***Richard P. Kluft**, M.D., F.A.P.A. is the Director, Dissociative Disorders Program, Institute of the Pennsylvania Hospital, Philadelphia, Pennsylvania. Dr. Kluft is also a Fellow member of the International Society for the Study of Multiple Personality and Dissociation, a past president of that organization, and is presently editor-in-chief of Dissociation, official journal of the ISSMP&D.*

I saw my first MPD patient in December of 1970. Since then I have had the opportunity to interview over 500 persons who suffer this condition, and treated over 130 past the point of integration through to the completion of their psychotherapies. In the last few weeks I have been reviewing this body of experience, studying the factors that seem related to prognosis. My goal is to generate information for both patients and therapists about how to make treatment more rapid and effective. Therefore, when asked to contribute an article to MANY VOICES on short notice, it crossed my mind to write, in a preliminary way, about how the patients who did best in treatment conducted themselves.

I am increasingly impressed by the heterogeneity of those who suffer MPD. Some MPD patients get well very quickly, and some seem to progress slowly, if at all. Some MPD patients' treatments are beset with apparently endless series of crises and complications; some therapies are smooth and flow from the resolution of one problem area to the conquest of another. Many factors bear on prognosis but are not within the patient's power to change. However, there are a good many that can be affected by the patient, although often at the cost of considerable effort, and can exert a powerful influence upon the course of treatment.

As I anticipate what I am about to say, I appreciate that many who will read this article will feel hurt, criticized, and depreciated. There will be those who feel offended. Nonetheless, since the findings in my study are so striking, I think that they are worth sharing. The presence of certain patient behaviors was associated with much shorter and more effective therapies. My preliminary findings will be expressed as advices on how to behave in therapy; patients who got well fast acted as if they were guided by these precepts.

Be prepared to work hard, and to explore your difficulties in cooperating with treatment. Psychotherapy is a form of collaborative work undertaken in order to alleviate the symptoms of patients' mental disorders and to help them live more effectively. It occurs within a particular framework under circumstances that are respectful of certain boundaries. Patients who appreciate the fact that there is work to be done within a given amount of time and under the rules of the therapy do much better than those who indulge their wishes to be liked and/or supported to the extent that they forfeit doing the work of the treatment. The latter defer treatment itself to their preoccupation with what they perceive to be their needs and wishes for succor and support. Patients who see therapy as a place in which it is understood that hard work is to be done are more likely to understand that the confrontation of their resistances has to do with the facilitation of that work. Conversely, patients who try to turn the therapy into a friendship, a reparenting experience, a spiritual union or quest, or an intellectual exercise, will experience the therapist's efforts to work with resistances as rejection, attack, betrayal, or a devaluing of themselves. A corollary: Do not confuse your needs with your wants. Many MPD patients waste months or years refusing to see that what they would most prefer and most earnestly desire are things that they want, but certainly do not need.

Expect to be held responsible for conforming your behavior to the standards of the world and the boundaries of the treatment. Although you may not like this, responsibility is tremendously empowering. Without rational responsibility, self-efficacy and mental health cannot be achieved.

Be prepared to engage in a painful treatment. Patients who understand that the treatment of the sequela of painful events involves the toleration of considerable hurt and the recovery of difficult material do much better than those whose incessant requests for rapid relief strangle the progress of the therapy. Many MPD patients want and expect the changes of treatment to be as magical and abrupt as the dissociative switches that they have developed to block out pain. Many as well try to defer dealing with painful material in the planful way that the therapist suggests ("It hurts too much" is the usual verbalization), only to find that it bursts into their awareness in between sessions. The therapist, confronted at midnight or beyond with material that he or she tried in vain to address in a mid-morning session, will not be delighted, and the patient will feel rejected as well as overwhelmed.

Be prepared to be asked to stick to subjects that you would prefer to leave or completely avoid. Your therapist should respect your anxieties to a certain extent, but bear in mind that many of your defenses are based on avoidances, conscious and unconscious. If the therapy tacitly endorses these defensive styles on a regular basis, your recovery will be delayed.

Be prepared to look for your support outside of therapy. Patients who develop their own resources and support systems do better than those who attempt to draw all their perceived needs from the therapist. The therapist is not inexhaustible, and is a poor substitute for a friend who, in turn, would be a poor substitute for a therapist.

Value rational flexibility and concerned caring from your therapist. Be clear in your own mind that this is quite different from indulgence and the creation of very special types of interactions that you may value in the short run, but which undermine the treatment. A good therapist is going to stick to the tasks of treatment rather than enter a series of interactions that take the therapy very far afield into situations that may be mutually gratifying but which, no matter how much they are cherished, have only a remote connection with advancing your recovery.

Be prepared not to tie your therapist's hands. By this I mean two things: 1) To the extent that you try to control your therapist you will get inferior treatment. If you could heal yourself, you would have done so. 2) Patients who extracted agreements from therapists that under no circumstances would they be hospitalized, take medication, be forced to obtain recommended medical help, etc., in general did far worse and had many more crises than those who neither made nor attempted to make such stipulations or "special arrangements". What at first made some feel safe and cared about ultimately endangered them and led to crises and prolonged stalemates. Often their therapists felt bound to honor agreements that were absurd under the clinical circumstances that developed.

Respect your therapist's boundaries and personal time. Your sense of isolation and urgency may impel you to make demands that are abusive of your therapist, and often a series of requests, each of which may be reasonable in and of itself, adds up to an unreasonable imposition.

Although you may say anything in a therapy session, you have no right to carry it to the extent that it is hurtful to your therapist. If you talk to your therapist outside of a therapy session you should talk as any reasonable person to another. The patient who works constructively in session on angry, even homicidal feelings toward the therapist, for example, is within the frame of the treatment. The patient who leaves death threats or character assassinations on the therapist's answering machine, or who threatens the therapist's family, is committing terroristic threats, a legal offense, and is indicating to the therapist that he or she may act out rather than discuss these impulses.

Realize that your therapist is not obligated to continue a therapy that has become untenable as a result of your behavior or uncooperativeness. As a corollary, expect your therapist to protect himself or herself from the possibly adverse consequences of your behavior. In circumstances in which therapists allowed themselves to be abused and/or exploited, therapy was prolonged and often unsuccessful. Reenactment of abuse scenarios within the treatment must be discouraged. One patient felt miserable and made incessant excessive demands of her therapist, who was compliant, albeit at great personal cost. Therapy was deadlocked. I saw the patient as reenacting the behavior of her chronically depressed and demanding mother toward herself (the patient) as a child. When the therapist changed her behavior accordingly the patient was mightily aggrieved, but ultimately a productive therapy was established.

Bear in mind that you have an unconscious that is not simply the memory of other alters. There is much more to you than your MPD. Many MPD patients come to believe that somewhere in their system of personalities all is contained and accessible. They become upset when something is said to which no alter is prepared to respond; this is a common reason for MPD patients to reject perfectly plausible observations that would enhance their insight and speed their treatment. Recently I saw in consultation a patient who was totally uncooperative with every therapeutic intervention. She told me that because all of her alters agreed that they were cooperative, it was impossible for her to be resisting.

Be open-minded even as you are suspicious. Many MPD patients have cognitive distortions that subtly influence their thinking processes away from rationality. This is one reason that they are so prone to revictimization. It is very important to give the therapist's observations thought before discarding them in a peremptory fashion. The therapist probably will not think the way the MPD patient does, and in that difference reside many valuable lessons.

These few hints all emphasize the importance of the patient's contribution to the therapeutic alliance. They do not surprise the therapists, who appreciate at once that the quality of the work that they and their patients do has a direct bearing on the outcome of treatment. They often are rather unsettling to MPD patients, many of whom have a hard time appreciating the rhyme and reason of psychotherapy.