American Journal of Psychotherapy

Official Journal of the Association for the Advancement of Psychotherapy
Founded in 1939

Table of Contents

SPECIAL SECTION: DISSOCIATIVE DISORDERS

Richard P. Kluft, M.D., and Brad Foote, M.D.
(Guest Editors)

Dissociative Identity Disorder: Recent Developments

RICHARD P. KLUFT, M.D.*
BRAD FOOTE, M.D.**

In recent years Dissociative Identity Disorder (DID), formerly known as Multiple Personality Disorder (MPD), despite the controversy that surrounds virtually every aspect of the phenomenology, diagnosis, and treatment of this condition, has been diagnosed and treated with increasing frequency. Careful studies using reliable and valid screening measures and structured interviews have demonstrated that previously undiagnosed DID is a rather common disorder, occurring in between 3-6% of psychiatric inpatients and 5-18% of patients in substance-abuse treatment settings (studies summarized in Ross [1] and Kluft [2]). Although some have argued that DID is a North American culture-bound condition (3), the inpatient studies summarized above included cohorts from the United States, Canada, the Netherlands, Norway, and Turkey, and all demonstrated roughly comparable findings. Although cultural forces may have been prevalent in the North American cohorts, and, to a lesser extent, in the Netherlands patients, DID was not part of the popular or professional cultures of either Norway or Islamic Turkey. This offers a substantial challenge to the "culture-bound syndrome" and iatrogenesis hypotheses, because if DID were indeed culture-bound and determined by social psychological factors, and if the iatrogenic creation of DID symptoms were

*Clinical Professor of Psychiatry, Temple University School of Medicine; Faculty Member, Philadelphia Psychoanalytic Institute; Philadelphia, PA. *Mailing address:* 111 Presidential Boulevard, Suite 231, Bala Cynwyd, PA 19004,

'Clinical Assistant Professor of Psychiatry, the Albert Einstein College of Medicine of Yeshiva University, Bronx, NY; Director, Dissociative Disorders Clinic, Montefiore Medical Center, Bronx, NY. *Mailing address:* Klau-1 Outpatient Dept., Montefiore Medical Center, 111 East 210th Street, Bronx, NY 10467.

widespread, one would expect significantly more DID patients to be found in those nations in which it had become part of the professional and cultural idioms, and in which the clinicians were presumably more "adept" at inducing its features.

The public health and ethical implications of these findings are profound, suggesting that in the interests of pursuing other agendas, we and our colleagues in many nations are failing to recognize and provide appropriate treatment to a considerable number of patients, further traumatizing a population of patients that is already deeply injured. Indeed, notwithstanding the undeniable vicissitudes of autobiographical memory in the traumatized (and the nontraumatized), excellent data demonstrates that trauma can be documented in 95% of children and adolescents with DID and allied forms of Dissociative Disorder Not Otherwise Specified (4,5), and initial studies have demonstrated that many memories recovered in therapy by DID patients can be corroborated as time goes on (e.g., 6,7).

Recent advances in treatment, many discussed by Kluft (8) in this special section of the *American Journal of Psychotherapy,* have made the psychotherapy of DID a more circumspect enterprise than it was in the early 1980s. Older emphases on aggressive trauma work and a march toward integration have given way to models consistent with the contemporary stage-oriented treatment of trauma victims (1,9). The use of containment-oriented hypnotic strategies has made it more possible to mitigate the pain and disruption of treatment between sessions (10). The more thorough development of various stances toward treatment, the emergence of knowledge about how to conduct the supportive psychotherapy of DID, and the identification of subgroups of DID patients with different degrees of psychological strength and comorbid psychopathology, have made it possible to individualize treatment planning and to more carefully match each DID patient with an appropriate psychotherapy (1). Sadly, however, it often is not possible to provide a given DID patient with the treatment appropriate to the needs of that patient, an issue to which we will return.

After developing models of its own in relative isolation, the dissociative disorders field has been enriched by the building of bridges between dissociative disorders treatment paradigms and psychodynamic and cognitive-behavioral therapies, and the study of DID has the potential to enrich these fields in turn. Furthermore, the rise of increasingly sophisticated psychopharmacological approaches to victims of trauma has been helpful, as has been the rise of newer approaches, such as Eye-Movement Desensitization and Reprocessing (11),

The articles in this special section speak to a number of contemporary concerns. In his article, Brad Foote (12) addresses some of the difficulties encountered by clinicians in approaching the diagnosis of DID, observing that conceptualizing DID as a modern variant of hysteria clouds the perception of this complex and chronic dissociative disorder. He points out that superficial similarities between DID and hysteria overlook deeper structural considerations that in fact make them quite dissimilar from each other. From this perspective DID is a pseudo-hysteria. Foote points out how the DID patients' sense of interpersonal helplessness, and their anticipation of rejection or even mistreatment from others, plus the skepticism of the clinician, may trigger despair, panic, and impotent rage in these patients, who may then react with "hysterical" distress that further undermines their credibility. His study can be understood as a plea to engage each patient in depth rather than to form judgments on the basis of superficial "first glance" impressions, and as a challenge to the clinician to scrutinize him—or herself—for unsuspected confirmatory bias and motivated skepticism that may impede the objective assessment of the patient.

Ira Brenner (13), working within the vocabulary and models of the psychoanalytic mainstream, reviews his theoretical contributions and illustrates them in action in the case study of a difficult patient whose treatment brings to life many of the pressures and concerns that arise in the treatment of the DID patient. He introduces us to his view of dissociation as a complex defense, explores the hypothesis that DID can be understood as a lower-level character disorder, and describes the "dissociative self," a unique underlying psychic structure that generates alter personalities from disowned experiences, fantasies, and feelings. His clinical material demonstrates his approach to the development of a therapeutic alliance with the DID patient, and his stance toward work with alter personalities.

In his contribution, Richard P. Kluft (8) attempts to provide an overview of the treatment of DID as it is understood in the mainstream of the dissociative disorders field. So much polarized and highly affective controversy surrounds DID and its treatment that often the controversy itself arrests the attention of many mental health professionals. Relatively few clinicians outside of the dissociative disorders field itself are actually conversant with the contemporary treatment of DID. This paper discusses the stages of the treatment of DID and their characteristic tasks and goals; the spectrum of various stances toward the therapy and the strategies that stem from them; a number of specific issues in the treatment of DID and their pragmatic resolution; the heterogeneity of DID patients and its implications for matching patients with appropriate treatment; and ad-

dresses specific aspects of both definitive treatments that attempt to bring about integration, and of supportive psychotherapies.

One of these treatments is the so-called tactical integrationalist model, well illustrated in the work of Catherine Fine. Within this important and influential model, Fine has created perhaps the most definitive application to date of cognitive-behavioral therapeutic principles to the treatment of patients with dissociative disorders. Because of the unique challenges posed by these complex patients, Fine has had to re-apply some of these principles in highly creative ways. In her article (14), she provides a detailed review of the tactical integrationalist model as it is conceptualized and practiced in 1999. Fine describes a meticulous, phase-oriented approach, which includes a variety of technical interventions that are crucial to the successful treatment of these difficult patients. Central topics include: techniques for suppression and dilution of affect in a planful manner; pre- and post-integration phases of treatment; a range of approaches to maladaptive, trauma-based cognitions and behaviors; and the complexities involved in engaging the personalities or identities.

The final paper, by Dr. Shielagh Shusta (15), is a fascinating case study from the cognitive-behavioral perspective in which a man with apparent refractory obsessive-compulsive disorder was found to have an underlying DID. When his previously intractable symptoms were addressed in terms of the alters and issues that underlay them, they resolved with impressive rapidity. She argues that patients. who exhibit refractory obsessive-compulsive symptoms should be assessed for dissociative symptomatology. It would be fair to enlarge this recommendation to virtually all refractory patients. Since DID is a "psychopathology of hiddenness" (Gutheil in 16), it has long been a clinical axiom in the dissociative disorders field to consider DID when a patient thought to have another condition has received diligent and competent treatment, but has not improved adequately. Since DID patients are within the mental health care delivery system for an average of 6.8 years before their DID is actually diagnosed (17), it is more the rule than the exception for DID to underlie (or co-occur with) another apparent condition that is diagnosed and receives treatment before the DID is recognized, and for the condition that has been diagnosed not to improve rapidly or completely. Many of the dissociative disorders that are found at the root of refractory symptom pictures fall short of DID diagnostic criteria, and are better described as patients with dissociative disorder not otherwise specified with some of the features and structures of DID. Many patients suffer considerably because of these delays.

Notwithstanding recent advances, the last decade has borne witness to a painful irony in the dissociative disorders field. The mental health professions now have in their possession an unprecedented amount of knowledge about how to diagnose and treat patients with DID. However, the knowledge is not widely disseminated throughout the professional community, and there are profound impediments to its being utilized optimally in the service of patient care. These impediments include continued skepticism about the reality and genuineness of the disorder (which often results in the dismissive treatment of the modern literature on the dissociative disorders); a backlash against trauma treatment, especially in connection with the controversies that surround patients' memories of traumatic events (which guarantees that most treatments of DID will take place in an atmosphere in which those therapeutic efforts are challenged rather than supported); the managed care movement's general trend to discount the value and challenge the appropriateness of intensive forms of psychotherapy (which *a priori* discards the accumulated wisdom and therapeutic recommendations that have developed within the dissociative disorders field); the dominance in the mental health professions of paradigms that do not accord a place of importance to traumatic stress and the spectrum of disorders that may emerge as its sequelae (making DID an orphan condition, not routinely accorded a place of importance in the curricula of the mental health professions' educational endeavors); and the paucity of mental health research funds available to study DID (which has resulted in the field's difficulty in demonstrating the effectiveness and efficacy of its methodologies, and compromises its ability to defend itself against opinions voiced against its practices). Taken together, these forces have been deleterious to the well-being and treatment of patients with DID, and have compromised their access to appropriate care, in effect revictimizing a victim population.

It is humorous when comedian Rodney Dangerfield complains, "I don't get no respect." It is tragic when this becomes the plight of a group of suffering human beings. The reality of their pain and distress easily becomes overlooked, or can be treated dismissively. It is both urgent and timely to move the study of the dissociative disorders into the mainstream of the mental health professions' concerns and priorities. Although the treatment of DID patients can prove challenging and difficult for therapist and patient alike, this is a group of patients that can benefit tremendously from psychotherapy that specifically addresses their disorders. Many DID patients attain full and stable recoveries and lead productive and gratifying lives, many others can benefit considerably and achieve dramatic improvements short of complete relief and integration, and still others will profit

enormously from supportive efforts that palliate their distress and confu sion, and enhance their capacities to function and to cope.

The guest editors would like to take this opportunity to thank Dr. T Byram Karasu, Editor-in-Chief, and the *American Journal of Psychotherap* for giving us the opportunity to create this special section on dissociativ(disorders. The free exchange of up-to-date information about these disor ders, in an open dialogue, is ultimately the best remedy for the conflicts anc polarizations that continue to hold back urgently-needed treatment ad vances for these traumatized individuals. Over the last several years, th(*American Journal of Psychotherapy* has consistently aired contemporarl contributions to the dissociative literature, representing a wide variety o views. These editors, workers in the dissociative field, and all therapist: who are attempting to incorporate an awareness of posttraumatic issue! into their models of psychotherapy, can rightfully be grateful.

REFERENCES

1. Kluft RP (1999). Current issues in dissociative identity disorder. *Journal of Practical Psychiatry any Behavioral Health,* 5,3-19.
2. Ross CA (1997). *Dissociative identity disorder: Diagnosis, clinical features, and treatment of multipl, personality*. 2nd Ed. New York: Wiley.
3. Fahy TA (1988). The diagnosis of multiple personality disorder: A critical review. *British Journal* 0 *Psychiatry, 153,* 597-606.
4. Hornstein N and Putnam FW (1992). Clinical phenomenology of child and adolescent multiply personality disorder. *Journal of the Academy of Child and Adolescent Psychiatry, 31,* 1055-1077
5. Coons PM (1994). Confirmation of childhood abuse in child and adolescent cases of multiple personality disorder and dissociative disorder not otherwise specified. *Journal of Nervous an(Mental Disease, 182,* 461-464.
6. Kluft RP (1995). The confirmation and disconfirmation of memories of abuse in dissociajvt identity disorder patients: A naturalistic clinical study. *Dissociation, 8,* 253-258.
7. Kluft RP (1998). Reflections on the traumatic memories of dissociative identity disorder patients. Is S .Lynn and K. McConkey (Eds.), *Truth in memory* (pp. 304-322). New York: Guilford.
8. Kluft RP (1999). An overview of the psychotherapy of dissociative identity disorder. *America, Journal of Psychotherapy, 53,* pp. 289-319.
9. Herman JL (1992). Trauma and recovery. New York: Basic Books.
10. Kluft RP (1994). Applications of hypnotic interventions. *Hypnos, 21,* 205-223.
11. Shapiro F (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, am procedures.* New York: Guilford.
12. Foote B (1999). Dissociative identity disorder and pseudo-hysteria. *American Journal of Psycho therapy,* 53, pp. 320-343.
13. Brenner I (1999). Deconstructing DID. *American Journal of Psychotherapy, 53,* pp. 344-360.
14. Fine CG (1999). The tactical integration model for the treatment of dissociative identity disorder and allied dissociative disorders. *American Journal of Psychotherapy,* 53, pp. 361-376.
15. Shusta SR (1999). Successful treatment of refractory obsessive-compulsive disorder. *America, Journal of Psychotherapy, 53,* pp. 377-391.
16. Kluft RP (1985) The natural history of multiple personality disorder. In RP Kluft (Ed.), *Childhooc antecedents of multiple personality* (pp. 197-238). Washington, DC: American Psychiatric Press
17. Putnam FW, Guroff JJ, Silberman EK, et al (1986). The clinical phenomenology of multip1(personality disorder: A review of 200 recent cases. *Journal of Clinical Psychiatry, 47,* 285-293.

CASE STUDY

Successful Treatment of Refractory Obsessive-Compulsive Disorder

SHIELAGH R. SHUSTA, Ph .D .*

A case study is presented of a 40-year-old man with obsessive-compulsive disorder (OCD). He had been treated with long-term institutional placement, electroconvulsive therapy, exhaustive pharmacotherapy, and psychodynamic and cognitive-behavioral psychotherapy. Nothing had relieved his excessive hand washing and door checking. Records from previous treatment revealed a diagnosis of dissociative identity disorder (DID). This information led to reconceptualization of the OCD symptoms as manifestations of the patient's ego fragmentation. When his fragments were catalogued and addressed, all overt OCD symptoms abated within weeks. It is believed that the patient's most anxious ego fragment communicated dread from the background of the patient's psyche, the executive component only being aware of the anxiety and not the triggering stimulus. The patient was taught to address this fragment verbally to elicit its cooperation, whereupon the fragment stopped sounding alarm, creating anxiety and driving the patient to check and recheck, wash and rewash. Symptoms have returned only when the patient has suspended his announcing behavior and have abated when this was resumed. Connections between OCD *and DID are addressed. Conclusion: patients exhibiting refractory OCD symptoms should be assessed for dissociative symptomatology.*

INTRODUCTION

The thoughts and behaviors characteristic of obsessive-compulsive disorder (OCD) can be extremely difficult to eradicate. Obsessions are defined as recurrent and persistent distressing thoughts, impulses or images, not due to real-life worries alone, that cannot be suppressed or ignored by these patients and that are perceived by them as originating from within their own minds. Compulsions are defined as repetitive behaviors or mental acts

*Clinical Assistant Professor of Psychiatry, Mt. Sinai School of Medicine; Senior Staff Psychologist, Mt. Sinai Services at Queens Hospital Center/Neighborhood Help Center. *Mailing address:* 114-02 Guy R. Brewer Blvd, Suite 218, Jamaica, NY 11434.

that the person feels driven to perform in response to an obsession or to comply with rigid rules. These behaviors are aimed at relieving or reducing distress. Typical compulsions are hand washing, counting or ordering of items, checking of door locks or stove knobs, repetitive rubbing, touching or blinking. Patients suffering from OCD can become so incapacitated by their obsessions and compulsions that by the time they finally seek treatment, they are close to despair.

Until effective psychotropic medications were developed, psychodynamic therapies alone were used with unpredictable results. Because the obsessive patient was seen psychodynamically as "rigid" by definition, clinicians found them quite resistant to treatment. For this reason, successful alleviation of obsessive-compulsive symptoms typically took years of intensive and often mutually frustrating treatment (1). Then, as they emerged, a variety of medications were tried, and the first to achieve widespread use and frequent success was the tricyclic antidepressant, clomipramine (Anafranil). Such medical interventions have enabled patients to better utilize psychotherapy and shorten the lag between starting treatment and beginning to experience some relief. There are side effects and potential caveats to the use of tricyclics (2), which prevented some OCD patients from being helped, however. Many newer medications have been introduced and tried, but none had the successes of clomipramine until the advent of the newer selective serotonin reuptake inhibitor antidepressants (SSRIs). All the various SSRIs have been studied in the treatment of OCD, and each has proven effective in many cases (2-4). Fluvoxamine (Luvox) was one of the first SSRIs studied, and it produced excellent results. Research has indicated that fluvoxamine is as effective as clomipramine and presents fewer side effects (5). Sertraline (Zoloft) has also been cited as working as well as or better than clomipramine (6). Fineberg (6) stated that OCD, long considered a refractory disorder, has in the last 15 years become rapidly and effectively treatable, thanks to clomipramine and the SSRIs. Psychotherapy has remained a viable treatment for OCD but has generally been seen in psychiatry as secondary to pharmacotherapy because the latter has been so dramatically and rapidly effective in many cases. In this era of managed care and insurance-mandated brief psychotherapies, most patients can no longer afford the luxury of lengthy, insight-oriented treatment without medication.

Unfortunately, many patients with OCD fail to respond to clomipramine or SSRI therapy. This phenomenon has led to various treatment approaches. Since the advent of effective psychotropic treatments for OCD, various permutations of psychotherapy and pharmacotherapy have

been used, some with considerable success. Combinations of medications have been administered to bring relief to patients still symptomatic after monopharmacotherapies—alone or with psychotherapy—failed to extinguish debilitating OCD symptoms. One of the most recent polypharmacotherapy approaches to evolve is the addition of the atypical antipsychotic medication risperidone (Risperdal) to a regimen already including one of the SSRIs or clomipramine (7,8). Risperidone blocks both dopamine and serotonin receptors, but it can have the paradoxical effect of exacerbating OCD symptomatology when used alone. Unlike the first novel antipsychotic, clozapine (Clozaril), risperidone does not require continual monitoring of blood levels over the course of treatment, hence its attractiveness as a possible adjunctive treatment. Although risperidone is contraindicated as a monotherapy, it has been surprisingly effective in treating those patients whose OCD has been refractory to both clomipramine and fluvoxamine or any of their related agents when it has been added. No pharmacological solution is without risk in the treatment of OCD, and polypharmacotherapy carries with it serious, potentially adverse effects (2).

The fact remains that some patients fail to respond to any of the aforementioned pharmacological approaches, and psychotherapy alone has proven insufficient treatment in many cases. The literature suggests that risperidone in combination with SSRIs works best with that subset of OCD patients troubled by horrific mental imagery and those with symptoms falling within the schizo-obsessive spectrum. This regimen has been found to work less well with OCD patients with comorbid tic disorders (7).

Various behavioral techniques have been suggested in the treatment of OCD, from aversion therapy to systematic desensitization. A recent review of the literature (9) indicates that OCD patients seem to respond best to a combination of clomipramine and either cognitive therapy or behavior therapy. DeRubeis and Crits-Christoph (9) cite studies using exposure and response-prevention treatments as well as confrontational treatment aimed at challenging a patient's irrational beliefs. Despite the impressive psychotherapeutic and pharmacological armamentaria available to OCD sufferers, some patients fail to achieve even minimal relief from their obsessions and compulsions. Symptoms in some patients prove quite resistant to treatment of any kind. Innovative approaches are indicated when attempting to treat refractory OCD successfully. At a community-based, satellite psychiatric clinic of a large New York City hospital, one such approach involved reconceptualizing a patient's symptoms within a larger framework, when all else had failed.

CASE STUDY: MR. M

Mr. M, a 40-year-old Caucasian patient, had suffered for most of his life with obsessive and compulsive symptomatology and was greatly distressed when he sought treatment. Mr. M's symptoms were typical of many OCD patients: compulsive checking of door locks and stove knobs, and compulsive hand washing. In addition to these troubling behaviors, he complained of "racing" in his mind, which seemed to be his way of describing his obsessive ruminations. Complicating this case were a host of physical diagnoses, including a seizure disorder, early-stage glaucoma, and hypertension. Previous treatment had included electroconvulsive therapy, use of most conceivable combinations of neuroleptic medications, and long-term inpatient hospitalization. Nothing had provided relief for his constant mental chaos and compulsive behaviors. His palms were red and thick with shiny calluses from continual hand washing. When Mr. M came into treatment with us, he had been off all psychiatric medications for about 30 days. He was a self-conscious, self-deprecating, and nervous man who said he had stopped his previous treatment because he felt the psychiatrist had been too forceful with him. Taking a careful history revealed that he had been raised in an orphanage and later adopted. He briefly stated that he had been abused in those early years, both physically and sexually, but he declined to elaborate. He said his mother blamed his seizure disorder on a head injury sustained in the orphanage, through abuse or neglect or both.

Mr. M began weekly psychotherapy, and the medications he reported having taken most recently were reinstated: risperidone and valproic acid. His first therapy issues were anxiety-based insomnia, a feeling of being conspicuously "different," anger with people who teased him for his oddness, and subsequent conflicts over this anger, and his fear of losing his elderly, infirm parents. Despite adjustments to his medication and ongoing supportive and cognitive-behavioral therapy, Mr. M still complained of compulsions and a racing and chaos in his head, saying: "You've got to help me with this." About six weeks after starting this course of treatment, Mr. M announced that youths had been tormenting him on the bus coming to session, and he could not return. He intended to return to a clinic he had once attended in the past. No efforts to convince him to continue in this treatment were successful. He left, and a few weeks later his new clinic confirmed that he had resumed treatment there.

A few weeks after he left treatment with us, clinical records from his previous treatment were received. These revealed that he had been treated with fluoxetine (Prozac), sertraline, and then fluvoxamine in combination with risperidone and valproic acid. They also listed his diagnoses over the course of several years of treatment as depression, bipolar affective disorder, obsessive–compulsive disorder, and dissociative identity disorder. Then about two months after leaving treatment, Mr. M called. He wanted to come back to the clinic after reporting an unsatisfactory encounter with a psychiatrist who, he said, had failed to understand him. Changes and additions to his medications had been made during his brief course of treatment elsewhere, including clonazep am, thioridazine, and paroxetine. Upon his return to us, all of these were continued, but eventually the risperidone was eliminated.

In exploring with him his goals and objectives for treatment, the issue of the former diagnosis of dissociative identity disorder (DID) was raised. He seemed unaware of this but not alarmed by it. Indeed, he was quite open and willing to discuss his dissociative experiences, even the more bizarre ones often concealed by such patients for fear of their appearing crazy. He often heard internal "voices" criticizing his actions, commenting on his thoughts, or arguing with him. He had memory loss so severe that he called his episodes "blackouts." Mr. M was able to admit that one reason he had left psychotherapy with us so abruptly, as he had done in treatment many times before, was that he felt that I was getting too close and might find out who he really was. I now began to establish his trust by presenting psychoeducational information to place his dissociative experiences within the context of his early abuse and neglect. An important part of treatment with any abuse survivor is an acknowledgement of the negative self-image provoked and perpetuated by the abuse, often with sadistic assistance from the perpetrator.

The connection between OCD and DID (then called multiple personality disorder) was first emphasized by Ross and Anderson (10) when they found a subgroup of OCD patients with prominent dissociative features. One previously diagnosed OCD patient was rediagnosed as having multiple personality disorder. They felt that all OCD patients should be screened for dissociative phenomenology. Goff et al. (11) followed the work of Ross and Anderson by administering structured interviews to 100 OCD patients. They found that the patients with the highest dissociation scores also had the most severe OCD symptoms. They also found that depersonalization was the most commonly reported dissociative symptom among the OCD patients, a finding that was not unexpected. They were surprised that amnestic experiences were also reported as fairly common experiences in their sample. They cautioned, however, against assuming that high scores meant the presence of dissociative disorders, and they

suggested that some symptoms of OCD may mimic dissociative phenomena. Nevertheless, they did recommend that clinicians routinely inquire about the possibility of dissociative symptoms in patients presenting with OCD.

To assess the degree to which he dissociated and hoping to rule out or confirm the diagnosis of DID given him earlier, I gave Mr. M the Dissociative Experiences Scale (DES) (12), This instrument is especially useful in uncovering therapeutically relevant subjective experience and should be considered whenever a patient speaks of subjective memory loss or lost portions of time, especially when co-existent with a history of childhood trauma, to screen for possible dissociative disturbances. Though not without controversy, the literature points to a connection between childhood trauma, especially sexual abuse, and the emergence of dissociative symptomatology (13,14). It is thought that vulnerable children who depend upon adults for basic survival needs and nurturing are likely to dissociate as a means of escaping, even temporarily, horrible circumstances they cannot actually avoid, such as abuse precipitated by a caretaking adult. Their dissociation may take the form of distancing or disowning emotional reactions to the experience, be it anger, terror, or even shame-inducing pleasure. They may distance themselves from the actual memory of the event while retaining the unpleasant emotions. Or, in the extreme, they may split off the entire experience so completely that in effect they remove themselves totally from the event and present another facet of their consciousness to deal with it. If this sort of event recurs often enough, either perpetrated repeatedly by the same abuser or re-enacted by a series of abusers, or a combination of these, the part of themselves that enables them to cope may take on outward characteristics of a separate individual. In essence, the terror must either continue long enough or recur sufficiently often to draw forth this hybridized fragment of self and allow it to fill out. We see two distinct criteria, each sufficient in itself, in the development of discernible personality fragments: anxiety and relevance. Feelings, memories, and experiences that trigger intolerable levels of anxiety can lead to dissociation, allowing the aspect of the self that is in distress to obtain relief. Once this part of the personality has developed sufficient skill and experience to take over control of behavior for periods of time, certain crucial tasks of learning take place within its purview. This tendency compartmentalizes any or all aspects of an experience to that particular fragment and the experience may not be recognized, recalled or retrieved by any other part of the personality system. Thus it is that relevance plays an important part in the fragmentation of ego states and the perpetuation of that fragmentation. The part of the personality system that owns the needed skill comes forth to provide it. The perpetuation of identity fragmentation is consistent with the concept of state-dependent learning and memory. Data processed in one ego state may be accessible to retrieval only from within that ego state.

Mr. M responded to answering the items of the DES with uncharacteristic, talkative enthusiasm, endorsing most of the 28 items on the measure, some to a great extent. His overall score was 33.37, a score that its authors (12,15) contend is highly suggestive of a dissociative disorder, possibly even DID. Carlson and Putnam (15) reported that factor analyses of a clinical population revealed three dimensions to the DES: the amnestic, the absorptive, and the derealizational/depersonalizational. Mr. M obtained scores of 20.0, 30.11, and 48.33, respectively. The authors have set a score of 30 as a rough cut-off, with persons suffering from DID usually scoring 30 or higher. Mr. M's score placed him above the cutoff, and his derealization/depersonalization score was unusually high, even for those with a definitive positive DID diagnosis. Goff et al. (11), in a 100-subject study investigating dissociative symptoms in a sample of obsessive-compulsive disorder patients, report that patients scoring high on the DES tend to be compulsive checkers, as opposed to those with either washing compulsions or obsessive ruminations. Mr. M presented with a strong mix of each of these categories.

Bernstein and Putnam (12) and Carlson and Putnam (15) have researched the DES extensively since its initial development. It has been used with a variety of clinical and nonclinical populations, and it has been translated into several languages and studied with non-English-speaking populations. Results have been remarkably consistent throughout. The authors maintain that the DES is a screening measure, as opposed to a diagnostic one, and they recommend following a high-scoring DES with a more detailed measure, such as the Dissociative Disorders Interview Schedule (DDIS) (16) to arrive at a definitive diagnosis. It is also accepted practice to refrain from confirming a DID diagnosis until either the clinician witnesses a change in the patient's ego state or such change is reported by a reliable third party (13,17).

I did not administer the DDIS to Mr. M until three months after resuming treatment, so as not to overwhelm him. His level of trust following the DES had led him to begin to express and exhibit his inner fragmentation and thus his DID diagnosis was confirmed. The DDIS served to flesh out the nature of his childhood abuse experiences and

catalogue his various somatic and psychiatric symptoms. For this reason, it is a valuable tool for treatment as well as diagnostic purposes.

During that first session after Mr. M's return to treatment, he admitted to believing he had other personalities within. He then made a perceptible shift to a childlike presentation, with twinkling eyes and bright smile. The nervousness vanished as he spoke of the adult Mr. M who is the one with all the compulsive behaviors. He spoke with distaste of the hand washing which had worn away the skin completely in his palms at one point. He held them up in the manner a child might do. During the next session, Mr. M began by saying he had heard a voice, the night after he was given the DES, saying he had said too much. This is very common in DID patients beginning to speak of their fragmentation for the first time in therapy. I reassured him that a certain amount of distrust is common, but that a crucial step toward successful treatment was taking inventory of the various identity states and their characteristics. This seemed to help put him at ease, and he revealed more about his fragments: Adult Mr. M, Little Mike, and two others who, he asserted, were no longer active, the Little Girl, and the Priest.

In Mr. M's case, relevance seems to be the reason his two reportedly absent fragments were dormant. The Priest came from his years of wanting to be a priest, a dream he reportedly abandoned at about age 14. The Little Girl came from his yearning to be a girl, probably one of the sequelae of his having been molested by both male and female perpetrators and precipitating a gender-identity crisis. He said that early in his adult sexual life, he considered himself to be bisexual. At the time he started treatment, he considered himself to be gay but maintained that he had no urges to engage in sexual behavior of any kind.

Mr. M's compulsive door-checking behavior had proved refractory to all medications. To summarize, he had been given fluoxetine, sertraline, paroxetine, thioridazine, risperidone, fluvoxamine, valproic acid, and clonazepam. Various combinations of these had been tried, pursuing the latest protocols suggested in the literature. Although little is known about the psychotherapy Mr. M received prior to treatment with us, the current treatment, beginning prior to his exit and continuing after his return, was eclectic in approach. Supportive therapy underscored the importance of following his medication regimens from the viewpoint of his OCD stemming from a biochemical imbalance. His psychiatrist and I supported Mr. M in staying on his medications while exploring his obsessions and compulsions and sense of fragmentation in therapy. We also supported one another with the patient to reinforce the importance of the combined psychotherapeutic and psychopharmacological modalities as his best hope for significant improvement. In addition, paraprofessional staff and support staff within this small outpatient setting were briefed regarding the significance of the patient's varied presentations in order to minimize confusion and negative reactions to the patient among those with whom he might have contact.

Treatment team unity and consistency are essential to minimize the splitting which can often occur with dissociative patients. It is also imperative that all with whom the patient interacts clinically have respect for the DID diagnosis. There is a strong tendency for one or more aspects of such patients' personality organization to cling to the belief that they are simply schizophrenics hearing voices rather than the more rare reality of being people with a highly fragmented ego structure. Any suggestion by a clinician that they are simply chronic mental patients who must make the most of their limitations plays into this belief. When they fall back on the schizophrenic diagnosis, they can point to their need for medication, chronic interpersonal difficulties, and often impaired overall functioning and remain dependent and stuck. This is a tragedy that cannot be overstated. DID patients, provided they are not comorbidly psychotic or of very limited intelligence, are highly treatable and stand to recover sufficiently, with appropriate long-term treatment, to lead productive and fulfilling lives.

Following the cognitive-behavioral model, I confronted Mr. M with his irrational beliefs that the door had somehow come unlocked since he last checked, or that his hands were mysteriously soiled minutes after being thoroughly washed, and offered healthier alternatives. In attempting to eliminate the compulsions, psychodynamic uncovering of relevant early life material and dream exploration were used. Perhaps the excessive washing was a manifestation of guilt over forbidden acts, a likely possibility since the symptom reportedly commenced when he was 14. Perhaps the compulsive door checking represented a paradoxical wish for an outsider to enter the household. Speculations can provide a springboard for therapeutic inquiry, but the answers lie within the patient himself. Hypnosis was suggested to get at the patient's resistance to all these many interventions, but he was fearful and continually deferred trying this.

All interventions, both pharmacological and psychotherapeutic, were only minimally helpful, and Mr. M continued to be plagued by his checking and washing compulsions. After I had worked with Mr. M off and on for nearly a year without significant symptom abatement, a bold, new reconceptualization of this case was indicated. Because he believed that his inner

space was partitioned and that the OCD symptoms were confined to his Adult Mr. M identity, it seemed possible that his repetitive actions might be due to alternate ego states being unaware of those actions. With this in mind, I explored with him his thoughts and feelings prior to the rechecking of the door, once it was locked. He said he would feel anxious and unsafe and feel compelled to check the door locks again and again. This relief would evaporate moments later and he would return. No satisfaction was gained from checking. He would lose hours of sleep in this exercise.

Having knowledge of any patient's history is crucial, and the fact that this patient had experienced sexual trammua in both childhood and adulthood proved an important piece of his particular symptomatology puzzle. The fifth fragment to be identified in treatment, Theo, a name derived from his designation of this identity as "the evil one," emerged in session to relate very frankly and without the familiar nervous and tic-ridden manner of Mr. M, the nature of the adult sexual trauma. He had visited a bar and been raped by several men. Theo had come forward to deal with this event and, once that crisis had passed, remained in the background most of the time unless danger demanded his help. Apparently, this aspect of Mr. M's personality structure felt in danger a good deal of the time, especially at night, and kept the patient up and pacing to and from the front door to check the locks. This prompting was insidious and vague, taking the form of "noise in Mr. M's head," which he interpreted as torment and for which Mr. M yearned to banish Theo forever from his experience and, ultimately, his ego organization.

In session, I suggested to the patient that the Theo identity might need to be informed that the door was locked, since he apparently remained in the background and only interjected his worry and not his entire conscious awareness into the door-checking activities. If his job had been to protect the patient frorA threats to his safety, he would need to be privy to the fact that safety had been achieved. I asked the patient to speak aloud next time he locked the door at night, addressing all aspects of his ego system and informing them that the door was now locked. He returned the next week ecstatic. The intervention had worked. This continued for several weeks, but then he said that occasionally the urge to check the door returned. Inquiry revealed that he had stopped announcing to all and sundry aspects of his ego system that the door was locked. The symptom returned after omitting the procedure several nights in a row. I suggested he return to stating that he was locking the door as he did so, and repeat this every night. At some point he could try saying it to himself instead of aloud.

Whenever the checking compulsion returned, he could resume the announcing procedure.

This same announcing procedure was utilized next with Mr. M. to eliminate compulsive stove-knob checking. It worked as well as it had with the door checking. The only repetitive behavior remaining was Mr. M's compulsive hand washing. He said there were times he would wash them so frequently the skin would come off, and at one point he had worn circles the size of quarters in the palms of his hands where raw tissue was exposed. This situation is qualitatively different from checking. It is a contamination compulsion, which may have its origins in guilt over masturbation or some other subjectively "dirty" behavior. When asked about this possibility, Mr. M looked at me with a suddenly piercing gaze, and leaning closer in the intense, frank, and terse communication style of Theo, admitted to having been a male prostitute in a seamy part of Manhattan many years earlier. He had abandoned the practice in the mid-1980s, with the advent of publicity about AIDS. I addressed this with the patient by speaking to him rather indirectly. I told him, and suggested that other aspects of his personality system might benefit from hearing this, too, that some people continue to suffer guilty feelings that are no longer relevant. I told him that the feeling of guilt usually comes from violating one's self-endorsed value system. He must have known that having sex with anonymous or exploitative persons was not what he really wanted to do. However, he had not been able to secure employment to meet his most basic survival needs any other way, and these needs took precedence over his wish to conform to his own standards. He, thus, violated these standards in the interest of his overall well-being, but the guilt and shame over not finding a better way persisted. It was now necessary to tell him that he had done the best he could at that time in his life. He apparently either had no knowledge of a better plan to execute, or he was mentally or emotionally incapable of discerning a better way, due to his history of abuse and neglect.

I suggested to Mr. M that it was important to his recovery from the compulsive hand-washing that he hear me as I told him he did the best he could do at the time. His sexual orientation was addressed from the same viewpoint. He was reassured that sexual attraction usually was not chosen but either innate or shaped at a very young age, and that his preference for men as partners is nothing in and of itself of which he need be ashamed. Choosing to stop his promiscuous behavior was a wise choice once HIV infection was a known risk. His stopping it ought not to be construed as confirmation that he had been "bad" and was now being "good." I urged him to keep this in mind when he felt compelled to wash his hands. He

could wash them at the appropriate times, and at the same time, announce that he was doing so, and that they were really and truly clean. I then encouraged him to tell himself that he need not feel guilt or shame about his past.

The following week, Mr. M reported that he had stopped washing his hands compulsively. He then presented them for inspection. To be sure, the palms of his hands, once reddened and rough with calluses from the constant washing, were nearly normal in appearance, the skin unremarkable in color and the surface smooth. Gone were the shiny areas of thickened skin visible just the previous week. Now, some months later, his hands appear completely normal.

Mr. M tends to remain an isolated, withdrawn person who trusts few other people. He does express gratitude for the therapeutic relief of his compulsive behaviors and recently has asked for help in quitting smoking. His once-refractory OCD symptoms have not returned, despite a recent event that exerted a great deal of stress on him. His mother suffered a stroke and was hospitalized. Because of this, his elderly father, who could not function well alone, was placed in a nursing home. Mr. M took the train up to the family home, attended to both parents in their respective institutions, and spent two nights alone in their home. He never felt compelled to check locks or the stove, and did not return to excessive hand-washing behavior. His response to questioning about this was simply, "I was too busy worrying about them to even think about it."

The therapy has continued with all aspects of his personality structure being addressed individually and collectively in regard to these various ongoing concerns. While integration is the usual goal of any treatment of DID, this goal typically takes quite a long time to reach. The work proceeds, meanwhile, as several continuous streams that are interconnected via the associations between ego fragments. Mr. M frequently asks for me to write down for him something said in session that he feels is especially important for the entire ego system to remember. Assignments are given in writing, too, so he can process them collectively and review them before the next session. Sometimes he writes down memories, questions, or ideas he has had in the interim to be sure to remember to bring them up when he comes in.

In pursuit of his desire to stop smoking, Mr. M at last submitted to hypnosis, with some success. Keeping the goal of hypnotherapy specific to his smoking rather than as a means to access memories, affect or hidden aspects of the system, helped him to be willing to try it. In time it may be

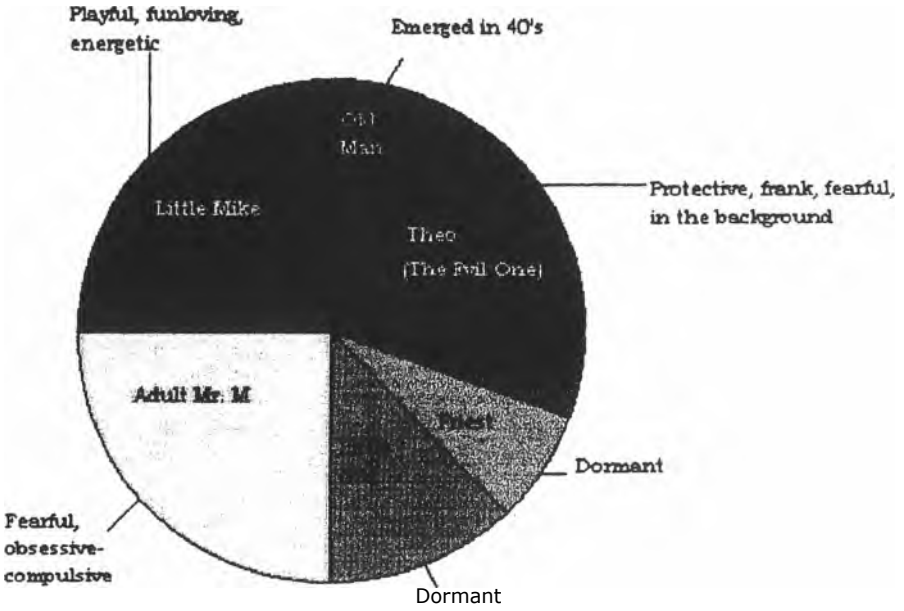

Figure 1.
IDENTIFIED EGO FRAGMENTS OF MR. M'S PERSONALITY ORGANIZATION

used as such, but this must be appealing to the patient or it will not be effective and could confound the work for a time. In addition, another ego fragment has been identified, the "Old Man," who, he says, emerged several years ago when he became aware of the inevitable aches, pains, and vision changes associated with the aging process. On my office computer, I maintain a pie chart for him and the other DID patients I treat. Usually, he asks that I bring up his chart on the screen (see Figure 1) at some point in a session. Several weeks after the Old Man had been added to his chart, Mr. M presented to session as Theo. When he saw the pie chart, he pointed to his wedge of the chart saying his segment ought to be larger and the Old Man's smaller. I made the appropriate adjustment, and he was very satisfied. Thus we have been able to visually capture his sense of the progress of his integration process.

CONCLUSION

Mr. M appears to be a dissociating patient exerting rigid controls on his ego fragments. They influence him, but they do so from the periphery, not from center stage. He fears allowing Theo to assume full control, not knowing

what he might do. He admitted that Theo prompted him continually to take more clonazepam than was prescribed, an urge he resisted. I supported him in his refusal to give in to this, but I wondered about the apparent contradiction. If Theo wanted to stay up and awake, why pester Mr. M to overdose on his medications? It occurred to me that this might be a form of reverse psychology, a type of ordeal therapy in itself. By urging the wrong behavior, he might be preventing it. After all, Theo's voice was one usually dismissed by the patient. Mr. M easily relegated Theo to the background, saying he actually located him in the "back of my mind." He spoke of wanting to eradicate him from the system.

The desire to eradicate an overly angry or volatile personality fragment from the system is a common desire of more mainstream identities, especially early on in the treatment. The disowned affect, and sometimes behavior, is cast as far from the rest of the system as the executive personalities can manage. I find that illustrating the ego system with a pie chart is the best approach to explain why this does not work. If any one of the segments of the whole is eliminated, the integrity is spoiled. Another way I often put it is, "If you remove any one of these aspects of yourself, you're not all there." And so it is.

This phenomenon of exclusion falls within the province of more conventional personality structure. Most of us can relate to feeling that murderous rage seems the farthest impulse from our awareness. Certainly, we can acknowledge becoming very angry, but most of us will stop short of saying that we wished the other dead or seeing ourselves carrying out the deed. But, most of us are also aware that it is entirely within the scope of human experience to be capable of murder under the right conditions. This might involve protecting our family or our own lives from sure annihilation. I call this the "mother lion" mode. When that mother lion mode is activated, we would do anything and everything to protect the weak. When we are able to accept and tolerate the concept that we are capable of all human emotions and reactions, we are more fully alive and present in our lives. The DID patient must come to trust this idea and learn to accept it in order to embrace each of his disowned affects and, therefore, his fragments.

When patients present with longstanding, refractory OCD symptomatology, despite the valiant efforts of their psychiatrists and psychotherapists, investigation of other explanations must be considered. While DID is indeed rare, it does sometimes coexist with OCD and for this reason, should be investigated when conventional treatment has failed, before ruling it out.

REFERENCES

1. Sullivan H (1956). *Clinical Studies in Psychiatry*. New York: Norton, 1973.
2. Laird L (1996). Issues in the monopharmacotherapy and polypharmacotherapy of obsessive-compulsive disorder. *Psychopharmacology Bulletin, 32,* 569-578.
3. Stein D, Spadaccini E, & Hollander E (1995). Meta-analysis of pharmacotherapy trials for obsessive-compulsive disorder. *International Clinical Psychopharmacology, 10,* 11-18.
4. Zohar J, Judge R., & the OCD Paroxetine Study Investigators (1996). Paroxetine vs. clomipramine in the treatment of obsessive-compulsive disorder. *British Journal of Psychiatry, 169,* 468–474.
5. Koran L, McElroy S, Davidson J, et al. (1996). Fluvoxamine versus clomipramine for obsessive-compulsive disorder: a double-blind comparison. *Journal of Clinical Psychopharmacology, 16,* 121-129.
6. Fineberg N (1996). Refining treatment approaches in obsessive-compulsive disorder. *International Clinical Psychopharmacology, 11(suppl 5),* 13-22.
7. Saxena S, Wang D, Bystritsky A, & Baxter L (1996). Risperidone augmentation of SRI treatment for refractory obsessive-compulsive disorder. *Journal of Clinical Psychiatry, 57,* 303-306.
8. Jacobsen F (1995). Risperidone in the treatment of affective illness and obsessive-compulsive disorder. *Journal of Clinical Psychiatry, 56,* 423-439.
9. DeRubeis R, & Crits-Christoph P (1998). Empirically supported individual and group psychological treatments for adult mental disorders. *Journal of Consulting and Clinical Psychology,* 66, 37-52.
10. Ross C, & Anderson G (1988). Phenomenological overlap of multiple personality disorder and obsessive-compulsive disorder. *Journal of Nervous and Mental Disease, 176,* 295-299.
11. Goff D, Olin J, Jenike M, Baer L, & Buttolph M (1992). Dissociative symptoms in patients with obsessive-compulsive disorder. *Journal of Nervous and Mental Disease, 180;332-337.*
12. Bernstein E, & Putnam F (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease, 174,* 727-735.
13. Kluft R (1996). Treating the traumatic memories of patients with dissociative Identity disorder. *American Journal of Psychiatry, 153,* 103-110.
14. Putnam F (1993). Dissociative disorders in abused children: Behavioral profiles and problems. *Child Abuse and Neglect, 17,* 39–45.
15. Carlson E, & Putnam F (1993). An update on the dissociative experiences scale. *Dissociation,* 6, 16-27.
16. Ross C, Heber S, Norton G, et al. (1989). The dissociative disorders interview schedule: A structured interview. *Dissociation, 2,* 169-189.
17. Putnam F. (1989). *Diagnosis and treatment of multiple personality disorder.* New York: Guilford.