, and
(d) the management of somatic symptoms.

A post-interview comment sheet (Appendix E) was given to each participant and subjective information gathered on the process is accounted for in the presentation of findings.

Interview settings were arranged to ensure confidentiality, privacy, and comfort. In all cases this was the participant's work environment. Participants were assured they could terminate the interview at any time for any reason. No one elected to do so. Original audio tapes were destroyed upon completion of transcripts, and all participants received a copy of the transcripts from their two interview sessions.

Analysis

This section describes the methods used to analyze the qualitative data collected in these six interviews.

The researcher first identified bibbits (Kirby and McKenna, 1989) in all of the transcripts. These consisted of comments and descriptions that revealed the participants' thoughts, feelings, and experiences in their work with Multiple Personality Disorder. Each bibbit was examined for its central idea or theme. These bibbits, or pieces of data, were then studied in relation to the categories proposed in the research -- these being four specific interventions and four aspects of treatment. All bibbits were then colour coded to organize them into categories. Colour coding allowed this raw data to remain in its original context for easy location and to maintain the integrity of each interview.

Each category was then reviewed individually and analysis notes were made. This involved the identification of key words and themes and the transcribing of a summary of the bibbits for each category. The analysis notes served as a basis for the discovery of emerging themes and theories across interviews.

Finally, all categories were studied in relation to each other to identify common characteristics and to look for any discrepancies in the emerging analysis.

In the view of the researcher, the question of therapists' outside the medical, psychiatric community offering effective and safe treatment to MPD clients was successfully addressed. The viability of alternative interventions was overwhelmingly affirmed in the study's outcomes.

Presentation and Discussion of the Interview Findings

Each of three therapists participated in two interviews focusing on their clinical experience with Multiple Personality Disorder. This chapter presents the data collected in these six interviews organized as follows: (a) summary of participants' experience with four interventions, (b) summary of participants' experience with four aspects of treatment, and (c) the interview process.

Participant Experience with Four Interventions

The following summarizes each participant's experience with four specific treatment interventions with Multiple Personality Disorder clients. These four interventions include: (a) hospital admissions, (b) the use of safe rooms and restraints, (c) the use of hypnosis, and (d) the use of psychotropic drugs.

Hospital Admissions

Participant 031: This therapist describes her attempts to have clients who required hospitalization admitted to the dissociative disorders clinic when it existed in Winnipeg. She describes the importance of having clients in that hospital:

> I knew there that they had training, and in fact were writing some of the books...that they believed that multiplicity was a fact ... that they would be helpful in the healing process, that is, they would listen. They would treat the person seriously, they would treat all the parts seriously, and that they would not over-drug or attempt to drug this person out of this.

In contrast, this therapist describes other hospitals as lacking training in MPD based on a belief "that multiplicity is rare if it exists at all."

Since the closing of the dissociative disorders clinic she works to keep MPD clients out of the hospital, having witnessed regression in those clients who have been hospitalized. She cites that the most support her clients have received during hospital admissions outside

the dissociative disorders clinic has been from psychiatric nurses "who believed what they (clients) were saying," and not from the psychiatrists responsible for their care. Despite this absence of appropriate treatment, she finds hospital admissions necessary when a client who is either suicidal or homicidal is unable to negotiate around safety. In these cases, this therapist recommends admission when possible, to a hospital where someone is familiar with the client.

She attempts to negotiate with the psychiatrist to "do nothing while the person is there, but just warehouse them, to keep them safe for a period of days until some stability again occurs." Optimally, she is able to visit her client in the hospital and continue therapy while the client is there.

The hospital is also described as a part of crisis planning and negotiating for safety. She informs all parts in the client's system that, if she is unable to prevent any part from hurting someone else, either on the inside or outside, she is going to have to arrange hospitalization. She describes MPD clients as having periods of "temporary psychosis" during which they are unable to distinguish between past threats and current reality. Hospitalization has then been necessary to ensure safety.

These episodes of "temporary psychosis," which sometimes require hospitalization, are described as "very short - two or three minutes" to forty-eight hours.

The hospital, then, is used as a last alternative when a safe place is needed. This therapist's thoughts on hospitalization are best summarized in her own words:

> Well, I think that when someone is just unable to stop slashing, or feeling that they cannot contract not to kill themselves, then I feel that that is a time there just is no choice but to go to the hospital. I also feel that if someone is homicidal, as well - they're either going to hurt themselves, or they're going to hurt somebody else - that in some of those cases hospitalization needs to happen. And so then I would encourage that. I

> encourage it, and at the same time I feel afraid of what is going to happen, because everything is out of my control once they go through those doors. And I feel worried that they're going to get shock treatment, that they're going to be doped beyond reasonable limits. So I do it, but believe me, it's my very last alternative at this point in time. I wish it wasn't. I feel very sad about that.

Participant N38: This therapist worked on a psychiatric ward in a hospital for ten years. During this time a dissociative disorders clinic was established, which she describes as an informal arrangement consisting of a team that included herself, a nurse and a psychiatrist. While the role of primary therapist alternated among members of the team, the psychiatrist was ultimately responsible for all clients' care and prescribed all medication. She explains that there were two types of admissions to this unit: planned and unplanned. Planned admissions were voluntary hospitalizations to do a specific piece of work. This might have involved an anticipated crisis around the retrieval of a particular memory or activity of some part perceived as dangerous. Unplanned admissions were emergency responses to clients in danger of hurting themselves or someone else. In reviewing this experience, this therapist acknowledges that, sometimes, bringing people into hospital is absolutely necessary: "when safety is a bottom line, what else are you going to do?" However, she does not now believe all admissions were necessary.

> In retrospect I think we made a great many mistakes. I think the admissions were sometimes foisted upon the staff - ill-prepared, and not wanting to be part of that process... So that just set up a very adversarial kind of system within the hospital... So I think we - I think we often did not need to do that. We did not need to put people into hospital. We could have handled things in a slower manner.

Now in private practice, this therapist uses hospitalization as a last resort to provide safety through a time of acute crisis.

> If I thought that someone could receive treatment of some sort in hospital - but as we know, there are no structured programs in Winnipeg for people who are dissociative....So the only reason that I can see for anyone going into hospital is for safety. Hopefully just being able to get through a crisis time.

She describes expecting no treatment in hospital currently for dissociative disorders. In one instance she has been able to visit her client in the hospital and provide therapy on the ward. Her caution with hospital admissions, given the absence of a dissociative disorders clinic, is that clients will receive inappropriate interventions such as electric shock therapy. She sees an additional dilemma in the atmosphere on the hospital psychiatric ward and its impact on the client:

> So, you have this sensitive person who comes into hospital and picks up immediately all kinds of vibes on the ward - knows the people who don't believe her - she's just acting, manipulative, borderline. (She) can pick up the conflict, the stress between staff and between those people who are trying to be supportive and trying to understand, and those who - and that is of course - all of that - counter therapeutic, counter productive for the work that she will be needing to do. So, going into the hospital could not only - that this person is not going to receive any treatment, but the whole atmosphere of the hospital could actually contribute to the stress and chaos that's already present.

She uses hospital admissions as a back-up in planning for safety. With the retrospective of experience in both a hospital and private practice setting, her view on the necessity of hospital admissions changed.

> What I do know though, from the people I'm seeing now, and working at a slower pace, nobody's gone to hospital. And we used to have people in and out of hospital all the time. It makes me wonder if we really needed to do that. Had we not pushed things and thereby, inadvertently, created crises.

Participant K315: This therapist describes a past planned admission to the dissociative disorders clinic. Her client was admitted to the hospital to do a particular piece of work and received therapy on the ward. Her more current experience suggests that therapy appropriate to MPD does not occur in hospital settings, and her admissions are now based solely on risk.

> So it's been going to emergency, waiting for eight hours, getting the person assessed, and if you're lucky, getting them admitted. And that is for purely safety reasons. Not for any hope of treatment while the person's in the hospital. Because my understanding is that that's not happening any more. And even if there is a recognition on the staff's part, I don't think that there is - I shouldn't say that there isn't a commitment - I don't even know if they have the resources or the mandate to work with it. So hospitals seem to be places basically to get people stabilized, patch them up and get them out. I don't think it's ever a good thing for somebody to be in the hospital.

The benefit of a hospital admission, as she perceives it, is that in some cases it provides the safety necessary to stabilize, for a client who is at risk. In her experience with clients who have been suicidal or homicidal, the hospital has provided the only option for that to occur. She emphasizes that it's not the psychiatric care in the hospital that is critical in those admissions, but the safety.

> The down side of the hospital is psychiatry that in many cases doesn't recognize the effects of childhood abuse, especially in its most severe form. Or where - in the case of people who are dissociative - where a part of themselves may have stored those memories in a young part of them - and so when the memories come back, they may seem a little weird and bizarre. Like, for example, the penis was this long. Well, when you're four years old, a penis might look that long, and that's the part that's remembering it. And really encountering - certainly one particular psychiatrist - certain disbelief of some of these things

> - and feeling like I had to nicely explain to him that she might remember it that way.

Even when safety necessitates a stay in hospital, this therapist believes it compromises the well-being of clients. For this reason, she works to help clients maintain as high a level of functioning as possible in their daily lives.

> Every time you lose it completely and feel like you've got no control and have to go into the hospital for a while - that's a really demoralizing experience. And that takes a lot away from you. And it takes a lot away in terms of your confidence. And the longer, in some ways, that this woman can stay out of hospital, the stronger she will be.

Discussion

The shared experience of these therapists with hospitalization suggests that it is a necessary intervention in times of acute crisis, but non-therapeutic beyond the provision of safety. These therapists indicate that they would value appropriate psychiatric treatment with their Multiple Personality Disorder clients, but do not have evidence that, at this time in this centre's hospital system, it exists. Each participant clearly states that she has no expectation that treatment for dissociative disorders would be offered to her clients in the hospital, and all share a persistent fear that inappropriate treatments such as anti-psychotic drugs or electric shock therapy would be administered. Inevitably, hospitalization introduces psychiatric assessment. From these interviews it seems evident that, in this hospital system, there is a lack of psychiatric support and intervention for the diagnosis of Multiple Personality Disorder.

A further concern with hospitalization appears to be the impact this has on the client's self-perception and sense of control. Participants choose this intervention with the knowledge that clients may regress, either in response to a potentially hostile environment or to the experience of having to abdicate control. Therefore, trying to keep MPD clients out of the hospital is an important goal for these

therapists throughout therapy. Even if an appropriate treatment facility did exist, as in the recent past with the dissociative disorders clinic, participants stress the importance of helping clients maintain as high a level of functioning in their lives as possible. This perspective leads one participant to question the frequency of past hospital admissions, believing that some may have been avoided.

However questionable the use of hospital admissions may have been in some cases during the existence of the dissociative disorders clinic, all participants report having benefitted professionally from association and consultation with the psychiatrist in this clinic, and all had clients who benefitted therapeutically from treatment received in this clinic. It is absolutely clear, from the unanimity of response, that the absence of this facility and a psychiatrist who believes in MPD has compromised the support available for these therapists and their clients. Consequently, all three therapists are working with MPD clients from an orientation that hospital admissions are not helpful except for "warehousing" clients in crisis. If there were an alternative environment which could ensure safety and respite for clients in need of stabilization, one wonders whether hospital admissions would be an option.

Safe Rooms and Restraints

Participant 031: This therapist believes safe rooms and restraints may be necessary at times, but cautions that their use be considered with the awareness that these interventions always cause further damage. She advocates that MPD clients requiring this intervention should never be left alone, but be accompanied 24 hours a day as is a patient in intensive care. She believes safe rooms need to be "safe" in terms of what we know about the needs of clients:

> I believe that this room needs to have more of a homey atmosphere than a prison-cell atmosphere. Like, concrete walls with a mattress on the floor is something I have a very difficult time with. A small room - concrete, mattress on the floor, sounds to me like a prison cell, and I am concerned whenever victims of abuse are treated more like offenders, or they're treated less humanely than those who have committed crimes and are in prison.

She suggests safe rooms be designed with healed survivors as consultants.

Her experience in a private practice setting is that the absence of a safe room alters the work that can be done, primarily by putting limits on the acting out of pain and anger.

> If anything, this space has probably resulted in my getting more creative to find ways that we can work within here - working with drawing with crayons, breaking crayons - drawing things in colours that would be extremely violent - painting, whatever. Really exploring a lot of their thinking and a lot of their fantasies around violence towards themselves and others, and trying to put that out in a creative, non-violent way.

Participant N38: As with hospital admissions, the use of safe rooms and restraints in this therapist's experience working in a dissociative disorders clinic was both planned and unplanned. In admission contracts clients and therapists would discuss the use of safe rooms.

> Usually in those contracts would be a statement about, "if I request to go to the safe room, I need to be accompanied there by staff, and I need somebody to stay with me while I'm there." or, "I will go to the safe room and I will stay there as long as I need to so that I don't kick the furniture around." People would use those rooms as a place to go where they could feel a little more secure if they were feeling out of control.

Unplanned use of these safe rooms was used to isolate clients whose behaviour was disrupting the ward. In these cases this therapist describes them as punishment rooms: "you act out, you have to go there." In her experience this was a necessary intervention to prevent disruption of the general population on the ward.

In terms of safe rooms being safe places for clients to express pain and rage, she describes them as, in fact, unsafe.

> Now the problem with these rooms are - these rooms are like any other rooms with the Tyndall block walls, with the window sills. There's no kind of padding or anything in the rooms, so if an angry part, for example, came out ... I mean all they had to do was turn around and punch the wall and hurt themselves. If those walls had been padded, it would have been a safer place for that kind of thing to go on. But they weren't padded... so they weren't safe rooms.

Restraints were used on two occasions with clients in this therapist's care. One client requested restraints so a part referred to as "the evil one" could come out to do some work. Another was put in restraints when a self-destructive part was present and running head first into walls. The dilemma for this therapist is that, as she puts it, "I hate the idea of restraints." But in this instance she could not see an alternative.

The absence of safe rooms and restraints in her current setting imposes some restrictions which she addresses by establishing clear rules. When asked if she believed these restrictions interfere with the potential for healing, she responded, "Again, it takes a great deal

longer to do this, but you can do the work you need to do in a less direct manner."

Participant K315: When this therapist had a client in the dissociative disorders clinic, her client would ask to go to the safe room in anticipation of a frightening switch. The alter who was present during this switch was so violent that the woman had to be restrained in the safe room to prevent self-injury "because it was just a regular room, basically, with nothing in it but a mattress." While the use of a safe room and the availability of orderlies to restrain this client seemed essential in this case, she responds to a question about how she might work with this client in her current setting - a community health centre - by questioning the possible control this client may have had over her switching.

> I don't know if that particular alter ever came out anywhere other than in the hospital. Like when she was on day passes, or outside the hospital - if that part of her ever came out ... It sure did in the hospital. And she was equipped with a helmet to protect her head. To me it's a speculation. It's an interesting question - the fact that it was allowed in some respects. I don't know what would have happened if it hadn't been allowed.

She acknowledges that the absence of a safe room puts parameters on her work, particularly on the levels of noise and acting-out behaviours that are permissible.

Discussion

All participants relate experiences which indicate that safe rooms and restraints are sometimes necessary in therapy with MPD clients, yet all describe alternative methods of working with clients in settings where no safe rooms or means of restraint exist. Two participants had experience with a client in the dissociative disorders clinic who was at risk of self-injury when a particular angry alter was present. In these instances the safe room and, sometimes, restraints were used for protection as well as isolation from the general unit. Neither could think of an alternative to these interventions, yet

neither report any similar incident in their work with MPD outside the dissociative disorders clinic. One participant articulates the question that arises here: was the threatening behaviour that necessitated these interventions somehow "allowed"? This, of course, leads to a further question as to whether this behaviour would occur in a different setting not designed to accommodate this violence.

All participants describe modifying their approach in response to their environment. This involves setting clear rules and boundaries which prohibit violent behaviour in sessions, and encouraging the expression of angry feelings through creative, non-violent means. This is further explored in the presentation around safety in sessions. What seems noteworthy here is the contrast in experience in and out of a hospital setting where, in one setting safe rooms and restraints are used and believed to be necessary, and, in another setting are non-existent and therapy proceeds within certain parameters that exclude violent behaviour. This suggests that, like therapists, clients modify their approach in response to the environment.

It is additionally important to note that all participants describe safe rooms as less than safe. Their design lacks anything distinguishing save the absence of furnishings. The cell-like appearance of these rooms is described as more punitive than therapeutic. For this reason they might more appropriately be referred to as isolation rooms, which seems to more accurately reflect their purpose as described in these interviews.

Hypnosis

Participant 031: While this therapist acknowledges that someone may appropriately advocate the use of hypnosis as a necessary intervention to keep an MPD client from killing herself or someone else, it is not a technique she uses or advises. Her belief is that every survivor has a system developed for her own protection which ensures that memory is retrieved at a pace she can survive. Introducing hypnosis - or sodium amytol - circumvents all the

survivor's coping mechanisms. She describes the experience of one client:

> One survivor whom I worked with very early on, who was extremely dissociative, who had feelings of being dead and didn't know why she was saying she was dead, felt like she had no alternatives and wanted to explore hypnosis. And so she did go into hospital, and through the use of hypnosis this memory was retrieved. And at the end of all that ... when she had retrieved this memory, she called me and said, "I want to tell you something. Don't ever suggest that anybody else ever go through hypnosis or sodium amytol. I did not believe that I would stay alive through that. It was just too much."

She explains that what we call hypnosis is often guided imagery and this is also a technique she avoids when horrible memories have been repressed or dissociated.

> I feel that we could step on a land mine that would just have them freaked out for days ... How reasonable is it to ask somebody to slip into that space and then after an hour or even two hours to slip out of it and walk out of here?

Particularly in a private practice setting without access to a safe room or treatment centre, she describes herself as "playing it safe" and proceeding at the client's pace, respecting that the client's denial will keep her going. She hypothesizes that she might push harder and do more imagery work if there were a safe house where these clients could be assured of appropriate support.

An additional concern around the use of hypnosis arises from her observation that certain alters can be so fearful of this process that they create more defense systems, resulting in further fragmentation. She describes one client whose system kept getting more elaborate after sessions with a hypnotherapist. From this experience she cautions that, if hypnosis is used, all parts be informed and agreeable. Finally, she advocates tape recording these sessions so all parts can discuss what happened.

Participant N38: This therapist reports initially using hypnosis all the time to make contact with different parts of the client's system. She describes helping clients get into a relaxed state and then asking to speak to a particular alter personality. She explains that the use of hypnosis, or induced relaxation was based on a belief that the therapist needed to talk to as many parts as possible. Currently she uses hypnosis, or relaxation techniques less frequently.

> Initially we used hypnosis all the time. Well, when I say all the time - a lot of the time - especially early on. So you help somebody get into a very relaxed state and then ask to speak to the part of the mind who calls herself "Susan". And then Susan could emerge and talk ... Now, I tend not to do that. I might do it a little bit initially, but it seems to me once you can move into the internal world as much as you can, and know the ways to ask for a certain part of the self to come out and talk, you can just do it by saying, "I'd like to speak to Blah blah." And it can just happen that quickly, rather than using a lot of hypnotic techniques to help that happen.

She does not see training in hypnosis as being critical to work with MPD clients but rather as "a useful thing that you might choose, given what's going on."

Sodium amytol, which is often paired with hypnosis to break through amnesia barriers was also used in the dissociative disorders clinic.

> I think that was a mistake. I don't think we should have done those things. I think we forced systems to deal with material and parts of the self that weren't ready to be worked with. I think we created crisis by doing that - crisis that could have been avoided. So I think we tried to do too much, too fast, without going at the clients' pace, but out of our own needs to get this work done.

Participant K315: This therapist reports using hypnosis in the past, though describes it as relaxation exercises and not as something

complex. "It's sort of a way to ... allow that person to relax and if some other part needs to come out, for it to come out." She has not used hypnosis, or relaxation exercises, when a client has been fearful of this process, and has found that alters appear spontaneously.

The assumption that the therapist must meet most of the alters in a client's system is no longer shared by this therapist. She encourages the client to do her work internally, and she communicates with that system through the client. This shift in approach minimizes the need for hypnosis, or interventions designed to call forth alter personalities.

Discussion

These interviews reveal a diversity of opinion regarding the use of hypnosis. Two participants describe hypnosis as part of their work with some MPD clients, and the third rejects it as a treatment approach with dissociative disorders. Interestingly, the term hypnosis was reframed by all participants who described it as an informal approach consisting of guided imagery and relaxation techniques designed to facilitate the switching process. The suggestion that no formal hypnotherapy is required for this purpose seems to support the profile that MPD clients are highly hypnotizable.

According to one participant, a basis for not employing guided imagery or hypnotic techniques is the intrusiveness of these interventions. Her assertion that therapy with MPD clients must respect their systems for coping is shared by the other participants, though their decisions to incorporate hypnotic techniques differ. All participants discuss the importance of proceeding at the client's pace, having observed crises created by therapy which attempted to move too quickly. This concern for safety is definitely connected to a lack of appropriate resources; if hospitals that do not offer treatment for Multiple Personality Disorder are the only option for safety in times of crisis, it becomes especially important not to proceed in any manner that might precipitate a crisis. As one participant (031) puts it, " I might push a little harder in here, and I might do more imagery

work... if I felt that there would be some place that I could use as a back up, if there was a treatment centre here."

The use of hypnosis is not currently an active part of any participant's therapy with MPD clients. This seems to result not only from a concern for the emotional safety of the client, but also from a basic therapeutic switch --shared by all participants -- characterized by more indirect communication with the client's internal system. This is described more completely in the discussion on communication, but it is raised in this context by one participant who describes her attempts to work through the client rather than calling out alters in sessions. Certainly, if therapy encourages stability and presence for the client versus fragmentation and switching, the need for hypnosis diminishes.

Finally, there is the consideration of hypnosis' causing fragmentation. In the literature this is referred to as iatrogenesis, a charge that dissociation is caused by the introduction of hypnotic techniques. While no participant describes a belief that MPD is therapist induced -- in fact, all articulate a firm conviction that MPD is a distinct response to severe trauma -- one participant did describe her experience with a client whose system became more elaborate in response to hypnosis. The important distinction between her description and attempts to discredit MPD as iatrogenic, is her emphasis on safety versus suggestibility. Her observations that someone who has developed this survival skill in response to overwhelming trauma may further dissociate in the presence of threatening therapeutic techniques assumes dissociation is a legitimate response to perceived danger. This is distinctly different from an assumption that clients will become symptomatic in response to therapist manipulations. Her experience suggests a cautious approach to the use of hypnosis with MPD clients, one she feels can be addressed by ensuring all alters are informed and agreeable before hypnosis is introduced.

Psychotropic Drugs.

Participant 031: This therapist states she believes in certain medications for short-term (3 to 6 months) intervention. Specifically, she advocates the prescription of anti-depressant medication or sleeping pills to alleviate anxiety and to help with intrusive memories which may interfere with sleep: "primarily for those who have to work to earn a living, and that's a reality. They have to get sleep at night." She is adamantly opposed to anti-psychotic medication, stating MPD is not evidence of psychosis. She clarifies that those short psychotic episodes experienced by MPD clients are trauma-based versus illness-induced, and that anti-psychotic drugs will have no effect on this disorder. She observes that MPD clients have survival systems that often circumvent medications, where "there can be a part of them who can be drugged to the hilt and another part that is vigilantly alert and observant and taking things in."

In her experience, more physicians are being educated about abuse and its effects and are therefore prescribing medication with caution, concerned about over-medicating and advocating medication be an adjunct to therapy. For these reasons, she refers clients to physicians when medication is warranted.

Her experience with clients and drugs leaves her questioning the motivation for chemical intervention.

> I'm not sure as over the years I've looked at drugs in general, how much drugs helped the person, or how much they help us the worker - or the people that have to deal with them on the outside. And I think that a lot of the drugs that we use help us feel a little better about this person. We don't have to see them in so much pain. We don't have to listen to the kinds of extreme violence that they're talking about. We don't have to face some of our own fears about looking at some of the things they are talking about, for instance, abuse.

Participant N38: In her experience with MPD clients in the dissociative disorders clinic, this therapist has seen the benefit of low-

dose, short-term medication prescribed to lessen anxiety or address sleep disturbance. She describes the psychiatrist in this clinic as being "really good with medications" and believes they can be an important addition to therapy.

> If you have somebody on, hopefully, low-dose, short duration medication in order to help them lower the anxiety enough so that you can get the work done - or, be able to sleep enough so you can get the work done - then that's what you need to do. Because by not having the medication, they just keep spinning the wheels... which then adds to the already strong levels of stress that people are going through when they're trying to deal with this.

As to the prescription of anti-psychotic medication, she states clearly that it "will not be effective", as a dissociative disorder is not psychosis. Having anti-psychotic drugs prescribed is one concern for her with clients who are hospitalized.

> There have been difficulties with certain psychiatrists. Somebody has been seeing a psychiatrist who just does not understand about dissociative disorders, and has somebody on Haldol - anti-psychotic medication. That could be a problem. Cause that won't - I mean it won't do anything. In fact, it might make things worse by having a certain effect on one of the parts, or none of the parts - and they get upset because they can't do their work.

She has observed that any medication may effect one part of the self and not another and, for this reason, believes it important to monitor what is happening and adjust medication accordingly. She refers clients with whom she is currently working to their physicians for consultation around medication.

Participant K315: Most of the clients in this therapist's care have been on some form of anti-depressant or anti-anxiety medication. She describes one client who used a fast-acting anti-

anxiety drug to circumvent the panic attacks which resulted in self-mutilation.

> I think I was telling you last time about the use of - with one of my clients - of Ativan - I think it is, the ones you pop and they instantly relieve the anxiety. And that seemed to be helpful in her case ... She would often blank out and then cut herself when she started to get anxious. So when she could pick up some of those cues, she would take this medication - and because it's very fast-acting, it would sometimes help her out of those situations.

She notes that, in her experience, many women with abuse histories have been prescribed anti-depressants by psychiatrists, and that this would, of course, include clients with Multiple Personality Disorder. She has not witnessed the effectiveness of this medication, and in her view, this is not surprising as these clients have "good reason to be feeling depressed."

> But it's hard for me to assess what the impact of the medication was. What that person would have looked like if they weren't on the medication that they were on.

In one case, where a client had been seeing a psychiatrist for medication, this therapist observed no connection between this intervention and her therapy with the client. She has not had any client over-medicated to the extent that drugs interfered with therapy and describes herself as "fortunate in that respect."

Her experience suggests that anti-anxiety drugs can be helpful to alleviate panic attacks and help clients who have difficulty sleeping, but that anti-depressant medications seem neither to harm nor help in any significant way. Her belief is that medicating symptoms is ultimately not as therapeutic as addressing why clients are experiencing these symptoms. She has had clients go off previously prescribed medication as a result of therapy. If medication is required, this therapist would refer to physicians in the community

health care setting, as her view is that they are fairly conservative in medicating.

Discussion

All participants cite the benefit of certain short-term medications with their MPD clients. Specifically, these therapists advocate the use of anti-depressant or anti-anxiety drugs to alleviate symptoms of anxiety and help with sleep disturbance. All have experience with MPD clients who have successfully used these drugs as an adjunct to therapy. All describe MPD clients as high-functioning individuals who, for the most part, have careers and significant relationships. Each of these therapists believe it is important to maintain the integrity of clients' lives outside of therapy and, therefore, all refer clients for medication when stress threatens their ability to function in or out of therapy. What participants also unanimously assert is that anti-psychotic medication is, at best, ineffective and, at worst, potentially harmful. Drugs are only seen as helpful for certain debilitating symptoms that occur as a result of trauma; not one therapist interviewed believes drugs would address the core symptomatology of dissociation. One participant explains her concern that anti-psychotic medication may cause internal chaos in a system that can circumvent the predictable effects of medication. This is an observable phenomenon mentioned by two of the participants who have worked with clients whose alters responded differently to drugs. While this may cause difficulty with any medication, it is described as specifically problematic with anti-psychotic drugs which may interfere with a particular alter's ability to function. One participant describes a client whose psychiatrist prescribed Haldol, the result being that some alters were "completely snowed" while others were apparently unaffected and vigilant. The potential harm is obvious if one considers the scenario where a "snowed" alter is responsible for monitoring and controlling another suicidal part.

The fear of inappropriate medication is based for each of these participants in her experience with a psychiatric system which, for the

most part, has not demonstrated a belief in MPD or knowledge about the long-term effects of childhood abuse. All three participants refer clients to physicians when medication seems warranted, having experienced more caution among physicians with medicating in general and more knowledge about trauma-based disorders. This again poses a dilemma for therapists and clients when referral to a hospital psychiatric unit becomes necessary.

A final issue around medication, raised in these interviews, is the motivation for medicating. All participants have experience with MPD clients who have been medicated inappropriately, though one, who describes herself as "fortunate", has not had this interfere with therapy. While one wants to assume that all interventions are well-motivated, there is an obvious conflict between medicating symptoms and treating the underlying causes of these symptoms. If chemical intervention precludes treatment, can it be therapeutic? This question is raised by all participants, with one suggesting that medications which make the expression of intense pain more palatable may sometimes better serve the therapist.

Participant Experience with Four Aspects of Treatment

In addition to eliciting information from participants about their experience with particular interventions in therapy with MPD clients, this interview was designed to encourage participant description of personal approaches in four treatment areas. These areas include (a) crisis management, (b) communication with alters, (c) safety in sessions, and (d) management of somatic symptoms. The following represents a summary, organized by each aspect of treatment, of participant responses.

Crisis Management

All three participants report the necessity of hospital admissions to intervene in acute crisis situations with MPD clients. However, all describe this as a last alternative to ensure safety, with

the essential component being the secure setting. All have had positive experience with client admissions to the dissociative disorders clinic, but with the dissolution of that clinic, all participants emphasize the importance of keeping clients out of the hospital. Participant 031 credits her crisis intervention training and experience as being critical to her work with MPD clients.

> ... struggling very hard at times, especially on a suicide call, thinking, "how am I going to find this person's strength? How am I going to keep focused on that, so that I don't just feel as helpless and hopeless as they're feeling" ... So I keep that strength, always right in front of me with every person - just looking for that.

Without exception, all participants describe MPD clients as creative and resourceful and describe their efforts to help clients identify those resources.

Crisis planning is mentioned consistently as a component of therapy with MPD clients. While this includes going to a hospital as a last resort, it also includes interventions designed to keep the client out of hospital. Breaking the isolation of clients is seen as important by all therapists interviewed. This is accomplished by mobilizing a support system of friends, non-abusive family members, of "alternative families", crisis workers and mental health professionals.

> 031: For individuals, I try to make an arrangement with them if at all possible that they trust someone, other than just me, with their history, with what they're going through, that they not remain isolated. To me that isolation is the most dangerous situation for anyone, and so I work very hard not to set myself up, either, as the be-all and end-all in resources for this person ... for those who don't have any resources and are reluctant to use any, I am still encouraging that they call places like the health centre, that we go over their survival plan.
>
> N38: I guess a way to help manage with crises, which people will get into, is by having a support system - that people will

need to have other people. You and I are not available 24 hours a day... if that person has some kind of a support network that they can hook into to help them through crises, that's immeasurably helpful.

K315: Safety - one of the strongest things we've used is contracting. And also using supports in terms of people that person may have in their life, the crisis lines, the hospital if need be...

One participant (031) describes the importance of group support in crisis planning for her clients who are participating in a group for ritual abuse survivors.

Now most of the multiples that I am currently dealing with are in fact part of the ritual abuse group that I'm doing. And so I will suggest that they get together with other group members. They will stay overnight with other group members, and the group will kind of huddle around someone who's in bad shape, and that's how they're getting through. Which quite frankly, is a better system, all in all, because the person feels and sounds more successful about their abilities to survive when they don't have to go to hospital.

Another participant (N38) discusses the helpfulness of an MPD group she is facilitating in planning ahead for stressful events.

We started off by kind of going around to see how everybody's doing, and if there are things that they want to talk about during the group. So everybody's saying, "you know, I've had a really bad week and Easter's coming up, and I'd like to talk about some ways to cope with the next major holiday."

And we'd have this kind of talk before Christmas and it worked really well, so I thought, "great".

A third participant (K315) mentions the importance of having clients identify a safe place in their own environment where they can plan to go in times of crisis.

Another aspect of planning for crisis management discussed by all participants is the introduction of creative, non-violent techniques for expressing the emotions that can precipitate crisis. All therapists use art work, journalling, collages and relaxation techniques with MPD clients. These are ways of expressing feelings that are encouraged not only in sessions, but outside of therapy to provide safe outlets for anger, fear and anxiety. As one therapist put it, using visual art can also be invaluable in making the internal system accessible and less frightening.

> 031: I think that collaging can help take - to make more visual - or plastecine, or whatever it might be - I think that once those images are brought from a verbal to a more tangible shape in front of us, that we can see quite clearly that this is - this is just sensible and that it's not the scary thing that we'd imagined in our heads ... when someone says to me, "well there's a demon there that's very scary." All I have to go on at that point is my own fantasy, and my own fantasy is never going to be the same as that of a child who was five or under at the time they created this demon.

Another participant describes how creative activity helped her client maintain some control over her own safety.

> K315: It was doing anything creative - you know, working with the hands. And that was a really good way for her to help keep herself safe.

All three participants talk about the importance of slowing down the work to avoid creating crises that they see as preventable. There was unanimous support for interventions which proceed at the client's pace, respecting her system and highly developed ways of coping. In two interviews this brought up the issue of abreactions. In neither therapist's clinical experience have they attempted to facilitate abreactions of all significant memories. A shared belief is that memories will be recovered in a variety of ways when the client is ready to receive that information. In one participant's experience

(N38) abreactions occur spontaneously, while some information is transmitted very differently through writing, drawing or dreams. For another participant (K315), abreactions and forcing memory raise ethical issues around who is in charge of healing.

> Well, then don't we get into - you know - what is healed? and you know, what is our judgment about when the person is healed, and what is the other person's judgment - the client's judgment about when they're healed? And I think that we have to go with the client's ... who am I to say, "no, you've got to drag yourself through the muck for another two years. We've got to go through every sort of horrific ritual abuse memory that you ever had in your life..."

A final proposal for crisis management was raised by each participant, independent of any reference to this idea by the researcher. Each participant uses the term "fantasy" to describe what she considers to be an ideal in the treatment of MPD -- the existence of a safe house. Consistently this was described as a non-traditional setting which would provide both residential and non-residential treatment to clients with Multiple Personality Disorder, though one participant (K315) suggests it might not be exclusive to MPD clients. All describe a multi-disciplinary team which would include psychiatrists who believe in MPD, counsellors, physicians and others such as art therapists, body workers, occupational therapists, music therapists, spiritual consultants and nutritionists who would add a piece to the healing process. What each participant stresses is that MPD clients are highly creative people who require that we be eclectic and creative in our work. This facility would be staffed by people interested in MPD and trained to do the work. Clients would be encouraged to maintain their lives outside of therapy and use the centre on an out-patient basis, though it would be available to provide respite or safety during times of crisis. Each client would participate in designing a program to use resources that fit her individual needs.

Finally, this facility would include group work to end the isolation of individual MPD clients.

Discussion

A fundamental assumption for all participants regarding crisis management with MPD clients appears to be the belief that MPD clients have the internal resources to get themselves through very difficult times. The profile of an MPD client which emerges from these interviews is of a woman who is highly creative, talented and resourceful. There is a respect for the strength of these individuals that characterizes the responses of participants as they talk about the crises that arise during therapy. Rather than assume crisis necessitates hospitalization, all participants describe interventions designed to help the client focus on the resources that got her through the original trauma. This orientation, which empowers rather than pathologizes clients, seems critical to the willingness of these therapists to do this work outside a hospital setting.

Value for the MPD clients with whom they work is also reflected in the participants' shared emphasis on creativity. Demanding creativity of themselves, they all employ a variety of techniques designed to elicit creative expression of trauma. Focusing the creative abilities of their clients is an important aspect of each participant's therapy with MPD which, as described in these interviews, often circumvents a debilitating crisis. Thus a key component of crisis management is prevention.

An interesting component of therapy emerged in the discussion around groups. All participants facilitate groups with MPD clients, though one participant describes the population of her groups as mixed. The collegial support of other survivors is cited as one of the most helpful and therapeutic interventions in times of crisis. The image of group members "huddling around" a woman in crisis, keeping her safe by offering a level of empathy only possible from shared experience is powerful. It suggests that these clients are not only

capable of surviving their personal crises but of assuming an active healing role in the crises of others.

Perhaps the most interesting picture to emerge from this focus on crisis management is the unanimous support for a safe house. The details that emerge in the description of this proposed facility reflect the themes that seem important to these therapists: it would be a place that unites the talents of an eclectic team, with an emphasis on creativity and developing whatever interventions work for the individual client. There would be a component of medical staff trained in MPD and sexual abuse, and it would be a place of respite designed to keep clients connected to their communities and lives outside of therapy.

The emerging reality seems to be that hospitalization can exist as an option on the periphery of therapy with MPD; however, with a safe house only a shared fantasy, it is a necessary last resort in times of crisis where other interventions fail to mitigate the potential for self-harm or harm to others.

Communication with Alters

All participants talk about an evolution in their process of communicating with the internal systems of their MPD clients. They report more direct contact with individual alters in their early years of working with Multiple Personality Disorder. Their belief that it was important to establish communication with as many alters as possible resulted in more switching in sessions than currently occurs. Each stresses a change in her approach characterized by teaching the client to do most of her work internally. This is best described in the participants' own words.

> 031: I try to get an intellectual overview of all the parts. From there, if I'm moving more into hearing things from the parts, I usually always begin by having the parts talk to the survivor and the survivor talks to me. The idea for most, of this part talking directly to me, is terrifying.

I'm constantly trying to encourage the team work. I want to hear from individuals from the team, but I also do not want to create such separateness in this office that I have a whole bunch of independents functioning separately. So I've found in private practice, for my own needs, that to keep them together operating through whoever - and it might not always be the same person who's appearing in my office every day, but whoever is in charge of the body today - that person is going to do the talking to me and the talking to the others. And they are all welcome to take that spot whenever they care to.

N38: What we used to do a lot of was saying, "I'd like to talk to Blah blah blah." And Blah blah blah would come out and then you'd - you see, you were always talking to two different parts of the self. And you didn't do an awful lot of work trying to train the inside system to talk to each other so that the client was doing more... so that the focus I prefer now, is teaching the client basically how to do her own therapy. So I am the outside helper. You have inside helpers and we all need to work together. Part of my job then is helping the inside people learn how to work together and to do their own therapy with me almost moving over time into a consulting position. I think that's much better for the client in that she will have more of a sense of control over her own therapy, over her own process. You're doing all these things which include internal dialogue - helping the parts of the self sort things out - primarily themself - without becoming overly reliant on me.

K315: Who really was it for? Calling forth alters all the time - was it really for the client's benefit? Or was it because this was sort of a neat and fancy thing to do way back when, when people first realized they could do this? ... maybe it's just as beneficial to direct the person inside to deal with their various parts, rather than calling those various parts outside.

> I guess because I do, on some level, buy into the belief that work should happen inside. And so, in theory, if maybe you had a presenting personality and maybe two or three other parts, to make it real simple ... and then there were, maybe, I don't know - a bunch more, or a few more - that you could work with the presenting personalities, sending them in, and perhaps work with one or two of the other alters - sending them in to work with the other little groups inside. Why pull things apart more than they need to be pulled apart if the work can happen inside?

No one interviewed has worked exclusively with one personality. All describe the experience of having alters "pop out" spontaneously and of having certain parts circumvent the presenting personality to share a piece of information with the therapist. When one participant (N38) was asked whether she thought it possible to work entirely in an indirect manner, she responded:

> That's a possibility. I think what tends to happen is that parts will pop out, but not necessarily. So I think that can work. I've never worked entirely the way you've just described. There's always been a certain amount of interaction between me and the parts of the self. But it's quite possible.

As none of the participants have this experience, it remains an interesting hypothesis.

The reasons expressed for a shift to internal work include building on the client's sense of control and addressing the fear that the presenting personality will disappear if others take over.

> 031: So they do the contact and that helps to relieve some of the fear that they have that they will disappear, vanish, that another part of them is going to come out and take over, and that the person that they have known will never be seen again. That's a tremendous fear for multiples in my experience - that they will disappear and never be seen again. And so, if they can do the communicating, it helps to relieve that fear. So

> they're talking to the parts of them on the inside, and then slowly putting together the mapping of their system.
> N38: I can't remember how much we emphasized in that first (interview) about that kind of indirect approach to talk - to contacting and negotiating with other parts of the self. And my thought was that if that wasn't emphasized enough ... that that might be a point to emphasize a bit more. That's a very - just in terms of safety - one piece, but more important than that - of helping the client be very much in control of her own therapy, so that the direction - in some ways teaching the client, then, to do her own therapy rather than you or I asking constantly to talk to different parts of the self - teaching her how to talk to different parts of the self.

Further details about this shared shift in communication include an expectation that all parts will participate, even if indirectly, by listening and observing. All participants acknowledge the presence and importance of all alters as part of their therapeutic approach, and encourage their participation in therapy through letter writing, journals and a process of directing comments and questions through the presenting personality. There is a stated expectation by all therapists that the presenting personality may change, but the goal appears to be to maintain as much stability as possible. In group work two participants explain their expectation, shared with clients, that only one personality will be present and that that needs to be an adult. As in individual therapy, all parts of the system are invited to observe. In reporting their success with this, both report having observed some switching, but always a shift that is subtle and unnoticed by most group members. The third participant describes similar experience in her group work with several abuse survivors; there may be some switching by members who are multiple, but it is consistently unobtrusive. No one reported incidents of florid symptomatology.

One participant (031) emphasizes more than others a need to sometimes make direct contact with particular alters. She describes this as necessary particularly when someone is suicidal.

> There's a couple of places that I usually interrupt - intrude into the system, and that is, I might talk about suicide ... and so I will talk about suicidal behaviour and I'll talk about suicide plans and I will ask, in general, and I won't go through the survivor then, if there's anybody there who's suicidal...

When it is necessary to speak to individual alters, all report it happens easily. Either an alter who needs to be present spontaneously appears, or, as the therapist becomes familiar with the system, she simply asks for an alter by name. In two interviews participants mention alters appearing spontaneously to offer information they believe important for therapy while the client remains amnesic for this exchange. Both respond similarly by keeping this information for their own reference but not passing it on to the client, trusting that her own system will make her aware of the information when she is ready to hear it. One participant (N38) describes an incident where she and a client visited a church to facilitate the retrieval of a particular memory:

> Another part came out while we were in the church, and then we went outside the church and the part told me what had happened. And so I now know about it and we're almost back to the hospital before the client came back again. And she didn't remember any of it, and I didn't tell her. I made a decision based on, "she will remember it when she's ready to remember it." Now I know about it, which gives me some information to help me help her...

Another participant addresses a similar experience:

> Say you had someone and an alter came out and told you about such and such. Right? So then the alter goes back in. The person's sitting there and they don't remember what happened. I don't think, generally speaking, if that person had told you a

> memory that was something pretty difficult and hard and horrific, to say "oh yeah, so-and-so just told me this. Here's some information for you. Here's a memory"... I don't think that that's a good idea. I think that when that part is ready to tell, and the other part is ready to hear, on some level that will happen.

This common decision again reflects a basic philosophy evident throughout these interviews, that therapy with MPD clients must progress at their pace. Interestingly, one participant (N38) who initially stated that an indirect approach would, of course, slow down the process of therapy, later, in a second interview, changed her position.

> You know, having listened to you feed that back to me, I'm now questioning what I said. Cause I don't know if that's a slower process. What about if - and you know I don't have any firm data on this, because the people I'm working with using this more indirect approach are in the middle of therapy. And we don't know how long that's going to last, huh? But what about if by using this indirect approach it may be slower at the beginning, as you have to do all this teaching, and it might take longer to figure out the internal system - but what about if at some point in the whole therapeutic process, it speeds up because the client is more in charge ... It may be slower at the beginning. But you may then be able to move at a much quicker pace in sort of middle, ending phases of therapy.

Discussion

As stated in the literature, all participants believe it is necessary to identify and understand the individual parts of a client's dissociated internal system. What is interesting, and perhaps different from common assumptions about how to achieve this, is that these therapists advocate an approach that minimizes therapist contact with that internal world. Certainly it has been suggested by other professionals in this area (Caul, 1985; Chu, 1986) that therapist

fascination with the switching process of MPD clients may impede therapy. At least one participant reflects this caution by questioning the motivation of past interventions which encouraged frequent switching. While it is obviously important that the therapist becomes informed about the dissociative process of individual clients, this approach suggests it is most important that the client achieve this knowledge. It respects that the client who created this system is capable of manipulating it to establish internal communication and break down the amnesic barriers. It encourages independence from the therapeutic relationship. Instead of a chain of communication based on therapist contacting alter - alter sharing information with therapist - therapist educating client, the communication occurs through the client. She, and not the therapist, becomes the central link.

One participant makes the connection between her shift to an indirect method of communication and her private practice setting. This connection is made by all participants when focusing on safety in sessions. It is introduced here as a rationale for encouraging internal work; if the setting is not equipped to handle the potentially disruptive behaviours that may accompany a parade of separate alters, then inviting alters to be present as listeners and observers makes sense. The utility of this approach is evident in the fact that these therapists are working with significant numbers of MPD clients in settings that impose some limits on noise and behaviour.

The experiences of these therapists with indirect communication again raise questions about the role of abreactions in MPD work. If information can be shared internally with the host personality receiving memories at a pace she can control, perhaps the experience of individual parts being out to re-enact the abuse is not as essential as suggested in the literature.

This approach seems to prioritize safety and control over all else - a focus that seems appropriate considering how severely these experiences have been compromised in the client's life. The

importance of this priority is reflected in the words of one participant (N38):

> For people who are diagnosed as MPD... you know there's an abuse history, and you know that this person is highly dissociative. The abuse has taught that I have no control over my life, over what happens to me. So the more in therapy you can build a sense of "I am in charge here. I'm looking after this," the better it is for the client. So that's just a major piece of the human process - to feel in charge of my own life. So the more you can build that in in the therapy relationship, the better.

Safety in Sessions

All participants have worked with MPD clients where angry, threatening alters have been a part of the internal system. All admitted some unpredictability around violence in sessions, yet none reported being attacked or having her office seriously damaged. No one interviewed questions the feasibility of doing this work outside of a hospital in the absence of a safe room or means of restraint. A shared perspective is that clients have a great deal of control and can be held responsible for ensuring their own and the therapist's safety. From this belief each therapist interviewed stressed the importance of clear boundaries and rules.

> 031: As soon as I'm aware that there might be a part that is dangerous to the person and others - I'm talking about some of the rules I have around dangerous behaviour. So, one thing that I want everybody to be very clear on is that neither myself, nor anything in the office must be damaged. And that I have some very firm rules on that, and that we will stop the session if this person damages anything in the office. and that, if that behaviour escalates, I will call the police - that I will not bargain about that - that that's going to be the rules - that no

one in here can be dangerous, and that would include danger to the others as well.

N38: I think there's an element of risk - always. I think that's true. But I think there's ways to handle it. I think, and part of this comes out of a belief system, people - the people with whom we work - people who are diagnosed as MPD - have a lot more control then they think they have. After all... everybody manages a life, huh? Like they're not switching left, right and centre. So maybe when that kind of thing gets out of control - maybe it's because we as therapists have not provided the structure that they need. Maybe in one way or another we've given messages that it's okay for you to do this - this is part of your therapy. When it's not okay for you to do it. It's not therapeutic, and we have to find another way for you to do your work. But, we will not have violence.

K315: It's pretty interesting and certainly there's no proof of it, but certainly there's some indications that it may be true that the client will adapt to the environment and what the environment allows...

(interviewer) So what you're saying is there may be some kind of interplay between what gets acted out and boundaries and rules.

K315: Exactly...

(interviewer) Do you have any thoughts about the specific rules or boundaries that would be important in doing this work?

K315: Well, there would be things around violence and volume and things of that nature, i.e. trashing my office is not appropriate; i.e. trashing yourself here is not appropriate. I guess basically you'd have to say any form of violence wouldn't be allowed or we can't continue treatment ... I mean I can put up with a lot, but I can't put up with feeling threatened or the environment threatened.

One of the interesting questions in this research for the participants who worked with clients in a hospital, using safe rooms and restraints, is whether past violent episodes could have been avoided. At the time both saw no alternative, but in the process of being interviewed, each focused on the absence of that kind of violence in their work outside of the hospital. Both are certain it is not because there have been no malevolent alters present in the client's system. One participant describes a single violent incident in her private practice setting which, she believes, was not repeated because of her very different response:

> One of my clients came in, switched to another part of herself spontaneously, and kicked over my little coffee table ... and, you know, the statement from her was, "I didn't do it. The other one did it." So, you know, I can't give you word for word how this went, but the bottom line was, "it doesn't matter who did it. This happened here and this is a private practice setting. We don't have the structure ... to handle violence here. There's people in the next room. That was very upsetting for them, and if this is going to happen, maybe we can't work together here ..." It's never happened again ... I can remember saying to people when something like that would happen, "don't worry about it. It's all right. It's all been looked after. Nothing really bad happened." I mean, in saying that, now I'm wondering if that was just giving permission for it to keep happening.

The second participant wonders what a different response from her may have elicited in a client who was particularly loud in another setting.

> Again, if the first person that I was discussing, who was quite noisy before ... If I had made it real clear to her that that's not appropriate, and that can't happen in here, we would have seen what would have happened. I don't know what the answer to that would have been. But I think, you know, that there is a reasonable success rate in doing contracting, and that the

different parts do have some control, and sometimes more control than sometimes the knowledge that they have.

Another factor in maintaining safety is described as "separating" -- helping the client and all the parts who are observing distinguish between things that are simply triggers in the present and real past dangers. This is work that recognizes the protective function of seemingly malevolent alters. One participant (031) explains that it is the role of a particularly menacing alter to keep potential abusers away. In her work she first acknowledges that role and then helps that alter, through her client, separate real threats from the perceived threats that may surface in sessions.

> So I first acknowledge that part for protecting all this time. But then talk about, it is time for some discernment, for some discrimination, and that it's not okay to be attacking of everyone, because not everyone is a danger ... And so I build up trust with the part with whom I'm doing the majority of the work, that part would say, "well Sam says you're dangerous." And then we'll start talking about why that is - what made Sam say that right now. "Well, Sam said they saw a pen. They see a pen and pens are used to hurt. And so since you put that pen over there today, that's a signal that you're going to hurt us." So we're sorting through that kind of thing. Well, my pen being over there does not mean I'm going to hurt you - that I do not - unlike the offender who, by the sounds of things, used a pen to abuse you - I do not use pens to abuse people... So we sort out those kinds of things in order to work at separation work, which is separating offenders from non-offenders.

All participants emphasize again, when discussing safety in sessions, the importance of introducing creative outlets and proceeding at the client's pace rather than forcing the system. No one screens clients for the potential of violence from an angry alter because, as two participants acknowledge, it is not possible to know

what's there at the beginning of therapy. But all have the experience of working safely with MPD clients in alternative treatment settings.

Discussion

The key components of these therapists' efforts to maintain safety in sessions are not only evidence that it is possible in their work to protect against violence, but also suggest the possibility that violence in other settings is avoidable. It is an interesting hypothesis that the client will adapt to the environment and what she perceives as permissible, and it raises questions about why any therapist would allow with an MPD client what would be cause for instant termination with another. It is, at best, a debatable perception that therapy which creates room for violent expression is ultimately helpful to the client. According to these therapists, in extending our boundaries, we further compromise the welfare of clients. One participant (N38) speaks to this in her interview:

> These people have lived with violence. They know all about violence, and nobody put any boundaries around that for them. So, as a therapist, it's our therapeutic, ethical responsibility to put the boundaries around.

There is a distinction made by all participants between anger and violence -- a distinction that is always muddied by abuse and cannot be compromised in therapy. Not one participant intimated that her clients should not have threatening alters or that they should not express anger in sessions. The bottom line for all seems to be that anger is expressed in non-violent ways and that, through therapy, it becomes focused on the events which compromised the client's safety.

No one denies the element of risk in therapy with MPD clients, but all participants establish clear parameters for this work and report success in working within these. A consistent feeling for all participants seems to be that their work is modified to the needs of their environment, but does not compromise the needs of clients.

The Management of Somatic Symptoms

This focus in the interview process was designed to elicit information about participants' interventions, other than medications, in assisting clients with the symptoms of anxiety, depression and sleeplessness. There was no definition to this category throughout the interviews, primarily because all discussion relating to alternative interventions occurred in the exploration of other areas. It also was clearly established by all participants that short-term, anti-anxiety and anti-depressant medications are appropriate interventions, and all have found these a helpful adjunct to therapy when these symptoms persist.

There is no new data for this category and, in retrospect, it is redundant in view of lengthy discussions on experience with medications and crisis interventions.

The Interview Process

All interviews were conducted in the participants' settings. While the interview guide provided direction and was consistently used as a reference for discussion, each participant spoke freely and fluently of her therapeutic experience with Multiple Personality Disorder. In their post-interview comment sheets, these therapists described this experience as an opportunity for reflection and consideration of new directions. All described their participation in this research as a valuable experience.

For the researcher it was a powerful experience -- a window into the day-to-day practice of therapists working with MPD. As a colleague, this process provided affirmation and challenge.

For all, researcher and participants, this mutual effort was a consolidation of years of experience and study. These interviews were conducted in a spirit of respect for past efforts as well as current practice.

Conclusions

This study was developed to gather information about the feasibility of providing therapy to MPD clients outside a medical setting. These interviews with therapists who are working with MPD in alternative environments suggest it is not only feasible, but that an approach developed to accommodate the absence of a secure setting may enhance therapy. In response to their environments, all participants have modified aspects of therapy with MPD clients. The commonalties across interviews of these modifications add strength to their viability.

All participants stress the importance of an eclectic, creative approach which introduces a variety of techniques designed to facilitate non-violent expression of highly charged emotional content. Their interactions with clients are not based on the traditional model of psychoanalytic psychotherapy. They each describe sessions that have clients drawing, painting, sculpting, pasting together collages -- doing whatever is necessary to create an image for internal pain. They encourage these activities outside of sessions as well, along with other techniques such as journalling. Designed, in part, in response to settings which restrict certain behaviours, these interventions have become an integral part of each participant's belief about what is important in therapy with MPD. All talk about the highly developed creative abilities of their MPD clients and have experienced a need for individualized, creative interventions. Optimally, as described by those interviewed, therapy with MPD clients would consist of a team approach, the membership of this team matching the individual needs of clients. This would not be the team approach of hospital psychiatric units, but an inter-disciplinary approach drawing on the talents and expertise of professionals from a variety of orientations.

Another modification is the move away from calling forth alters in sessions, to encouraging the client to do the majority of work internally. Again, this is a shift initiated, in part, in response to the

issue of safety. However, it is clear that these participants share a philosophical belief that this approach is more therapeutic. It is an approach that encourages integration and enhances the client's experience of control. She, and not the therapist, is appropriately in control of her internal system and the process of memory retrieval. With alters present in therapy as observers, communicating through the client, the host personality is encouraged to remain present -- an ability important to her survival outside of therapy. The success of this approach, described by each of these participants, challenges the need for dramatic interactions between the therapist and alter personalities and suggests that this work may proceed with safety and stability.

The imposition of clear boundaries and rules seems to have been sufficient to prevent violence in the practices of these participants. It is interesting to notice that, when violence was expected and protection in place, clients responded violently. When violence was prohibited and the only protection was trust in the client's ability to maintain control, clients were not violent. This suggests that violence need not be a part of MPD therapy.

The interplay of three components in these participants' approach -- (a) creative, non-violent expression of emotional experiences, (b) indirect communication which discourages overt switching, and (c) clearly stated prohibitions on violent behaviour -- have changed the dynamics of therapy for these participants and their clients. There were questions raised for participants during the interview about previously held assumptions. Though they each had occasion to use safe rooms and restraints with MPD clients, and had all experienced florid presentations, they are not now certain that these experiences are to be expected in this work.

Two proposals for treatment with MPD that arose unexpectedly in this research are the use of group therapy and the expressed need for a safe house. These therapists are unanimous in their recommendation for both. Groups are seen as an important adjunct to

individual therapy, with their main benefit's being contact with other survivors. This helps to mitigate the stigma of victimization and dissociation and introduces a support that is invaluable in times of crisis. Contrary to some arguments that MPD clients lack the stability to participate successfully in groups, all of these participants report positive experiences in group work with MPD clients.

The proposal for a safe house acknowledges that secure settings are sometimes necessary in this therapy. It also acknowledges that traditional psychiatric units are not "safe" for MPD clients, particularly when these units are staffed with professionals lacking in either belief or training in MPD. When these participants described their experience with hospital admissions it was clear that their hope was that their clients would receive no treatment. This was the best scenario, as expected treatment would include the prescription of anti-psychotic drugs or electric shock therapy. In contrast, when these participants described their vision of a safe house, it was with the expectation of treatment provided within that facility. This reality suggests the need for a review of funded health care services. If the only subsidized treatment available to survivors of severe trauma is a hospital-based system that responds with skepticism to the impact of that trauma, then it seems clear that either that system needs intervention or an alternative must be created.

Recommendations for Further Research

This investigation is the only study known to the researcher that focuses on the specific interventions used by therapists working outside the traditional medical model with Multiple Personality Disorder. The experience of participants in this study is significant and invites similar research which allows for the clinical views of non-psychiatric care-givers.

Certain observations in this study also suggest further research. The profile of hospital systems that emerges from these interviews is counter-therapeutic to the needs of MPD clients. It suggests the need for a review of this system. A series of interviews that focus on attitudes and beliefs around MPD, conducted with psychiatrists and other health care workers in hospital psychiatric units across Canada, would add to this picture.

A second observation is that clients, like therapists, adapt to their environment and what it allows. This is an interesting premise that merits further investigation, for it calls for a re-examination by therapists of their expectations of the therapeutic relationship. It is recommended that a study be designed to interview therapists who have clinical experience with MPD clients in both hospital and out-patient settings to assess the incidence of violence in both environments.

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Appendix A

Dissociative Disorders(or Hysterical Neuroses, Dissociative Type)

The essential feature of these disorders is a disturbance or alternation in the normally integrative functions of identity, memory, or consciousness. The disturbance or alteration may be sudden or gradual, and transient or chronic. If it occurs primarily in identity, the person's customary identity is temporarily forgotten, and a new identity may be assumed or imposed (as in Multiple Personality Disorder), or the customary feeling of one's own reality is lost and is replaced by a feeling of unreality (as in Depersonalization Disorder). If the disturbance occurs primarily in memory, important personal events cannot be recalled (as in Psychogenic Amnesia and Psychogenic Fugue).

Depersonalization Disorder has been included in the Dissociative Disorders because the feeling of one's own reality, an important component of identity, is lost. Some, however, question this inclusion because disturbance in memory is absent.

Although Sleepwalking Disorder has the essential feature of a Dissociative Disorder, it is classified as a Sleep Disorder.

300.14 Multiple Personality Disorder

The essential feature of this disorder is the existence within the person of two or more distinct personalities or personality states. Personality is here defined as 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 important social and personal contexts. Personality states differ only in that the pattern is not exhibited in as wide a range of contexts. In classic cases, there are at least two fully developed personalities; in other cases, there may be only one distinct personality and one or more personality states. In classic cases, the personalities and personality states each have unique memories, behavior patterns, and social relationships; in other cases, there may be varying degrees of sharing of memories and commonalties in behavior or social relationships. In children and adolescents, classic cases with two or more fully developed

personalities are not as common as they are in adults. In adults, the number of personalities or personality states in any one case varies from two to over one hundred, with occasional cases of extreme complexity. Approximately half of recently reported cases have ten personalities or fewer, and half have over ten. (In the text below, both personality and personality states will be subsumed under the term *personality*.)

At least two of the personalities, at some time and recurrently, take full control of the person's behavior. The transition from one personality to another is usually sudden (within seconds to minutes), but, rarely, may be gradual (over hours or days). The transition is often triggered by psychosocial stress or idiosyncratically meaningful social or environmental cues. Transitions may also occur when there are conflicts among the personalities or in connection with a plan they have agreed upon. A transition may also be elicited by hypnosis or an amobarbital interview.

Often personalities are aware of some or all of the others to varying degrees, and some may experience the others as friends, companions, or adversaries. Some personalities may be aware of the existence of other personalities, but not have any direct interaction with them. Some may be unaware of the existence of the others. At any given moment, only one personality interacts with the external environment, and none or any number of the other personalities may actively perceive (i.e. "listen in on") or influence all or part of what is going on. The personality that presents itself for treatment often has little or no knowledge of the existence of the other personalities.

Most of the personalities are aware of lost periods of time or distortions in their experience of time. For example, the person may be aware of periods of amnesia or periods of confusion about his or her experience of time. Some admit to these experiences if asked, but few volunteer such information because they fear being called liars of being considered "crazy." Others are unaware of their amnestic experiences, confabulate memories that cover the amnestic periods, or have access to the memories of the other personalities, which they report as if they were their own.

The individual personalities may be quite discrepant in attitude, behavior, and self-image, and may even represent opposites. But they may also differ only in alternating approaches to a major problem area. For example, a quiet, retiring spinster may alternate with a flamboyant, promiscuous, bar habituee; or a person may have one personality that responds to aggression with childlike fright and flight, another that responds with masochistic submission, and yet another that responds with counterattack. At different periods in the person's life, any of the different personalities may very in the proportion of time that they control the person's behavior.

Associated features. One or more of the personalities may function with a reasonable degree of adaptation (e.g., be gainfully employed) while alternating with another personality that is clearly dysfunctional or appears to have a specific mental disorder. Studies have demonstrated that various personalities in the same person may have different physiologic characteristics and different responses to psychological tests. Different personalities may, for example, have different eyeglass prescriptions, different responses to the same medication, and different IQs. One or more of the personalities may report being of the opposite sex, of a different race or age, or from a different family that the other personalities. Each personality displays behaviors characteristic of its sense of its stated age.

One or more of the personalities may be aware of hearing or having heard the voice(s) of one or more of the other personalities, or may report having talked with or engaged in activities with one or more of the other personalities. These internal conversations and the belief that one has engaged in activities with another personality when the latter is actually a dissociated aspect of the person must be differentiated from other forms of hallucinatory and delusional experiences.

The personalities often exist in groups of two or more, all of whom represent the same period of life (e.g., adolescence). When this occurs, one or more may have the role of protector of another member or members of the group.

Most often the personalities have proper names, usually different from the first name, and sometimes different from both the first and last names, of the individual. Often the names have symbolic meaning, for example, "Melody" as the name of a personality that expresses itself through music. Occasionally, one (or more) of the personalities is unnamed, or is given the name of its function, for example, "the Protector."

Frequently, one or more of the personalities exhibits symptoms suggesting a coexisting mental disorder, for example, changes of mood suggesting a Mood Disorder, complaints of anxiety suggesting an Anxiety Disorder, or marked disturbance in personality functioning suggesting Borderline Personality Disorder. It is often unclear whether these represent coexisting disorders or merely associated features of Multiple Personality Disorder.

Age at onset. Onset of Multiple Personality Disorder is almost invariably in child-hood, but most cases do not come to clinical attention until much later.

Course. The disorder tends to be chronic, although over time the frequency of switching between the personalities often decreases.

Impairment. The degree of impairment varies from mild to severe, depending primarily on the nature of, and relationships among, the personalities and only secondarily on their number.

Complications. Suicide attempts, self-mutilation, externally directed violence (including child abuse, assault, or rape), and Psychoactive Substance Dependence Disorders are possible complications of this disorder.

Predisposing factors. Several studies indicate that in nearly all cases, the disorder has been preceded by abuse (often sexual) or another form of severe emotional trauma in childhood.

Prevalence. Recent reports suggest that this disorder is not nearly so rare as it has commonly been thought to be.

Sex ratio. In several studies of psychiatric patients, the disorder has been diagnosed from three to nine times more frequently in females than in males.

Familiar pattern. Several studies have demonstrated that the disorder is more common in first-degree biologic relatives of people with the disorder than in the general population.

Differential diagnosis. Psychogenic Fugue and Psychogenic Amnesia may be confused with Multiple Personality Disorder, but do not have its characteristic repeated shifts in identity, and usually are limited to a single, brief episode.

Psychotic disorders may be confused with Multiple Personality Disorder because the person reports being controlled or influenced by others, or hearing or talking with voices (of other personalities). These symptoms may be interpreted by the clinician as the delusions or hallucinations of **Schizophrenia** or of a **Mood Disorder with Psychotic Features.**

The **belief that one is possessed** by another person, spirit, or entity may occur as a symptom of Multiple Personality Disorder. In such cases the complaint of being "possessed" is actually the experience of the alternate personality's influence on the person's behavior and mood. However, the feeling that one is "possessed" may also be a delusion in a psychotic disorder, such as Schizophrenia, not a symptom of a Dissociative Disorder.

Borderline Personality Disorder may coexist with Multiple Personality Disorder. However, often the person with Multiple Personality Disorder is incorrectly diagnosed as having only Borderline Personality Disorder because the alternation of the personalities is mistakenly thought to be the instability of mood, self-image, and interpersonal behavior that characterizes Borderline Personality Disorder. Similarly, **other mental**

disorders may coexist with or obscure the presence of Multiple Personality Disorder.

Malingering can present a difficult diagnostic dilemma, which often can be resolved only by obtaining additional data from ancillary sources, such as hospital and police records and family members, employers, and friends.

Diagnostic criteria for 300.14 Multiple Personality Disorder

A. The existence within the person of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these personalities or personality states recurrently take full control of the person's behavior.

Appendix B

Interview Guide

Section A: Demographics

1. What is your current position?
2. Could you describe your academic and professional training and your clinical experience?
3. Have you had training or supervision particular to MPD?
4. With how may MPD clients have you worked?
5. What is the gender ratio of the MPD clients with whom you have worked?
6. Over what time period have you been involved in the treatment of MPD?

Section B: Experience with hospital admissions, hypnosis, safe rooms and restraints, and drugs in the treatment of MPD

7. In your work with MPD clients, what experience have you had with:
   a) hospital admissions
   b) the use of safe rooms and restraints
   c) the use of hypnosis
   d) the use of psychotropic drugs
8. What, if any, factors in the treatment of any MPD client prohibited or discouraged any of the above interventions?

Section C: Experience with alternative interventions in the treatment of MPD

9. Other than through those interventions we have discussed, how have you addressed the following treatment areas:
    a) the management of acute crises
    b) communication with and within the internal system of alter personalities
    c) safety for the client and others when working with a malevolent alter
    d) the management of somatic symptoms

10. What, if any, non-medical supports or treatment methods not already described would you recommend in the treatment of MPD?

Appendix C

Introductory Letter

Dear

I am a counsellor in private practice and a masters student in Educational Psychology at the University of Manitoba. In fulfillment of my thesis requirement, I am conducting research on treatment methods with multiple personality disorder. Specifically, I am interested in gathering information on treatment approaches from the personal experiences of non-psychiatric caregivers. I will be conducting two 60 to 90 minute interviews with five to six therapists and social workers. These interviews will focus exclusively on treatment interventions. No client information will be solicited or included in this study. Those interviewed are guaranteed anonymity and responses will be coded before inclusion in the study. Anyone who expresses interest in a summary of results will be provided with a copy. Participation is by choice and any participant may withdraw from the interview at any time.

I appreciate your consideration of participation in this study and will be contacting you to arrange an interview time and location. Should you have any questions, please contact me at the above number.

Sincerely,

Judy Hill

Appendix D

Release Form

Dear

The interviews conducted in this study require tape recording and will be transcribed. The confidentiality of every participant is ensured. All transcripts of recorded interviews will be coded and will include no identifying information. Only transcripts will be reviewed by anyone other than the researcher. All tapes will be destroyed upon completion of the data analysis.

This form requests your permission to tape record the interview in which you will participate. If for any reason you wish to terminate the interview, you are free to do so at any time.

Thank you for your cooperation.

Sincerely,

Judy Hill

I consent to the tape recording of my interview.

Signed _____

Date _____

Appendix E

Post Interview Comment Sheet

Please share any feelings or comments about the interview process.

Do you have any observations on the focus of this study?