The inevitability of ego-state therapy in the treatment of dissociative identity disorder and allied states

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Although many approaches to the treatment of Dissociative Identity Disorder (DID) and allied forms of dissociative psychopathology have been proposed, all reports of the successful integration of these conditions have been achieved with approaches in which the alter personalities have been addressed rather than bypassed in the course of the treatment. Even in therapies that are not attempting integration, it is useful to work with the personalities to facilitate their constructive cooperation toward a more stable pattern of interaction, called a resolution. Since working with the personalities and their relationships to one another and to the therapist are inevitable components of these treatments, and ego-state therapy offers a thoughtful and effective approach to addressing the alters, ego-state therapy should be studied by all therapists who work with complex chronic dissociative disorders. This presentation will describe what Kluft has called "The Dissociative Surface," discuss fifteen advantages associated with working directly with the alters, and the place of ego-state therapy in such efforts.

Dissociative Identity Disorder (DID) and allied forms of Dissociative Disorder Not Otherwise Specified (DDNOS) is diagnosed in increasing numbers of patients in increasing numbers of nations. Although the condition itself and its treatment remain controversial, there is general agreement that, within the literature of the dissociative disorders field, all reports of the successful integration of such patients have been accomplished with psychotherapeutic approaches in which the alter personalities were addressed and worked with rather than bypassed, not reinforced, or suppressed. In fact, there has long been evidence that 97-98% of patients treated with methods that do not address the alters continue to have diagnosable dissociative disorder with persisting alters on follow-up (Kluft, 1985).

As the modern era of DID treatment began, the appreciation that the alters could be understood to constitute an inner "family of self" (Watkins,1984; H. Watkins and J. Watkins, 1993; J. Watkins & H. Watkins, 1997) and that their issues and conflicts could be approached with group and family therapy techniques was systematically explored by John G. and Helen H. Watkins, who developed ego-state therapy, and by the late David Caul (1984), who, using a diplomacy metaphor specifically for DID, described the methods of inner group therapy. Caul did not survive to develop his model completely.

Over the years, the Watkins have written prolifically and taught widely, developed the ego-state model as a theory of psychological development and function, and have spread the ego-state model of psychotherapy to many nations. It is a tribute to their success and to the power of their model that many clinicians have embraced their approach in their treatment of a wide variety of patients, and that many practitioners who use ego-state approaches have never been taught by the Watkins or read their work, but instead have learned them from new generations of ego-state-oriented mental health professionals.

Watkins "define[d] an ego state as an organized system of behavior and experience whose elements are bound together by some common principle but that is separated from other such states by boundaries that are more or less permeable" (Watkins, 1984; H. Watkins & J. Watkins, 1993, p. 278). Ego-states in most patients and research subjects have more or less permeable boundaries and are not necessarily maladaptive; in contrast ego-states in chronic complex dissociative disorders (DID and DDNOS) often have some boundaries that are relatively rigid and impermeable, permitting little communication among them.

The Dissociative Surface

To the clinician who does not understand ego-state phenomena, an encounter with a dissociative patient may prove comforting, because he or she will not recognize the indicators of a dissociative process at work and not be impelled to deal with them; or confusing, if he or she realizes that the fluctuating and often perplexing presentation of the patient, the dissociative surface (Kluft, 1999a), is an indication of some process at work which the clinician cannot understand.

To the clinician who is sensitive to ego-state phenomena, the dissociative surface is a rich source of information, and one of the keys to understanding how to understand and intervene with the dissociative patient. The dissociative surface is the external manifestation of the alters' behaviors and interactions both with the external environment and the inner world of the alters, the so-called "third reality" (Kluft, 1998) to which is often accorded equal or more importance by the DID/DDNOS patient than external reality. Without such appreciation, the clinician is restricted to dealing with the host (the most commonly encountered alter over a period of time), and those alters which take over executive control in complete "switches."

Tab 1: The Dissociative Surface

- I The Host, or the "Usual Patient"
- II The Semblance of the Host or "Usual Surface"
  - A. Passing for
  - B. Isomorphism
  - C. Tag-Teaming
- III Co-Presence Combinations
  - A. Mixed Presentations
    - 1. Cooperations
    - 2. Clashes
    - 3. Vectors
    - 4. Temporary Blendings
  - B. Fluctuating Presentations
  - C. One-Plus Presentations
  - D. Shifting One-Plus Presentations
- IV Instructed Behavior
- IV Intrusions
  - A. Simple
  - B. "Up the Food Chain"
  - C. From the "Third Reality"
- V Imposed or "Made" Behavior
  - A. Simple
  - B. "Up the Food Chain"
- VI Switching, Rapid Switching, and Shifting

However, it long has been appreciated that overt switches constitute a small minority of the alters' actual behavior (e.g., Franklin, 1988, 1990; Kluft, 1985, 1987, 1991b). Most manifestations are more subtle manifestations Franklin (1988, 1990) appropriately describes as "shifts," in which they become present enough to be copresent or able to exert an influence upon the alter ostensibly in executive control. Combining ego state concepts with an awareness of the inner complexity of DID makes it possible to explore puzzling manifestations such as mixed combinations; one-plus presentations in which the apparently dominant alter shows aspects of one or more other alters; intrusions from other alters, from alters imposing commands upon still other alters that influence the alter in apparent executive control ("up the food chain"); and many related phenomena. Often a series of simple ego-state-oriented inquiries will unravel difficult clinical dilemmas.

For example, a usually cooperative DID patient suddenly became frightened and ran to the door. She said she felt that her body wanted to run, even though she did not, and she did not know why she was terrified. I asked if I could speak to the part that wanted to run, and discovered a scared child part was afraid of me. When I asked why, I learned that still another personality had told it I was a bad man and that she had to run. This "up the food chain" intrusion would have been difficult to deal with if I had con-

versed with only the host and the child, but resolved rapidly when I spoke with the alter whose interventions in the inner "third reality" (Kluft, 1998) were creating the problem.

Using Ego-State Interventions in the Treatment of DID/DDNOS

My experience has been that either regarding the alters of a DID (hereafter I will refer to both DID and forms of DDNOS with alters as DID) patient as if they were completely separate persons or treating the DID patient as if he or she were a person with no separateness at all denies and/or dissociates both the nature of DID phenomena and the subjective world of the DID patient, and sets the stage for a failure of accurate empathy and for difficulties in the therapeutic alliance. In fact, the clinician must be prepared to understand and work within the "double book-keeping" of DID, that the patient is a single individual whose personality is to have multiple personalities (Coons, 1984; Kluft, 1991a). At times the immediate goals or emphases of the therapy may appear to endorse either extreme perspective, but the careful clinician avoids the self-deception of endorsing either perspective as a reified reality.

In practice, DID and allied forms of DDNOS are remarkably heterogeneous with regard to the alters' relationship to one another, the inner worlds of the patients, the rigidity of the dissociative barriers, the alters' narcissistic investment in their sense of separateness, and many other factors as well (Kluft, 1991b). While the mind of one DID patient may become sufficiently accessible for a successful therapy to proceed without making special efforts to access and address the individual alters, another may be so constituted that in the absence of efforts to access and address the individual alters, a stalemated or failed therapy is inevitable.

The choice to address the alters as entities that are more effectively engaged when their sense of subjective separateness is openly acknowledged and worked with or the choice not to do so should never be made on the basis of theoretical considerations remote from clinical reality. Instead, the choice should be made on the basis of pragmatic therapeutic considerations and, as therapy proceeds, an increasingly sophisticated appreciation of what works with a particular DID patient. For example, if I were dealing with a patient that was completely accessible without addressing particular alters, but whose alters resented being bypassed, I would work with them in order to avoid unnecessarily complicating the therapy by inflicting perceived slights and by being considered unempathic and unable to relate to the patient's subjective reality. Whenever I make such a choice, my interventions inevitably enter the realm of ego-state therapy.

Why would one chose to address the alters individually (or in groups), and thereby enter the world of ego-state therapy, instead of working through the apparent host? Here we can only address a few of many considerations.

First, the host is simply another alter, and may not be agreed upon by the others as the essential core of the patient. They may not take exclusion lightly.

Second, most of what is withheld in DID is withheld by reluctance, not by repression. That is, the withholding is done on a conscious basis and does not constitute an unconscious resistance to the treatment. Reluctance is best dealt with by persuasion, and it is easier to persuade if you acknowledge the subjective reality and perspective of the part you are trying to persuade. A family of self approach (Watkins & Watkins, 1993) is very effective here.

Third, if all alters are not accessible directly, the failure to address the alters or aspects of mind that presumably contain crucial mental contents constitutes a decision to leave major aspects of mental content, structure, and function unaddressed. That constitutes a collusion to avoid important issues and material. This is what Langs (1981) has eloquently described as "lie therapy," and is ineffective in most cases.

Fourth, the alters are more than social psychological phenomena. They express, personify and enact wishes, defenses, adaptations, object relations, and the dynamics and genetics of symptomatic behaviors, enactments, and reenactments. They express themselves in the transference, elicit countertransference, and are a major source of projective identification from "behind the scenes." These are fairly critical matters in treatment. Again, their neglect constitutes "lie therapy" (Langs, 1981), and may beget dysfunctional actions on their parts to cause attention to their concerns.

Fifth, it is easier for the therapist to get history or to reverse amnesia without intrusive interventions by simply asking alters to tell him or her about themselves and their experiences, and then sitting back and listening. To "pull" historical material "through" a host or via more leading techniques takes the endeavor away from free recall, and enhances the risks of both censorship, contamination, and confabulation.

Sixth, the easiest path to symptomatic relief often is the accessing of the alters "behind" a symptom, behavior, affective state, etc., and negotiating with it or them(Kluft, 1983). As noted when we discussed the "dissociative surface," alters behind the scene often cause intrusive symptoms that may be misunderstood unless they are explored.

Seventh, the host, as it tries to act normally, often engages in such denial and dissociation that it may become impossible to discover dangers that may be lurking over the horizon, and thereby to preempt crises rather than pick up the pieces after the crises have taken place. The revictimization of dissociative patients on this basis is commonplace (Kluft, 1990). Accessing the alters to draw upon their knowledge and gain their perspectives may be very helpful.

Eighth, empathy expressed in direct contact with an alter is a much more effective eroder of dissociative boundaries and a more convincing corrective emotional experience than filtering the experience of receiving empathy through other alters. Not only is it more direct, but it bypasses the frequent phenomenon of one's alters inability to own the experiences of another alter.

Ninth, abuser alters often, unless accessed directly and brought into the therapy, are more likely to cause chaos and inspire self-injury from behind the scenes. Their defen-

sive narcissistic constellations often preclude their feeling included in approaches that do not address them directly. Their experience of the clinician's caring and empathy is crucial to their changing in a constructive manner.

Tenth, many useful approaches to the treatment of DID such as ego-state therapy (H. Watkins & J. Watkins, 1993), tactical integrationalism (e.g., Fine, 1991, 1993), and hypnotic and non-hypnotic containment and shut-down techniques (among others) (e.g., Kluft, 1994; Phillips & Frederick, 1995) require negotiating with the alter system, and these are very powerful interventions, to be discarded at the patient's peril.

Eleventh, often the DID patient is overwhelmed, or gives a history of much higher function in the past, and the resources currently unavailable for such a higher level of functioning are attributed to other alters which are currently not active or accessible. Accessing and mobilizing alters with such strengths may be essential to the rehabilitation of the DID patient.

Twelfth, the more alters can be helped to overhear and see one another in action, the more, after initially being preoccupied with their differences from one another, they ultimately are impressed by their commonality, and move to better communication, collaboration, mutual empathy and identification, and then to integration.

Thirteenth, often the reality of the inner world, which I have called "the third reality" (Kluft, 1998), may be more compelling to the patient than external object relations and situations. Much of the patient's emotional energy and interest may be withdrawn from the here and now, leading to prolonged difficulties in helping the patient address here and now concerns. In such situations, often the inner world is inaccessible either completely or for long periods of time to the host or through the host, who may be seen as either an enemy of the inner world, or a drone necessary to deal with the mundane realities of a world from which most alters have withdrawn. It may be possible, by addressing the parts that have turned away from the external world, to enter the "third reality" and/or to bring the alters into the here and the now.

Fourteenth, work on shame dynamics (Nathanson, 1992) is crucial to the resolution of traumatic insults to one's identity and one's self. Work on shame with particular alters about experiences and actions they consider mortifying is more effective "face-to-face." Often such work done through a host is less than effective, because the involved alters may not believe that: 1) they are truly accepted despite their difficulties; 2) their issues have truly been addressed, 3) and that they have truly mastered their concern.

Fifteenth, often the DID patient's treatment is complicated by the expressed needs of child alters, trying to create a tangibly more satisfying childhood in a regressive relationship with the therapist. As Putnam (1989) observed, the most appropriate person to respond to such perceived needs is not the therapist, but the patient, by mobilizing more grown-up alters to provide the requested nurture and play experiences. Working with the alter system as a family of self facilitates this.

Having made the case for ego-state oriented approaches to alter states, we must now

ask why would one choose to avoid addressing alters. There are several reasons apart from those dictated by theoretical predilections.

First, not withstanding the controversy that surrounds allegations that DID can be cause iatrogenically, forensic considerations may preclude one's doing any intervention that might later be interpreted as instigating rather than exploring dissociative phenomena.

Second, it is possible to encounter systems in which all alters are either overwhelmed or trauma based, and their being brought forward is associated with a high risk of disequilibrium.

Third, the patient's circumstances may necessitate that the therapy address issues in the outer world to the exclusion of work with the DID per se.

Fourth, some patients with compromised ego strength must be discouraged from opening up their DID because they do not have the psychological wherewithal to address the alters and/or trauma work (see van der Hart & Boon, 1997; Kluft, 1999b).

Fifth, when therapy must be supportive, there is much to be said for avoiding bringing out alters that may bring with them too many issues or concerns for a patient whose plate is already too full. The alters, under these circumstances, should be dealt with only as it becomes necessary, but they should, generally, not be sought out, unless unique considerations favoring their being addressed outweigh these concerns.

In the above paragraphs I have tried to give a brief overview of considerations that incline me favorably toward the use of ego-state therapy interventions in the treatment of DID. In therapies attempting the definitive resolution of DID, it is usually necessary to achieve goals and objectives that may require direct access to and work with alters in order to succeed, but that these goals and objectives may or may not be a necessary or prominent part of some primarily supportive treatments. Determining whether to deal with the alters or not on the basis of abstract theoretical concern will usually beget errors of judgment that may lead to sub-optimal psychotherapy for the DID patient.

Concluding Remarks

Ego-state therapy interventions are virtually the inevitable concomitants to therapeutic efforts attempting to bring about the definitive and integrative treatment of DID. They are useful whether one believes DID is an iatrogenic or a naturalistically- occurring condition, and find a place in most reasonable therapeutic stances, despite their different paradigms and theoretical bases. They find a place in both the supportive and definitive treatment of this condition. This is probably because they respect and address the structure of the DID patient, which is to be a self or identity consisting of many selves or identities and their interactions (Coons, 1984; Kluft, 1991a).

Ego-state therapy, although associated with hypnosis, owes its origins to psychoanalysis. As psychoanalysis developed, a number of authors took note of mental structures that did not conform with classic psychoanalytic paradigms. Most of these authors were British; Brenner (in press) has described their contributions. However, it was

Federn (1952) who first described ego states as understood by John G. Watkins, and his analytic training brought him into contact with Federn's ideas.

As a system of thought, psychoanalysis values preeminently the non-judgemental exploration of both conscious and unconscious mental conflict and activity. It is within this tradition of psychoanalytic exploration that ego-state therapy makes a monumental contribution to the treatment of DID. When conflicting or alternate understandings are outside of conscious awareness, techniques designed to relieve repression and unconscious defenses are called upon to make the unconscious conscious. When conflicting or alternative understandings come to exist in personified forms, in dissociated "elsewhere thought known" (Kluft, 1995) configurations, it is necessary to use techniques designed to access alternative or parallel conscious mental configurations and to bring about a resolution of their differences. Ego state therapy interventions fulfill this need.

I will end by reflecting on the importance of ego-state therapy in conducting an honest exploration of the dissociated psyche. Earlier I referred to Langs' (1981) concept of "lie therapy." Although it is difficult to translate Langs' idiosyncratic conceptual scheme of psychoanalytic work into the context of the current discussion, Langs' concept of truth is that it constitutes the actualities of the patient's material, the therapist's thoughts and interventions, and the therapist-patient interaction. Truth therapy is designed to arrive at the patient's actualities as they arise in the the therapist-patient interaction. Langs' concept of lie is a nonmoral reference to falsifications of those actualities, falsifications which offer some substitute for the truth, deny the presence of the truth, and erect some defenses or impervious barriers to the realization of the truth. Lie therapy is any form of treatment designed to bypass of falsify the true basis or actuality of the patient's problems. Even true facts can be used to functionally deny and falsify expressions of the truth.

Watkins' ego-state therapy, by providing us with a method of approaching the inner world of the dissociative patient, is a major contribution toward the truth therapy of DID patients, toward acknowledging and approaching what is actual in their inner world and psychological structures. For this reason, it should be an inevitable component of their psychotherapies.

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