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Dealing with Alters: A Pragmatic Clinical Perspective

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Alternate identities or personality states are core phenomena of dissociative identity disorder (DID) and found in several forms of dissociative disorder not otherwise specified (DDNOS) [1]. Whether they are called identities, personalities, personality states, ego states, subpersonalities, parts, disaggregate self-states, alters, or any number of other descriptive terms (hereafter termed alters), they form a central and often colorful and controversial feature of these disorders.

Clinicians confronted with DID and related forms of DDNOS (hereafter referred to collectively as DID) must determine how they will approach and address the alters. Working with alters has long been an important aspect of DID treatment, but many mental health professionals have been (and remain) reluctant to elicit or work directly with the alters. Such colleagues prefer to understand the alters as obstacles, distractions, or artifacts to be bypassed or suppressed; they may endeavor to address the issues raised by the alters and their activities obliquely, employing allusive circumlocutions but without dealing directly with the alters.

Although these stances are not without their supporters, they are buttressed more by strongly held and vigorously voiced opinion than by scientific data or clinical experience. A longitudinal study [2] demonstrated that 97% of those patients who had DID (termed multiple personality disorder at the time of the study) and received treatments that did not work directly with the alters still satisfied diagnostic criteria for DID on follow-up. To date, no substantial scientific literature or major series of successfully treated cases has been published that describes the definitive psycholytic treatment of DID (ie, a treatment to the point of eliminating the condition) without addressing the alters. In contrast, available reports of successful treatment (eg, Coons [3],

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Kluft [4,5]) have involved therapies in which the alters are addressed. Therefore, despite the support voiced for treatments that avoid working with the alters in DID, those who follow such plans of action are implicitly following an experimental path that is likely to prove therapeutically futile and may expose the patient to danger and excess morbidity [6,7].

Those experienced in the treatment of DID do not regard the alters as mere curious phenomena. They understand the alters to ''express the structure, conflicts, deficits, and coping strategies of the DID patient's mind'' [7]. As Coons [8] and Kluft [9] have observed, the personality of a patient with DID is to have multiple personalities. Kluft [7] observed that

> Bypassing or disregarding the alters creates a therapy in which major areas of the patient's mental life and autobiographic memory will be denied an empathic hearing. Furthermore, it is rarely sufficient simply to address the alters as they emerge. The alters are aspects of a process of defense and coping. It would be naïve in the extreme to imagine that the patient will predictably present in those alters most relevant to the conduct of the therapy. Considerations of facilitating day-to-day function, shame, guilt, and apprehension dictate otherwise. Therapists who await the emergence of alters to work with them may prolong the treatment considerably.

When voices are raised to dispute the practice of eliciting or working with the alters, the objections make two basic and closely related forms of argument. The first starts with the assumption that the alter phenomenon is iatrogenic [10,11]. From this perspective, it is reasonable to propose that alters have (usually) emerged in response to inappropriate therapeutic pressures, subtle or overt, and if their manifestations do not receive attention, then they will cease to exist. Deprived of reinforcements believed to instigate and to sustain the alters, it is assumed that they will wither into oblivion. The second argument starts with the assumption that there are more important therapeutic goals than treating the core phenomena of DID and that diverting attention from the alters while prioritizing the attaining of stability and function directs the treatment toward these more important or reasonable therapeutic objectives. It shares the implicit assumption that attention to the alters reinforces them and makes them a more prominent and difficult clinical problem to address.

The first objection is a matter of strong opinion, but definitive proof of the iatrogenesis of DID/DDNOS has yet to be presented [6]. There is widespread agreement that DID can be worsened and complicated by iatrogenic errors, and that additional personalities may be formed in response to a therapist's expectations and pressures [12–17]. Many also agree that a patient who has a form of DDNOS that falls just short of the diagnostic criteria for DID may be ''promoted'' to fulfill DID criteria by therapist expectation/pressure or by the pain inherent in the treatment of traumatic issues. The laboratory studies purporting to demonstrate the reality of iatrogenesis, however, fall far short of doing so [6,18] and are conceptually flawed

by the assumption that inducing an individual to manifest behavior consistent with DID is the same as the creation of DID. The following helps to illustrate the problem: if a person is induced to behave like a chicken under hypnosis, it does not follow that he should be given a diet appropriate for a chicken, kept in a chicken coop, or cooked for dinner.

The second objection is more complex and nuanced. Indeed, there are many times in the treatment of DID when concerns other than the phenomena of DID per se must be the center of clinical attention [7,19]. The treatment of the DID is only one aspect of an overall therapeutic strategy and may be a minor or incidental concern for long periods in some therapies. A strategy of omitting attention to the phenomena of DID, however, leaves the patients who suffer DID only partially treated and may condemn them to lives in which a definitive treatment and a complete cure is deliberately withheld from them. To initiate a course of treatment that from the first denies a patient a definitive resolution of his or her difficulties remains a questionable course of action [6,7,19].

In this article, I offer a perspective on working with alters in the treatment of DID. I draw on my experience in treating hundreds of patients who have DID and my clinical study of the treatments of thousands of others seen in consultation for colleagues or observed during their inpatient treatment at the Dissociative Disorders Program at The Institute of Pennsylvania Hospital, where I served as director for 8 years. My personal series of DID cases includes just under 170 DID patients who have achieved stable integration [5] in the course of our work together. Many others have reached integration but could not be followed up or re-evaluated in a manner that allows me to state that their integrations fulfilled criteria for stability [4].

What are alters?

Many attempts have been made to define and describe alters in DID patients. It is well appreciated that the minds of normal subjects and of psychiatric patients have a certain degree of differentiated modularity [20]. Concepts such as ego states [20,21], representations of interactions that have become generalized [22], affect scripts [23], and core conflictual relationship themes [24] address, from different perspectives, the phenomenon of persistent patterns of structure and behavior that can be found to underlie aspects of human psychology. One of the most widely accepted approaches to describing such phenomena is Watkins and Watkins' [20,21] work on ego states. They defined 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'' [21].

Normal ego state phenomena have very permeable boundaries; the more pathological ego states that are found in DID have boundaries that are often

relatively impermeable. All alters necessarily fall under the broad rubric of ego states, but most ego states are not alters. Ego states that are also alters generally have four characteristics that are not intrinsic to the ego state phenomenon per se [19]: (1) they have their own identities, involving a sense of self (a center of initiative and experience [25]); (2) they have a characteristic self-representation, which may be discordant with how the patient is generally seen or perceived; (3) they have their own senses of autobiographic memory, distinguishing what they understand to be their own actions and experiences from those done and experienced by other alters; and (4) they have a sense of ownership of their own experiences, actions, and thoughts, and may lack a sense of ownership of and a sense of responsibility for the action, experiences, and thoughts of other alters. Clinicians often find this latter point unsettling.

In 1988, Kluft [26] attempted to define the phenomenon of alternate identities or personality states:

> A disaggregate self-state (i.e., personality) is the mental address of a relatively stable and enduring particular pattern of selective mobilization of mental contents and functions, which may be behaviorally enacted with noteworthy role-taking and role-playing dimensions and sensitive to intrapsychic, interpersonal, and environmental stimuli. It is organized in and associated with a relatively stable (but order effect dependent) pattern of neuropsychophysiologic activation, and has crucial psychodynamic contents. It serves both as recipient, processor, and storage center for perceptions, experiences, and the processing of such in connection with past events and thoughts, or present and anticipated ones as well. It has its own identity and ideation, and a capacity for initiating thought processes and actions.

Alters are complex phenomena not easily encompassed by simple descriptions or definitions that may acknowledge some of their features but that fail to address the full range of their characteristics.

The development and nature of alter systems

Over a period of time, a person in the process of developing DID is likely to generate a number of alters in his or her attempt to cope with life situations and to find ways to live with intolerable circumstances. The alters may be understood as being developed in the service of sustaining a more fundamental "multiple reality disorder" that includes alternate and often incompatible ways of understanding and trying to live in a difficult world, including gross distortions of autobiographic experience and the debasement of concepts of safety and causality [4,5,26–28] in the interests of security and the protection of important relationships.

Illustration of an alter system

Lois (see references [6,27,28]) was the daughter of good, religious, but rigid and undemonstrative parents. The light of her life was her Uncle Ben,

who was warm, effusive, generous, and playful. His visits and her weekly excursions with him became the emotional center of her life. Over a period of time, Uncle Ben became more seductive and introduced several "games" into their times together. These games became "secret games" that progressed to sexual acts that Lois experienced as sometimes frightening, painful, pleasant, or stimulating but always overwhelming and confusing.

Table 1 illustrates the roster of alters discovered when Lois was mapped in treatment some 30 years later. Each alter had emerged to play a role in keeping Lois going and in protecting her from the loss of Ben, the person she most loved and the person by whom she was most abused. It is apparent that coping styles that served Lois well in her family during her difficult childhood and adolescence are prescriptions for disaster in dealing with the world at large and generally dangerous when used by an adult individual. For example, having sexually receptive and aggressive personalities such as Sherri and Vickie exerts a form of damage control under circumstances of chronic abuse by accepting sexual advances rather than being hurt or made to submit. Such stances, however, may lead to self-destructive and unstable relationships under other circumstances.

Alters' understanding of themselves and one another

Although situations are encountered in which alters are completely unaware of one another, it is more common to find varieties of asymmetric amnesia in which some alters know about others but are not known by all of those about whom they are aware. In a given patient, one may encounter

Table 1
Coping strategies and alter formation

Coping strategy	Alter or alters created
This did not happen	A Lois who knows, and a Lois who does not
I must have deserved it	Bad Lois, whose behavior would explain trauma as punishment
I must have wanted it	A sexual alter, Sherrie
I can control it better if I take charge	An aggressively sexual alter, Vickie
I would feel safe if I were a boy	Louis, Lois' male "twin"
I wish I were a big man who could prevent this	Big Jack, based on some person of power
I wish I were the one who could hurt someone and not be hurt	Uncle Ben, or a more disguised identification with the aggressor
I wish I could feel nothing	Jessie, who endures all yet feels nothing
I wish someone could replace me	"The Girls," who encapsulate specific experiences of trauma unknown to Lois
I wish someone would comfort me	Angel, with whom Lois imagines herself to be while the body is being exploited and "The Girls" are experiencing the trauma

From Kluft RP. Reflections on the traumatic memories of dissociative identity disorder patients. In: Lynn S, McConkey K, editors. Truth in memory. New York: Guilford; 1998. p. 315; with permission.

instances of mutual unawareness, directional or asymmetric amnesia, and alters aware of most or even all of the others.

When alters share a degree of mutual awareness of one another, they may understand themselves to have all manner of relationships with one another. For example, certain parts often care for or try to protect scared child parts. In addition, life experiences may be recapitulated in the alter system; for example, an alter based on an abuser may see itself entitled to hurt alters based on the patient's experiences of being unable to prevent or interrupt victimization by the abuser or abusers.

The alter system frequently replicates the DID patient's experience of the relationships and circumstances that prevailed in his or her family of origin. An "inner world" is commonly developed in which the alters interact. It is common that some alters active in the inner world may never assume executive control of the patient as the patient interacts with external others and may never manifest themselves in therapy unless they are sought out. Furthermore, events in this inner world constitute a "third reality" to the patient and may be experienced as just as real as events that take place in external reality [27]. Stored together in memory with autobiographic memory of "real world events" and often severed from indicators of their source or origin (source amnesia), events from the inner world may be reported as if they had occurred in external reality, often seriously complicating life and treatment.

The issue of complexity

Many clinicians have difficulty coming to grips with reports of large numbers of personalities. Patients with hundreds or even thousands of alters have been reported [26]. Often the large numbers in and of themselves evoke shock and disbelief, with countertransferential disparagement of the patient who claims such complexity and the clinician who reports such phenomena. My perspective is that reacting to the number itself rather than what the number signifies is counterproductive. Claims of a large number of alters should be heard empathically and explored thoughtfully. Kluft [26] listed 20 pathways into extreme complexity. These pathways can be condensed into four general mechanisms: (1) coping with particularly severe, sustained, and vicious abuse over a long period, (2) employing coping strategies that in themselves generate large numbers of alters, (3) using coping strategies driven by character issues, and (4) the sequelae of unique patient response patterns.

It stands to reason that more abuse may generate more alters to cope with and sequester the additional overwhelming experiences; however, the role of coping strategies in and of themselves in generating large numbers of alters may not be as apparent. Let us assume for the moment that Lois, who sequestered much abuse into a group of alters called "The Girls," had been taught by her religious parents to pray every night. Lois prayed every night after an abuse episode that God would make her into a "better

little girl'' so good and sweet and loveable that no one would ever want to hurt her. This prayerful wish involved the creation of a new, ''better'' alter after each occasion of mistreatment, with the goal of preventing further abuse. Each newly created alter would encounter the same fate as its predecessors because what drove Uncle Ben to abuse Lois was not under Lois' control. One patient in Kluft's [26] 1988 series of complex DID patients was abused several times per week by two male relatives for over 10 years and developed over 1000 alters in that manner.

Other DID patients may create a caretaker, protector, or consoling friend for each new trauma-based alter. Imagine an increasing number of abused child alters, as in the previous example, of which each would also have its own version of Big Jack. Numbers in the hundreds or thousands would be reached easily. Finally, some patients who have DID harbor rebirth fantasies. At some junctures, they may replicate their systems of alters, replacing those who endured ''the bad old days'' with new and undamaged versions of themselves, hoping to start all over and put their pasts behind them. Kluft [26] termed such events ''epochal division.'' The superceded group of alters often becomes inactive or is relegated to the inner world. In one patient known to the author, the same 20-plus alter system was replicated when the patient went from elementary school to junior high school, junior high school to high school, high school to college, and finally on the occasion of her marriage, leading to well over 100 alters. This process was repeated during the course of a painful divorce.

DID patients who are extremely avoidant, obsessive, or without strong nondissociative defenses are prone to develop larger numbers of alters. For the group without strong nondissociative defenses, dissociation is not a last-ditch defense—it is their first response to stress. In addition, some idiosyncratic patterns are encountered in which patients come up with unique strategies that lead to large numbers of alters. Some create elaborate inner worlds or multiple inner worlds and populate them with alters designed to have specific functions and roles in those inner worlds. Others imaginatively transform their histories to conform to myths, movies, television shows, or pieces of literature and generate large numbers of alters to play roles in them. Rarely, DID patients become involved with some system of symbolism or numerology and generate enormous systems of alters consistent with these systems. For example, one DID patient believed that seven was a powerful number for her and generated clusters of seven alters whenever severely overwhelmed beyond the capacities of the alters already in place.

In such cases, the large number of alters is a potentially unsettling distraction, but when placed in perspective, it need not be disquieting. With some unique exceptions, large systems based on considerations other than the characteristics of the abuse that had been experienced generally collapse uneventfully as the treatment moves forward. A large number of alters derived from the extensiveness of the abuse suffered generally indicates a prolonged and difficult course of treatment because it may prove necessary to process all

or most of that abuse, but it does not necessarily indicate a worse long-term outcome. Some complex DID patients demonstrate astonishing resilience.

A rationale for working directly with the alters

Working with the alters remains an unfamiliar area of practice to many mental health professionals. When a clinician accepts the possibility of working with the alters, a whole new avenue of interaction with the patient is possible. Exploring the alters and their meanings, like exploring a patient's other productions such as fantasies and dreams, may be stabilizing and encouraging for a patient who otherwise has never before felt heard and understood so completely. Toward this goal, a number of pragmatic considerations that are derived from personal clinical experience and from doing thousands of consultations over the course of 30 years are presented.

In working with DID, should a clinician work with the alters? If so, should the clinician try to elicit or bring to the surface the various alters, or simply to work with them as they present themselves spontaneously in the treatment setting? Those who question the genuineness of DID or believe that working with the alters reifies or concretizes the condition would respond to both concerns in the negative, maintaining that attention to such sociopsychologic artifacts, often iatrogenic, makes a bad situation worse. In contrast, those who are convinced that the condition occurs naturalistically would generally recommend working with the alters and eliciting alters to facilitate the treatment. Between these perspectives are those who believe that the condition occurs naturalistically and will talk to alters if they present spontaneously but hold the opinions that the condition can often be treated without directly accessing and working with the alters and that efforts to do so may reinforce the condition.

When I began my work with DID, I sought the advice of an eminent authority. This person believed that DID was an artifact and confidently predicted that nonreinforcement of the alters would lead to their disappearance. I followed his recommendations for months. One of two things happened: my patients who had DID stopped talking about their DID phenomena but were still miserable or their alters became more frantic and driven in their efforts to communicate their concerns to me, and the patients' situations deteriorated. Confronted with uniformly negative responses to my use of this strategy, I rethought the issue. I appreciated that the strategy I had used inflicted ongoing narcissistic injuries to my patients and was detrimental to the formation of a therapeutic alliance. I began to communicate with the alters and to make deliberate efforts to establish and maintain dialogs with them. With this approach, my patients uniformly stabilized and began to improve. A series of articles drawn from this work [4,5,29,30] reflects the positive impact of treatments that work with and elicit the participation of alters. Summarizing the results of this work, 89% of the patients who had DID in this series achieved stable integration. This work

also identified three groups of DID patients: one group that had relatively little comorbidity and moved rapidly toward improvement and integration; a second group that had considerable comorbidity and progressed more slowly and might or might not achieve full integration, and a third group that had serious comorbidity and external impediments to recovery and that progressed slowly and chaotically, rarely achieved integration, and generally would have been better served by a supportive treatment [31,32]. Similar groupings have been recognized by other investigators [33].

My experience has taught me again and again that approaching DID as if the alters were completely separate persons or as if the patient were a person whose subjective experience of having separate selves can be discounted is counterproductive. These approaches deny, dismiss, and disavow the nature of DID phenomenology and the subjective world of the DID patient. Such stances lead to failures of empathy and profound difficulties if not overt disruptions of the therapeutic alliance. The patient is a single individual whose personality is to have multiple personalities [8,19]. Although the personality systems of some patients who have DID may be sufficiently accessible for treatment to proceed with no need to access and address individual alters, others may be organized in a way that will not allow treatment to move forward without such efforts. In my experience, the former group is much smaller than the latter, making it more appropriate to assume that such efforts may prove necessary.

There are many reasons that might move a therapist to address and access alters individually or in groups instead of working on their issues through the apparent host personality. The host personality is the personality in apparent executive control most of the time over a particular period [34]. Many clinicians and theoreticians assume that the host constitutes the patient's true identity and should be regarded as the core of who the patient really is, but there is no scientific or clinical reason to proceed on this basis. Twenty such reasons for working with and accessing the alters are noted Box 1. The list could easily be longer. This list and the discussion that accompanies it draw heavily on Kluft [35].

Potential contraindications for working with alters

Having noted the advantages to be had from working with and accessing alters, it is important to acknowledge that there are reasons for avoiding such approaches that are not based on mere opinion and abstract theory but have a substantial legitimacy and merit under certain circumstances.

1. Notwithstanding the controversy raised in some forensic cases surrounding allegations that DID can be caused iatrogenically, the requirements of forensic assessments may preclude making any interventions that might later be vulnerable to the assertion that they may have created rather than investigated dissociative phenomena.

Box 1. Twenty reasons for working with and accessing the alters

1. Acknowledging the dissociative surface. The more the concept of the host personality is studied, the clearer it becomes that what has been understood to be the host personality is often the manifestation at the ''dissociative surface'' [28,35] of a far more complex phenomenon than is generally appreciated and represents an aggregation rather than a single entity. Many clinicians attribute to the host a strength, persistence, resilience, and face validity as ''the real person'' on the basis of the theoretic orientation of the therapist or the unconscious defensive efforts made by the therapist to make the strange and different feel more familiar and manageable. There is no basis in science or clinical experience to justify this stance. Such attributions also are often more a tribute to the presentation of a ''good act'' and a survival-oriented camouflaging of the DID due to the actions of many alters than to the stable presence of an actual core identity.
2. Decoding the dissociative surface. Working with and identifying alters allows us to decode the dissociative surface, which therapists are more likely to encounter than a host personality in pure culture. Unless efforts are made to access the alters and learn their manifestations, the therapist will not develop the capacity to interpret complex phenomena of the dissociative surface, appreciate the interactions within the alter system that are giving rise to them, and enlarge his or her capacity to understand and intervene effectively with the DID patient. The ''decoding'' process is addressed later.
3. Making alters stakeholders in the treatment. Engaging alters is likely to make them stakeholders in the therapy and more invested in, rather than oppositional to the treatment and its outcome. Because alters have senses of themselves, they are sensitive to narcissistic wounds, rejection, and dismissive treatment—all of which is inherent in any strategy that does not strive to reach out to them and instead promotes their being bypassed or neglected. Making efforts to reach them and solicit their participation and their perspectives holds the potential to diminish such difficulties and to enhance the therapeutic alliance.
4. Putting the ''host'' in perspective. Often the host is simply another alter and may not be seen by the other alters as constituting or representing the essential core of the patient.

In many if not most alter systems, the host is scorned and perceived as a ''wimp,'' a ''human shield,'' or ''cannon fodder'' by other alters. In some situations, one aspect of the host's role is to shield a part or parts understood to be the true core or identity of the person. Any proclamation by the therapist to the effect that the host is the patient's center and reason for being may encourage disruption rather than cooperation by other alters. It may convince them that the therapist does not understand what is going on, and is trying to impose an unwelcome and illegitimate authority on them.

5. Approaching reluctance respectfully. Most of what is withheld by DID patients is withheld by conscious decisions rather than by unconscious resistances to treatment. That is, the withholding is due to reluctance rather than to resistance. Alters may have knowledge that they withhold for a wide variety of reasons. Reluctance is best addressed with persuasion, and persuasion is more easily accomplished when one acknowledges and treats with respect the subjective reality and the perspectives of those (the parts) that one is trying to persuade. An ego state therapy ''family of self'' model [20,21,33] is very effective here.
6. Declining to collude with avoidance. If all alters are not directly accessible, then the failure to address them and their perceived experiences and concerns, which may play important roles and contain crucial mental content, constitutes a decision to leave major aspects of mental content, structure, and function unaddressed. Such a collusion with the patient to avoid addressing important issues and materials is what Langs [36] eloquently described as ''lie therapy'' and is usually ineffective. The problem is very analogous to what Freud [37] observed about secrets in psychotherapy. When there is an agreement to avoid the exploration of any particular area of the mind, all manner of mischief will congregate in that area, escaping exploration and undermining treatment.
7. Understanding alters/alters' behavior as communications. Alters are more than sociopsychologic phenomena. In expressing, personifying, and enacting wishes, defensive operations, object relationships, and the dynamics and genetics of symptomatic behaviors, enactments, and re-enactments, alters bring crucial material into the treatment. They express themselves in the transference, elicit countertransference, and are a major source of projective identification ''from behind the scenes.'' That is, they embody

and communicate material essential for a meaningful treatment. Their neglect constitutes lie therapy [36] and may cause the alters to initiate dysfunctional ''interventions'' to bring attention to their concerns or to punish the other alters or the therapist for their neglect and its perceived consequences.

8. Eroding amnesia by engaging alters. When the therapist asks the alters to talk about themselves, their attitudes, and their experiences and listens carefully and respectfully, it is easier to obtain history or undo amnesia due to withholding without making intrusive interventions that have the potential to generate inaccurate recollections. This approach avoids the perceived need for more intrusive or potentially ''leading'' techniques and efforts to ''pull out'' or extract the material against resistance/reluctance and reduces the risks of censorship, contamination, and confabulation.
9. Exploring and relieving symptoms due to alters' intrusions. Often the most rapid path to symptomatic relief is to address or access the alter or alters ''behind'' a problematic symptom, behavior, affective state, or perplexity and to negotiate with the alters for relief [38–40]. An alter-driven intrusion into the dissociative surface is the most common source of such disruptions. An hallucination may be the voice of an alter trying to make itself heard or issue a command; a ''made'' feeling or action may be an alter's efforts to impose its will on another; an unexplained pain may be the somatic discomfort component of a memory, the narrative structure of which remains obscure; and so forth.
10. Disabling ''being normal'' as self-sabotage. As the host strives to pass for ''normal,'' it often engages in such vigorous disavowals of present or potential problems that indicators of potential danger that might prompt preventive measures are banished from awareness or minimized and not communicated to the therapist. This pseudonormality and defensive disavowal facilitates revictimization [41]; the process of the therapy may falter and stall when the possibility of true understanding is avoided by the patient's presenting and trying to believe in a pseudo-normal facade. Regular efforts to access the alters and to draw on their perceptions, knowledge, and perspectives is useful in anticipating and avoiding crises [40].
11. Enhancing the impact of empathy. Empathic expression in direct conversation with an alter is much more effective

in eroding dissociative barriers and provides a more convincing corrective emotional experience than that alter's experiencing the therapist's empathy vicariously as it is expressed with, to, and through other alters. It helps to bear in mind that alters regularly cannot or will not own the experiences of other alters of whom they may not be aware and for whose experiences they may have amnesia. One of my workshop axioms is that ''DID is that form of psychopathology that dissolves in empathy.''

12. Bringing ''abuser alters'' into treatment. Alters based on abusers often cause chaos and instigate self-injury behind the scenes but are more likely to become amenable when regularly accessed and brought into the therapy. Their defensive narcissistic constellations often preclude their feeling included in approaches that do not address them directly. Their experience of the clinician's caring and empathy are crucial to their changing in a constructive manner. This concern may be problematic with alters of all sorts. Their not being directly addressed is often perceived as a rejection and a narcissistic insult.
13. Negotiating with alters as an aspect of treatment. Many approaches to the treatment of DID that are understood to be very useful by a consensus of those who treat dissociative disorders, such as ego-state therapy [20,21], Fine's version of tactical integrationalism [42,43], and hypnotic and nonhypnotic safety, containment, and shut-down techniques (eg, see [44–47]) require negotiating with the alter system. To discard such important and well-regarded interventions may imperil rather than improve the treatment of the DID patient.
14. Mobilizing currently inaccessible skills. Often a DID patient who is currently overwhelmed gives a history of significantly higher function in the past and indicates that the resources (such as job-related knowledge and skills) essential for better function are associated with a particular alter or alters that are currently not available. Accessing and mobilizing alters with such strengths may prove essential to the rehabilitation of a DID patient. The patient creates his or her own sense of safety through the application of his or her own skills.
15. Creating interactions that anticipate integration. Alters can be helped to overhear and view one another in action. Initial preoccupation with their differences from one another ultimately yields to an appreciation of their connections and commonalities. This awareness moves them toward better

communication, collaboration, mutual empathy and identification, and ultimately toward integration. The usual pathway by which this occurs is through the alters' shared experience of their encounters with the therapist [48].

16. Reaching out to and enlisting alters in the third reality. Often the reality of the inner world, the third reality [27], is so compelling that much of the patient's emotional energy and interest may be withdrawn from the here and now, leading to prolonged and painful difficulties in helping the patient address pressing concerns in external reality. The inner world may be inaccessible to or through the host for long periods. In fact, those in the inner world may see the host as an enemy of the inner world or a mere drone necessary to deal with the mundane or painful reality from which many alters have withdrawn. It may be possible for the therapist, by addressing the parts that have turned away from the external world, to communicate with those immersed in the third reality and bring them into the here and now or enlist their help in addressing problems in the here and now.
17. Resolving shame face-to-face. Work on shame dynamics [23] 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. Such encounters challenge the shamed part's perception that it is ''shorn from the herd'' and unwelcome by others. Efforts to reduce the shame of a particular alter by working through another alter, the host, are less effective than working directly with the alters who are experiencing the shame as their own. Without the direct subjective experience of the therapist's empathic attunement with their plight, shame-bound alters may not believe that they are truly accepted despite their difficulties, that their issues have actually been addressed, and that they have truly mastered their concerns.
18. Enlisting more mature alters to care for child alters. The treatment of DID is often complicated by the deeply felt needs of child alters, often expressed in their wishes or efforts to create a tangibly more gratifying childhood in a regressive relationship with the therapist. Putnam [49] wisely observed that the most appropriate person to respond to such perceived needs is not the therapist but the patient, who should be helped to mobilize more grown-up alters to provide the requested nurture and play experiences.

Addressing the patient as a family of self and helping particular alters work with the child alters facilitates this process and reduces the extent to which child alters obstruct the psychotherapy.

19. Avoiding re-enactments of rejection and neglect. For many patients who have DID, their experiences of neglect, not being listened to, empathic failure, and rejection have been as important or more important than overwhelming trauma in the development and perpetuation of their disorders. Attachment issues may prove to be major concerns. When a decision is made to avoid dealing directly with individual alters, the DID patient's childhood mistreatments by the omission of appropriate attention and consolation are recapitulated, re-enacted, and legitimized under the aegis of therapy.
20. Paving the way for integration. Integration involves the bringing together of alters. Integration occurs or can be facilitated when the reasons for maintaining the separateness have been resolved and when each alter has received what had been sequestered in the other alters and, in turn, has shared its unique experiences, reactions, and perspectives [48]. Without accessing, consulting, and working with individual alters, it is very difficult to be sure that these issues and concerns have been addressed. Follow-ups on such patients are discouraging. In 1985, I reported [2] that less than 3% of patients who had DID treated in this manner achieved and maintained integration. Many cases referred for consultation for distress subsequent to purported integrations or for the failure of apparent integrations are found to be related to alters that were never encountered in the treatment or that assumed to have spontaneously integrated but had merely absented themselves from the treatment process [50,51]. During the 1-month period in 2005 in which I wrote this article, I evaluated three female patients in their 50s whose prior therapists believed that they were integrated after the spontaneous presentation of alters in therapy and everyday life appeared to have ceased. The natural history of DID is that its manifestations wax and wane [2]. It is common for therapists who are unaware of this phenomenon and who do not make efforts to access alters to mistake fluctuations and reconfigurations of the DID process for improvements and cures. Therapists who make efforts to access alters and to follow their responses to treatment are less likely to make such errors.

2. In some DID personality systems, it may be found that all available alters are currently overwhelmed or trauma based and that the system is without parts able to function or to contain disruption and protect stability. In such cases, bringing other alters forward brings a risk of worsening the disequilibrium and should be avoided until the patient becomes more stable.
3. The patient's circumstances may necessitate that therapy should address issues in external reality and defer any exploration of the DID itself.
4. Patients who demonstrate compromised ego strength or whose ego strength resources are stretched to their limits by their life circumstances, situational stressors, comorbid mental disorders, medical illness, and other burdens must be discouraged from opening up their systems and their histories because they do not, at least at that point in time, have the psychologic resources to address the alters or trauma work [7,52]. They already "have too much on their plates."
5. In a therapy that must be supportive, it often is best to avoid deliberately bringing out alters that bring with them too much pain and concern for a patient who is already struggling to get by. When alters of this sort emerge spontaneously, they should be addressed supportively when necessary, but in general, their issues and memories should not be raised by the therapist. In some uncommon situations, such alters and their issues may intrude in a manner that is disruptive and may not respond to supportive and shut-down interventions. Under these circumstances, sometimes they have to be worked with until they are more settled and unburdened and the situation can be restabilized [53].
6. Many therapists begin work with DID patients without having become conversant with the dissociative disorders field, its literature, and its opportunities for training. Therapists should not proceed with exploratory work of any sort, access alters, or press for historical material until they have the expertise to undertake these endeavors in a manner that is safe for the patient.

Learning to identify manifestations of the alters at work

When an argument is being made that it is useful to work with alters, it is useful to wonder, "What does this mean in practice?" Patients who have DID are often under clinical observation for many years before they are diagnosed with DID. It is not unusual for clinicians to encounter a patient who has received the DID diagnosis from other diagnosticians and emerge with the impression that the disorder is not present. Clearly, the alters that one is urged to work with do not appear to be making themselves manifest in a recognizable way most of the time. To work with the alters, one must learn how to recognize and find them.

A study of the natural history of DID [2] found that most patients who have DID spend most of their time manifesting little or no evidence of DID.

With the exception of a small minority of DID patients who are consistently and dramatically florid in their presentations, DID is, as Thomas Gutheil observed, ''a psychopathology of hiddenness'' [2]. For most patients who have DID, there are certain ''windows of diagnosability'' (due to stress, loss, retraumatization, injury, illness, a contemporary situation that triggers a strong connection to the traumatic past, or when the alter system has been opened up by psychotherapy) during which the symptoms of DID can be more readily observed or elicited [2].

Most of the time, even in treatments by mental health professionals who are working with DID patients whose diagnosis has already been made and confirmed, the clinicians who work with DID patients are confronted with the ''dissociative surface'' [28,35] referred to earlier. ''Overt switches constitute a small minority of the alters' actual behavior'' [35]. The dissociative surface is the external manifestation of the alters' behaviors and interactions with the external environment and with the third reality—the inner world of the alters [27]. The inner world may be accorded equal or superior importance than the outer world of external reality.

Without an appreciation that much of the alters' behavior is expressed indirectly by their impacts upon the host from behind the scenes and an approach to beginning to decode and work with their impact upon the dissociative surface, clinicians are restricted to dealing with the ''host'' (the alter in apparent executive control most of the time over a period of time) and those alters that assume executive control after overt switches. The dissociative surface, however, is composed of manifestations more complex and varied than these (Box 2).

Alters may pass for the host or be copies of the host. Several may switch off in a tag-team manner but fail to change in appearance. Clinicians often encounter mixed combinations of alters. These combinations may include a dominant alter's (1) showing aspects of one or more other alters that are copresent, (2) following the instructions of another alter, (3) response to the impact of intrusions of other alters, and (4) being overwhelmed and experiencing its behavior as made or imposed from elsewhere. These influences may come directly from one alter to another, from an alter itself influenced or commanded by a more powerful alter (up the food chain), and from the inner world of alters that often includes alters that rarely or never take over executive control in the external world and may be unknown to most of the personality system.

The most productive way to go about decoding the dissociative surface is to take careful note of the appearance, voice, and mannerisms of each alter one encounters and to observe the patient when one has reason to believe that a particular alter is active but its manifestations are somewhat different or inconsistent. The clinician may make an observation of a change in these qualities to the host or to whichever alter is understood to be primarily present and ask for clarification. This interaction may be followed by a request to talk directly to the present alter or the alter whose

Box 2. The dissociative surface

The Host or the ''Usual Patient''
The Semblance of the Host or ''Usual Patient''
- Passing For the Host
- Isomorphism
- Tag-Teaming

Copresence Combinations
- Mixed Presentations
  1. Cooperations
  2. Clashes
  3. Vectors
  4. Temporary Blendings
- Fluctuating Presentations
- One-Plus Presentations
- Shifting One-Plus Presentations

Instructed Behavior
Intrusions
- Simple
- ''Up the Food Chain''
- From the ''Third Reality''

Imposed or ''Made'' Behavior
- Simple
- ''Up the Food Chain''

Switching, Rapid Switching, and Shifting

influence is changing the appearance or behavior of the one ostensibly in control.

For example, if a clinician understands himself to be speaking to Lois but notices that she is becoming somewhat confrontational, appreciates that her voice has become somewhat deeper, and notes that her body language has become less explicitly feminine, then the dialog might proceed in the following manner:

Doctor: Lois, as we have been talking about these issues, I have noticed that you are seeming to be more assertive and opinionated than you usually are and taking issue with some matters that usually are not a problem for you. Your voice and manner seem to have changed a bit. Are you aware of anything out of the ordinary?

Lois: I don't know, but I am feeling and thinking a little different from usual. A little out of it, detached.

Doctor: Are you aware of anything that might be influencing your point of view?

Lois: Well, I hear a voice telling me to be careful, not to just go along with what you were saying.

Doctor: Please tell me all that you can about this voice.

Lois: It is male. And it seems worried, and angry.

Doctor: Is this voice familiar to you?

Lois: It sounds like Jack (usually referred to as "Big Jack"). But I'm not sure.

Doctor: OK. Well, Jack, or whoever else it might be if it is not Jack, I do want to understand what is concerning you and to take your concerns into account.

Lois: It is Jack. [Switches to Big Jack] You keep on getting her to talk about the stuff that happened, and she goes along 'cause that's what she does. But I don't think you get it. She can't handle this right now. She isn't telling you that she is still upset about the last things she talked about, and you didn't notice that. She's trying to give you what you ask for even if it messes her up. She can't say no to you.

Doctor: Well, that's important Jack, and I thank you for the information. Let me talk to Lois again, while you stay nearby and pitch in, and let's try to figure things out.

After a series of such encounters with various alters, the clinician would be in a position to make a reasonable guess when Lois (or some other alter) was being intruded on by particular others, even if the others were not taking over. With such awareness, the clinician could make remarks and observations that take into account the concerns and issues of the alters that seem to be playing a covert role in the conversation. For example, some months later, the clinician might notice some signs that Big Jack was near the surface while the clinician was discussing a possible medication change with Lois.

Doctor: It seems that Big Jack is taking some interest in this conversation. Big Jack, if you have some concerns about this medication I am recommending, I'd like to hear from you.

Lois: [In Big Jack's demeanor] You know she is going to look it up on the Internet, and if she's afraid it'll make her gain weight, she is not going to take it. And I'll be stuck with all of them little ones screaming inside about how bad they feel, and they will be angry as hell at Lois. They'll sneak out and take the medicine. If Lois finds out she'll stop eating and she'll be too afraid of getting you angry to really tell you what is going on. Do you think you really know what the hell you are doing with these pills and how they mess up these girls inside?

After following up on several changes in appearance in the host or other alters who are not being replaced but are being influenced by still other alters, the clinician can develop an increasingly rapid and accurate appreciation of which alters are becoming involved with certain issues and concerns.

This ability to infer the involvement of alters which have not assumed complete executive control but which are exerting important influences from behind the scenes allows the clinician to follow the alters' actions even in the absence of overt switching and makes it possible to follow and to treat DID in a more knowledgeable and nuanced manner.

Accessing alters for the purposes of treatment

Accessing alters is a venerable topic, discussed in depth in classic texts on the treatment of DID (eg, see reference [49]). After access has occurred—by an alter's spontaneous emergence in response to a direct request by the therapist or as a result of a hypnotic intervention—it is often possible to access an alter again by direct request or by initiating discussion of an issue or event that concerns them. At times, one or more alters may oppose the therapist's efforts to speak to a particular alter; this failure to gain access should be followed by inquiry about why access is being denied. The many possible rationales for refusal of access include all manner of apprehensions about the potential consequences of the anticipated interaction between the therapist and the alter he or she is trying to reach and concerns about this interaction's impact on the inner world. The therapist should (1) appreciate that these blockages are indications of important work that must be done before the alter system is ready to move forward into whatever material may be coming up next and (2) almost always work with the apprehensive alters rather than exert pressure for compliance with his or her request. The exceptions to this approach involve circumstances under which the therapist has reason to be concerned about the safety of the patient or about someone whom the patient may be at risk for harming.

The importance of working with alters to optimize pharmacotherapy for dissociative identity disorder

Many of the symptoms suffered by patients who have DID appear to be reasonable targets for psychopharmacology, but before prescribing, it is useful to try to learn what is behind the target symptom [54]. This determination is often impossible until one has established some relationship with the patient and has become at least somewhat familiar with the alter system. In his classic review of the psychopharmacologic treatment of DID, Loewenstein [54] discussed the importance of appreciating that many symptoms suffered by DID patients are best approached with other therapeutic modalities. Hypnosis is often useful to explore and control problematic symptoms in patients who have DID.

It is often useful to ask for feedback from all alters about the impact of a medication that has been prescribed or about the effects of a medication given the patient by a prior prescriber. The personality of the DID patient with whom one is conversing may or may not have all of the memories

relevant to assessing the safety or the effectiveness of a medication. On dozens of occasions, I have learned that I was about to prescribe or had actually already prescribed a medication to which the patient had had a serious reaction that was unknown to or had been forgotten by the alter or alters to which I was speaking.

It is also useful to ask for alters' perceptions of why particular symptoms are occurring when they occur and to inquire whether any alter has an idea of whether the symptom has been experienced before. The latter inquiry raises a fascinating differential: is the symptom recurrent because it is part of a recurrent autonomous process such as an affective disorder? Or, is the symptom recurrent because it is (1) part of a memory/body memory that has been triggered by some material in the treatment? (2) part of a flashback or revivification? or (3) experienced as being created in the here and now due to a reenactment of a past trauma or one analogous to it in the inner world of the alter system?

The psychopharmacologist who determines that the symptom is the epiphenomenon of the DID patient's response to trauma or to problematic interactions among the alters next has to determine whether the symptom is within striking distance of the psychotherapeutic process itself. It does the patient and the therapy no good to withhold medication because a psychotherapeutic cure may be possible if, at present, the symptom is problematic and the treatment process itself does not yet have the capacity to contain the symptom. It may be safer to prescribe knowing that one may, at best, elicit a response from an active placebo than to withhold medication and insist that the DID patient resolve the symptoms in question when one knows that such a solution may be months or years in coming.

Case 1

Beverly was subject to profound panic attacks that were frequent and only partially responsive to massive doses of selective serotonin reuptake inhibitors and benzodiazepines. Her psychiatrist learned from the alters that the panic attacks reflected Beverly's experience of the panic of two child personalities. The psychiatrist asked all alters to listen in and participate in a discussion of treatment options. The alters came up with the strategy of creating a safe place to which these child alters could be sent, along with some protective and consoling alters. Furthermore, a wall would be created that would protect the remaining alters from experiencing the disruptive panic. The psychiatrist helped the patient create these images with the use of hypnosis, and made a tape that could be used to reinforce and strengthen this approach. When the patient demonstrated the ability to use autohypnosis to repeat his interventions successfully, Beverly was sent home with the instruction to use the tape and to practice the autohypnotic containment strategy she had been taught. Medication was not prescribed for the symptoms of panic.

Case 2

Early in the treatment of Wendy, a talented professional woman who had DID, her psychiatrist became convinced, in contrast to the opinions of Wendy and her primary care doctor, that her painful and disabling somatoform symptoms were recapitulating the pain associated with particular abuses. Wendy had reported painful traumatic experiences, aspects of which might have been recreated in these symptoms; however, preoccupied with matters of safety; maintaining her function as a wife, mother, and professional person; and dealing with contemporary stressors, she was by no means prepared to explore the terrible experiences her psychiatrist believed to underlie and determine her many severe pain problems. The psychiatrist, in consultation with Wendy's primary care physician, made the decision to treat the severe pains with moderate doses of oxycodone. Wendy became able to carry on her personal and professional lives. After 3 years of additional psychotherapy while maintained on oxycodone, Wendy was a much stronger individual and had demonstrated her capacity to work through painful memories without decompensating. At this point, the memories the psychiatrist thought were associated with her pains were accessed and processed. As the power of these memories diminished, Wendy's opiate analgesic medications could be gradually tapered and then discontinued uneventfully. She has remained free of these symptoms for several years.

Summary

The treatment of DID is facilitated by therapists' being prepared to work directly with alters. Interventions that access and involve the alters in the treatment are vital components of the successful treatment of DID and should be a part of the therapeutic armamentarium of those who treat this patient population.

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