THE EVOLUTION OF ALTER PERSONALITY STATES IN DISSOCIATIVE IDENTITY DISORDER

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Though several theories have been proposed to explain the manifestation of alter personality states in dissociative identity disorder (DID), the majority have failed to explain how alters develop over the life span and why the disorder becomes more complex after childhood. Expanding on Marnier (1991) and Putnam's (1995) concept of a developmental window of vulnerability for DID, this article proposes a three-stage model of alter personality formation, integrating theory and research on hypnotizability and imaginary companionship with perspectives on individuation and identity formation in adolescence. The author also speculates about possible courses of development leading to other trauma-related disorders. The author proposes that alters evolve out of childhood imaginary companions that merge with dissociative states of consciousness before individuating into distinct personality states during adolescence. Treatment considerations are raised emphasizing the need to diagnose DID early in its course of development before the alters have become invested in their separateness and begun fighting for control over the body.

Introduction

Dissociative identity disorder (DID) has been described as the most extreme response to psychological trauma (Putnam, 1989), the most striking feature of which is the presence of two or more personality or identity states that recurrently take control over the body. Large-scale epidemiological research (Putnam, Guroff, Silberman, Barban, & Post, 1986; Schultz, Braun, & Kluft, 1989) links DID to various forms of childhood abuse. However, the same research indicates most patients do not get diagnosed until their mid to late 20s, spending years in the mental health system before they are accurately diagnosed and treated. Initially serving an adaptive function by protecting the child in the face of severe and overwhelming psychological trauma, reliance on the dissociative defenses creates problems in the course of development, interfering with social, occupational, and familial relationships. In many cases what leads a patient into treatment are bizarre and frightening experiences such as waking up 300 miles away from home with no memory of how he or she got there.

Though several etiological theories have been proposed, ranging from attachment to state-transition to neurological models (Barach, 1991; Blizard, 1997; Li & Spiegel, 1992; Putnam, 1988), how alter personalities develop over the life span has not been adequately explained and remains open to debate. Most of what has been written about the natural history of DID comes from the clinical observations of Kluft (1993) who noted that the disorder usually becomes more complex after childhood and that the symptom picture changes from a florid presentation in the 20s to a more depressive presentation in the 30s before dissipating in late adulthood. Even after considering Kluft's observations, however, several important questions remain unanswered. Do alter personalities develop spontaneously, or is their development more gradual? Is there a rela-

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tion between alter personalities and childhood imaginary companions? If so, what leads to the transformation from companion to alter? At what point do alters develop into distinct personalities? At what point do alters emerge in the every day world? What determines which alters emerge in the lived-world? How is the core set of identities that predominate adulthood determined? Why do alters fight for control over the body? When does this fighting begin?

Putnam’s (1995) review of the psychological literature reveals that “few data actually link dissociative disorders to developmental psychopathological constructs” (p. 581). He concluded that “much work remains on the developmental substrates of dissociation” (p. 603). Fink (1988) emphasized the importance of life span developmental models noting that “inclusion of a developmental perspective offers a number of advantages to the study and treatment of patients with multiple personality disorder (MPD) and other dissociative disorders” (p. 47). This article examines the evolution of alter personalities across the life span, integrating theories and research on infancy and early childhood development with perspectives on individuation and identity formation in adolescence. While the author acknowledges these hypotheses are speculative and require further investigation and validation, they are believed to contribute to the demystification of this intriguing disorder.

A Brief History of DID

Ross (1989) commented that “the first step in understanding MPD is to review its history, placing the disorder in a broad context” (p. 6). Among the most historic of the psychiatric disorders, the study of multiple personalities can be traced to ancient forms of shamanism and demonic spirit possession (Braude, 1995). Clinical interest in DID can be traced to Puseygur’s practice of magnetic sleep, Charcot’s experimentation with hypnosis, and Janet’s work with hysterics at the Salpetriere. It was Janet, in fact, who coined the term dissociation to describe the split in consciousness that resulted when patients were exposed to traumatic events.

Albeit brief, interest in dissociation swept across Europe during the late 1800s, only to give way to the rise of behaviorism and the emergence of schizophrenia. These factors along with Freud’s repudiation of the incestuous seduction theory would contribute to the demise of multiple personality so that only a handful of cases would be reported in the literature during the first half of the twentieth century (Ross, 1989). By most accounts, it was not until “Eve” and “Sybil” that DID, then referred to as MPD would gain renewed attention among mental health professionals and the popular media. These two cases, along with psychophysiological research led by Ludwig, Brandsman, Wilbur, Bendfeldt, and Jameson (1972) and Larmore, Ludwig, and Cain (1977); the Vietnam War; and the Women’s Liberation Movement, would push trauma back into the forefront of psychological research and contribute to the recognition of MPD as a diagnosable psychiatric condition in the Diagnostic and Statistical Manual of Mental Disorders-3rd ed. (DSM-III). After surviving a name change to DID in the fourth edition, interest in the dissociative disorders appears to be at an all-time high, with the last couple of decades bearing witness to an exponential increase in the number of cases reported in the literature (Ross, 1991).

An Iatrogenic Artifact or a Legitimate Psychiatric Condition?

Perhaps no other disorder has endured as much skepticism as DID. One problem that has plagued DID is the way it has been presented as a mystical, exotic disorder that can only be treated in a certain way by certain clinicians. Those who question the disorder conceptualize it as an iatrogenic artifact of the therapeutic relationship where naive, needy, overdramatic patients manufacture alter identities in response to media influence, hypnotic techniques, and the demands of their therapists. Spanos, Weekes, and Bertrand (1985) presented research supportive of this notion demonstrating that college students were able to manufacture alter identity states under hypnotic instruction. Others have commented on what they see as a disproportionate number of DID cases diagnosed in North America, compared to the rest of the world, as evidence that DID exists through media and therapeutic influence (Fahy, 1988; Mersky, 1992).

A closer look at the literature, however, does not reveal much support for the iatrogenic position. Ross, Norton, and Fraser (1989) collected data on 236 cases from four groups of clinicians: general Canadian psychiatrists, Canadian psychiatrists who specialize in DID, American psychiatrists who specialize in DID, and a sample of nonmedical Canadian and American psychothera-
pists. The data were analyzed in several ways relative to the iatrogenic position. First, assuming the iatrogenic position is correct, one might hypothesize a higher number of alter personalities per client in the cases seen by the specialists. No such difference was found. A second analysis examined whether hypnosis resulted in the proliferation of alter personalities. Cases were divided into three groups: patients who had never been hypnotized, patients who had been hypnotized only after diagnosis, and patients who had been hypnotized before and after diagnosis. If hypnosis is responsible for creating alter personalities, as posited by the iatrogenic position, the group that had been hypnotized prior to diagnosis should have demonstrated a greater number of personalities in addition to a more graphic presentation of the disorder. Once again, no significant differences were found. These findings poke holes in the notion that DID is influenced by hypnotic techniques and therapists eager to diagnose the condition.

In other research, Schultz et al. (1989) investigated the therapist's role in DID by collecting data on 355 cases of DID and 235 cases of major depression from 448 independent clinicians. One hundred forty-two clinicians each provided information on one case of DID and one case of major depression. These cases were compared to reports of 93 cases of major depression provided by clinicians who did not report a case of DID. The iatrogenic position would predict that cases of depression reported by clinicians working with DID patients should be more exaggerated in terms of dissociative symptomatology due to the clinicians' eagerness to diagnose DID. No differences in dissociative symptomatology were found between the two groups of major depressives.

Recent investigations continue to question the accuracy of the iatrogenic position. Beere, Pica, and Maurer (1996) found that dissociative college students endorsed dissociative symptoms independent of the need to present themselves in a favorable light. Research by Bowman (1997) revealed that DID cases have been increasing worldwide in countries as diverse as Australia, Turkey, Italy, the Netherlands, and Japan. These findings contradict the needy-patient theory and the conceptualization of DID as a North American phenomenon.

**Toward a Theory of DID**

To fully understand DID is to understand the developmental factors that give rise to this complex disorder. In the past decade, writers have begun to talk about a developmental window of vulnerability for DID. Marmer (1991) suggested "the window between 18 mos and 4 to 5 years of age represents the period of greatest vulnerability for the development of DID" (p. 685). He attributed this to the tendency to use splitting defenses during this time in development and the still cloudy distinction between self and object. Putnam (1995) extended this window of vulnerability after reviewing the work of several clinicians who documented initial personalities emerging between the ages 3 and 8 (Bliss, 1980; Coons, Bowman, & Milstein, 1988; Greaves, 1980; Putnam et al., 1986). Putnam and colleagues noted "a significant negative correlation between the age of first appearance of an alter personality and the number of alter personalities" (Putnam et al., 1986, p. 587). This finding is consistent with the observations of Allison and Schwartz (1980) who found that children traumatized before age 6 displayed greater disorganization and a larger number of personalities, while children traumatized after 8 years of age tended to exhibit fewer personalities and greater ego strength.

While the author agrees that alter personalities are created during a window of vulnerability (between ages 2 and 8), it is possible that early life experiences may shape the infant in ways that predispose him or her to developing alter personalities later in life. Stated differently, children who develop DID may move into the developmental window wired in a way that makes them more vulnerable to developing alter personalities than other traumatized children. Further, while alters may take form during the developmental window, the author takes the position that their development is not complete. They continue to be shaped during latency, merging with dissociative states of consciousness, before evolving into distinct personalities during adolescence.

**The Core Self**

Stern's (1985) research suggests that the most important task the infant faces in the first 6 months of life is the development of a core self. This development of a core self provides the basic context from which to integrate and make sense of further life experiences. Stern defined the core self as the secure sense of being a unified, integrated person; one who exerts control over the initiation and continuance of his or her actions; experiences the self as a single, bounded entity; is
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able to tolerate, discriminate, and own affectively charged experiences that are recognized as coming from the self; and experiences a continuity of experiences across time, leading to the development of a life history. Stern referred to these aspects of core self in terms of agency, coherence, affectivity, and continuity.

Fink (1988) commented on the similarity between the symptoms exhibited in DID and disruptions in various aspects of the core self. For instance, he equated disruptions in agency with the patient's lack of control over the body, disruptions in coherence with the subjective experience of multiple selves, disruptions in affectivity with the inability to tolerate intense emotional experiences, and disruptions in continuity with episodes of memory loss and confusing past with present. An important point to note is that these disruptions may not be traumatically induced. Outlining a model to understand the context from which dissociative pathology arises, Fink suggested that the "pathologic findings inherent in MPD reflect a predominant disorganization in core self experiences" (p. 46).

Concrete Operational Thinking, Hypnotizability, and Imaginary Companionship

Assuming Fink's theory is correct, children who develop DID may be organized in ways that make them prone to developing this disorder. They lack control over their bodies, experience internal fragmentation, have trouble integrating emotional experiences, and have a tendency to confuse past with present. According to this author, however, what determines whether the child will develop DID depends more on whether he or she is traumatized at a point in life that allows for the creation of alter personalities.

There are several developmental factors that make the window of vulnerability concept enticing to theorists, researchers, and clinicians. From what we have learned from Piaget (though more recent research [Harter, 1988] raises important questions about the accuracy of Piaget's traditional concepts), during this time in development, the child operates at a preoperational to concrete operational level of cognitive reasoning, interpreting the environment in rigid, polarized, and concrete ways. It has been demonstrated that dissociative individuals and patients diagnosed with DID do not respond well to ambiguity and have trouble integrating new experiences into the way they have come to understand themselves and the world around them (Beere, 1996; Beere & Pica, 1995; Fine, 1988). Their thinking tends to be fairly compartmentalized, perceiving things in black-and-white, good or bad, all-or-nothing terms just like the preoperational and concrete operational child. Ross and Gahan (1988) noted that discussions of DID patients are often marked by overgeneralizations, dichotomous thinking, and selective abstraction. They suggested that treatment might be facilitated by addressing these cognitive distortions. Fine (1991) suggested that cognitive distortions might be responsible for maintaining the dissociation of powerful affects. She urged therapists to correct these distortions in thinking before beginning abreactive work.

In addition to thinking in concrete and dichotomous ways, the child, during this window of vulnerability, is believed to be highly hypnotizable and possess the capacity to form imaginary companions. Putnam (1989) reviewed research (Ambrose, 1961; Gardner, 1974, 1977; Gardner & Olness, 1981; London, 1965; London & Cooper, 1969; Place, 1984; Williams, 1981) that suggests children are more hypnotizable than adults and that their hypnotic capacity peaks at about age 10 before declining during adolescence and stabilizing in adulthood. It seems reasonable to conclude that children use this "natural" hypnotic capacity to dissociate in response to psychosocial stresses. Given equal circumstances, children who display the highest hypnotic capacity will find it easier to dissociate.

A critical point to note is the absence of a soothing caregiver, the lack of which causes the child to rely on the dissociative defenses to soothe and protect the self. With continued reliance on the dissociative defenses, distinctions between fantasy and reality, past and present, become difficult, if not impossible to distinguish. Without knowing the conditions under which these children live, teachers, babysitters, and neighbors are likely see these kids as moody, hyperactive, shy and withdrawn when really they may be experiencing continuous dissociation, drifting in and out of fantasy depending on the stress they experience in the environment. Kluft (1993) noted that these children may exhibit many behaviors resulting in their misdiagnosis. These include "trance-like behaviors; fluctuations in abilities, age-appropriateness, and moods; intermittent depression; amnesia; hallucinated voices; passive
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influence experiences; disavowed polarized behaviors; and disavowed witnessed behaviors” (p. 23).

About the same time the child begins using dissociation to escape immediate threats in the lived-world, he or she stumbles across another means by which to protect the self from owning the horrendous experiences of traumatic abuse, namely, the ability to form imaginary companions. Dierker, Davis, and Sanders (1995) noted that approximately one-third of all children between the ages 2 and 10 (consistent with the developmental window of vulnerability) develop imaginary companions. However, while imaginary companionship has been accepted as a normal developmental experience in some young boys and girls, the role they serve has yet to be fully explained. Some of the pioneer writers on this topic, Wickes (1966) and Nagiera (1969), believe children use imaginary companions to meet their psychological needs. Nagiera suggested children use imaginary companions as scapegoats for their failures, to express unacceptable impulses and wishes, and to replace the loss of significant others. Of course, there is the issue of individual variability. Some children may be more fantasy-prone than others, enabling them to use their companions in unique ways. Lynn, Rhue, and Green (1988) identified a particular group of fantasy-prone individuals, approximately 4% of the population, who are highly hypnotizable, hallucinate vividly, and have trouble distinguishing between fantasy and reality. Might these be the children who develop DID?

Differentiating normal and pathological uses of imaginary companions, Wickes suggested that imaginary companions serve a transient function, in the “normal” case, and are discarded when the child no longer needs them. She discussed the case of a little girl, an only child, who lived in a neighborhood where there were not many children with whom to play. The girl created a garden of imaginary companions in her back yard to keep herself stimulated and amused. When she began school and began interacting with children her own age, the imaginary companions disappeared.

This is quite different from the way imaginary companions are used in the pathological case, where the child uses them to escape from reality, furnishing what Wickes described as “a basis for neurotic withdrawal” (p. 206). Conceptualizing imaginary companions in a way which may help us understand the development of DID, Wickes notes that the pathological use of imaginary companions often produces a split between the thinking self and the self of feeling and relationships, personifying those things the child cannot own, accept, or tolerate as coming from or happening to the self.

There is a growing line of thought linking imaginary companions with alter identity states. Lovinger (1983) suggested that children who develop DID may be prone to using imaginary companions to master the developmental demands of early childhood. Young (1988) described imaginary companions as “frequently forgotten precursors of subsequent personalities” (p. 15). He provided several clinical examples of alters that developed originally as imaginary companions and later emerged in treatment. Katy, for example, created an imaginary companion named Ann who played with Katy when Katy hid in the closet from an abusive father. Ann later emerged in treatment as a child alter. Betty’s imaginary playmate, Elizabeth, did all the naughty things Betty could not do. Michelle played with imaginary playmates when her parents locked her in the yellow room. These playmates developed into alters that took over for Michelle when she felt stressed.

Among the few investigations of imaginary companions, Sanders (1992) interviewed 14 DID patients about their experiences with childhood imaginary companions. Seventy-eight percent said they were still in touch with their imaginary companions. A question that begs to be asked is were these imaginary companions, or were they really alters? Sanders, unfortunately, did not pursue this line of questioning. In many cases, the companions served specific childhood functions, providing company, consolation, and protection, as well as expressing anger, taking blame, and doing things the child could not do. Like Bliss (1984) and Young (1988) before her, who wrote about the difficulty distinguishing imaginary companions and alter personalities, Sanders suggested there may, in fact, be no distinction between the two. She concluded that:

One possible relation between an imaginary companion and an alter is that in the developmental history of the multiple there is a change in the phenomenological experience such that the imaginary companion becomes an alter. An alternative is that there is no transition. It may be that for the multiple, the childhood imaginary companion experience is subjectively the same as the alter personality experience, once the childhood experience is seen in a new light. That is to say, that what was once considered to be an imaginary companion is
now seen to have been an alter personality... what it implies is that the early imaginary companions of multiples may possess characteristics not ordinarily ascribed to the imaginary companions of normal children... chief among these is the capacity for independent action, that is, action which runs counter to the conscious wishes of the child or for which the child is amnestic. (p. 162)

The Evolution of Alter Personalities: A Three-Stage Theory

Expanding on the notions of Sanders, Bliss, and Young, the current theory proposes that alters evolve as extensions of childhood imaginary companions. Without getting too ahead of the discussion that follows, the transformation from companion to "alter" is hypothesized to occur during adolescence when the alters respond to a need to individuate and establish their own identities separate from the original personality and the rest of the companions. Before moving on, the reader is reminded that the theory is speculative and merits further investigation, venturing into new areas that have yet to be explored by dissociation researchers and theorists. Again, the goal is not to provide the final word on alter personality formation, but to initiate thought about an aspect of DID that remains open to question.

The theory proposes three stages in the development of alter personalities that characterize adult DID. These stages are illustrated in Figure 1. Figure 2 depicts alternative courses of development leading to trauma-related disorders, including dissociative disorder not otherwise specified (DDNOS), posttraumatic stress disorder (PTSD), acute stress disorder, DID superimposed on a borderline personality structure, and schizodissociative disorder. A critical point to note is that the process of alter personality formation may be broken at any time in the developmental process. For example, a child may be removed from an abusive home, or find refuge, comfort, and protection in a grandparent, uncle, sibling, or therapist. With these outlets to process and make sense of the traumatic experience and the avoidance of further traumatization, the child may no longer feel the need to delve into fantasy or defer to imaginary companions as a way to cope with a chaotic and unfriendly world.

Stage One

Stage one begins when the child moves into the developmental window for DID. In stage one, the child, already struggling with a disturbance in the sense of core self, defers aspects of the traumatic experiences to age-appropriate imaginary companions. These "aspects" include memories, thoughts, and feelings that are too threatening to own as happening to or coming from oneself. At this point, the child is not consciously aware of the association between the companion and the traumatic experience, though the dissociated state and the imaginary companion have been linked. One may begin to hear the child talk about a boy named "Jimmy" who is weak and lets bad things happen to him, or "Dave" who protects all the little boys from mean adults, or "Susie" the bad girl who makes Daddy hit her. Frightened, hostile, good, bad, sexualized, protective, and self-punishing companions begin to emerge as the child attempts to cope with and own overwhelming feelings of anger, fear, shame, and self-devaluation and to make sense of why someone in whom they trust would hurt them in such ways.

Figure 2 outlines several different experiences that may impact stage one development. Some children, for example, may experience severe and repetitive trauma prior to entering the developmental window. Will these children develop classic DID symptoms? As depicted in Figure 2, the answer is no. These children are apt to manifest some form of psychosis or borderline personality disorder. However, should the trauma continue during the developmental window, one might wit-
ness the development of what Ross (1995) referred to as a "schizodissociative" condition, or DID/DDNOS (depending on the capacity for imaginary companionship) superimposed on a borderline personality structure. Moreover, the earlier the trauma is experienced during the developmental window, the more likely the DID/DDNOS patient will exhibit an underlying borderline personality organization in addition to a greater number of personalities. These individuals will be most difficult to treat.

A second issue to consider is the extent to which the child is traumatized during stage one. If the child does not experience any trauma during the developmental window there is no chance he or she will develop DID. However, what if the child experiences a single or isolated trauma(s)? Chances are that he or she will experience no major affective disturbances if a soothing caretaker or significant other is present. On the other hand, if the trauma(s) is severe and no one soothes the child after the traumatic event(s), the child may exhibit anxiety, depression, impulse control problems, and/or conduct disturbance. In terms of dissociative pathology, the child may display prominent dissociative symptoms over the course of development, but is not likely to develop DID. This is because the trauma stopped at some point or was not continuous enough to allow companions to merge with dissociative states and eventually evolve into alter personalities. Another possibility is that the child does not possess the capacity to form imaginary companions and relies solely on dissociative defenses to cope with the trauma(s). Children, in these cases, might receive a DDNOS or childhood PTSD diagnosis, experiencing ongoing dissociative symptoms until treated.

There is yet another possibility to consider, that being the child who experiences repetitive trauma who does not possess the capacity to form imaginary companions. How will this child soothe the self and make it through such a horrifying and degrading existence? In this case relying on "normal" dissociative defenses may not be enough.
These children could exhibit symptoms consistent with DDNOS; however, they will be at risk to become severely depressed and psychotic, exhibiting delusions, hallucinations, and catatonic withdrawal.

**Stage Two**

Stage two is marked by the imaginary companions taking on a new function, manifesting, or "filling in" for the child during situations in which they feel a significant degree of anxiety or threat. In stage one, a link was made between an imaginary companion and a dissociative state of consciousness. At this point, the companion or companions begin merging with these dissociative states of consciousness. Essentially, stage two is similar to what Young (1988) described in his theory of multiple personality as a "a gradual crystallizing of a fantasy that is amalgamated with dissociative defenses" (p. 15). Relative to the current theory, the fantasy is a fantasized imaginary companion that amalgamates with dissociative states.

How many different companions will fill in for the child will depend on the types of trauma being experienced and the range of emotions associated with them. In other words, the more dissimilar the traumatic circumstances and feeling states, the more likely it is that different companions will be created. Likewise, which companion emerges and takes over for the child, will depend on what images, thoughts, or feeling states are triggered by events in the lived-world, that is, whether the child feels angry, frightened, helpless, and so on. Beere's (1996) analysis of switching in 16 cases of adult DID revealed that switching resulted when experiences in the lived-world activated a set of feelings, thoughts, or memories that were too intolerable for the executive alter (the alter in control) to bear. The alter gave way to a nonexecutive alter that was able to cope with these sorts of experiences and/or feeling states. Tying this into the examples mentioned in the preceding paragraph, "Susie" would become energized and take over when "daddy" begins to hit her, when she anticipates this happening, is reminded of it in some way, or when she feels she is being bad. "Jimmy" would emerge when the child feels helpless or needs someone to blame after he did something wrong or "caused" his mommy to hit him. Two important points are of note. First, because the companions fill in during dissociative states of consciousness, the child will lose memory for the period that he or she is "out" of the lived-world. Second, as "fill-ins" for the child, the alters have yet to become invested in their separateness, nor have they begun fighting for control over the body. Their continued functioning in the lived world, however, will increase their strength in the intrapsychic world, expand their repertoire, and prepare them for the battles that lie ahead in adolescence.

As in stage one, certain experiences may alter the course of development or lead to different sets of symptoms. Time-wise, stage two begins when the child is traumatized during the developmental window for DID and ends with the onset of adolescence. What if the child is traumatized after the developmental window for DID but prior to adolescence? While some children may make it through the trauma unscathed, others will be less fortunate, depending on the severity and repetitiveness of the trauma. Children traumatized after the developmental window, but prior to adolescence, are no longer able to defer trauma-related experiences to imaginary companions. However, they remain fairly hypnotizable and concrete in their thinking, able to block the experience out of conscious awareness through strong dissociative defenses, succeeding in not "owning" the experience. Furthermore, their sense of identity has not been internalized. Children traumatized at this point might experience memory loss, profound depersonalization/derealization, and identity confusion characteristics of DDNOS. Adolescents, on the other hand, because of a dip in hypnotic ability, the development of abstract reasoning skills, and a more internalized sense of self, are less likely to develop a dissociative disorder in response to psychological trauma. At this age the diagnosis changes to PTSD or acute stress disorder. Though highly speculative, the author takes the position that adolescents and adults who exhibit PTSD-like symptoms have a history of trauma as children and that those who exhibit the most debilitating PTSD were most likely traumatized during the developmental window for DID. Those without a trauma history will experience acute stress reactions to adolescent and adult trauma, causing some temporary disturbance, but easily overcome and resolved even without therapy.

**Stage Three**

In stage three, imaginary companions that have been "filling in" for the child and merging with
dissociated states of consciousness are trans-
formed into distinct personality states that have
become invested in their separateness, and think
of themselves as autonomous entities. The first
two stages were hypothesized to occur during the
developmental window of vulnerability and
through latency. Stage three transformations take
place during adolescence, providing a unique per-
spective on the development of alter personality
states that challenges traditional assumptions and
calls for a shift in the usual way of thinking about
the course of development in DID; it is consistent,
however, with the notion that alter personalities
become internalized during puberty (Putnam,
1995) and “more invested in retaining their auton-
omy” (Kluft, 1993, p. 23).

The common perception of adolescence is that
of a stressful and awkward period in life that one
would rather soon forget. In addition to experi-
cencing numerous physiological and psychological
changes, adolescents are faced with a variety of
developmental tasks. The most important of these
tasks is establishing their own sense of identity,
meaning, and place in the world, independent
of their parents’ influences and ideologies. Bios
(1962) described adolescence as a time in which
the individual sheds his or her family dependen-
cies in order to become an independent and free-
thinking member of the adult world. Likewise,
Erikson (1975) described adolescence as the time
in which the individual experiments with new
roles in an attempt to find his or her own unique
niche in society, one which will “bridge what he
(she) was as a child and what he (she) is about
to become” (p. 187).

While there is no doubt individuals who de-
velop DID experience the same adolescent strug-
gles, the way they handle them is likely to differ
from “normal” adolescents. The author hypothe-
sizes that the adolescent press to individuate and
form a distinct identity turns inward, in the case of
DID, where it is experienced in varying degrees
across each of the different companions. As these
companions struggle to individuate, their role
changes from filling in for the child during disso-
ciated states of consciousness to becoming sepa-
rates, distinct entities that possess their own ways
of thinking, feeling, and behaving in the lived-
world. What once emerged as childhood imagi-
nary companions begin to fight for control over
the body, triggering a sense of internal chaos and
loss of control that will predominate the individ-
ual’s experience in adulthood.

Without the intervention of therapy, it is un-
likely that the system will break down. In fact,
there may be a few experiences that intensity the
process. The coming of adolescence, for exam-
ple, may be so anxiety-provoking for the individ-
ual that a certain group of alters step forward and
assert themselves in a stronger role than ever.
Another possibility is the alters respond out of
fear that, should the adolescent achieve a sense
of identity, they will no longer be needed. This
could make them more invested in establishing
their own identities, taking control over the body,
and making their presence felt in the lived-world.

By the end of adolescence, the imaginary com-
panions that made it through the individuation
process have undergone a significant change in
their phenomenological experience and are seen
in the new light that Sanders (1992) described as
alter personalities. These alters comprise the core
set of personalities that will predominate in adult-
hood. As a result of their becoming invested in
their separateness and fighting for control over the
body, the original personality will begin spending
less time than ever in the lived-world. As men-
tioned earlier, “who” will be present at any given
time will depend on what is being triggered in
the lived-world.

It is important to note that some imaginary
companions will not individuate into alter person-
alities. Only those that carry the most meaning,
house the most horrifying memories and affects,
and serve the most important functions will indi-
viduate into distinct personality states that pre-
dominate adulthood. Those that do not individu-
ate may still emerge when situations in the lived-
world call them into being. However, since they
have not fully individuated, their appearance
should be less intense. One further point is of
note. Even though the adult personality system
crystallizes at the end of adolescence, this does
not mean that new alters cannot be created. The
author, however, would hypothesize that they are
spin-offs of the core personalities created as a
result of new demands or further experiences in
the lived-world. To illustrate, a bad-boy alter may
take on a new role that involves using drugs or
acting violently.

Discussion

While issues pertaining to imaginary compan-
ionship and the natural history of DID have been
touched upon by other writers, the importance of
this article lies in pulling it all together and plac-
individuals might possess this ability, the author as independent from the self. As to which to perceive the imaginary companion as real? If the child can see the companion as real, it makes for independent action due to the child's ability to defer traumatic experiences to an imaginary world. In addition, there needs to be a process by which the companions merge with dissociative states of consciousness so that they may evolve into distinct personality states. An interesting question pertains to children who play with imaginary companions who develop DID and children who play with imaginary companions and do not develop DID. What sets them apart? The simplest explanation is the experience of trauma. Playing with imaginary companions in and of itself does not result in the development of alter personalities. Trauma contorts the picture, giving imaginary companions what may become a life of their own. Another explanation relates to the composition of imaginary companions of individuals who develop DID and individuals who do not develop DID. Sanders hypothesized that the imaginary companions of DID individuals may possess some capacity that wires them for independent action. While there is no empirical research to support this position, Dierker, Davis, and Sanders' (1995) investigation of DID patients and "normal" college students revealed that DID companions were experienced as more real and vivid than the companions of college students. In fact, only 5% of the college group reported such a perception of their companions. Is the capacity for independent action due to the child's ability to perceive the imaginary companion as real? If the child can see the companion as real, it makes sense that he or she would experience the companion as independent from the self. As to which individuals might possess this ability, the author would once again point to the research of Lynn, Rhue, and Green (1988) who identified a particular group of fantasy-prone individuals that comprised about 4% of the population. Allison (1998) echoed similar statements in his own theory of MPD noting that individuals who develop alter personalities must be highly hypnotizable, falling in the top 4% of the population. Another hypothesis pertains to Stern's research. Does the infant's lack of integration into a core self make the imaginary companions of DID individuals more autonomous? Might this arise out of a disturbance in coherence? Before closing, there are at least a couple of treatment considerations that deserve mention. First, one might conclude that childhood cases of DID should be easier to treat than adolescent and adult cases. Again, this is because the alters have yet to individuate themselves from the original personality, become invested in their separateness, and begin fighting for control over the body. Of note here is the consistency of the theory with the psychological literature, which suggests that "children with MPD or its precursors infrequently are invested in remaining divided" (Kluft, 1993, p. 23), and that the treatment of childhood DID is usually a lost quicker than the more entrenched adult condition (Fagan & McMahon, 1984; Kluft, 1986). Notes Kluft (1986),

it is clear that with controlled, protected, and active treatments child MPD patients usually recover unity rather rapidly and that the length of time required may be age-related. Fagan and McMahon's (1984) patients, averaging 5.5 years of age, improved within a few sessions. My patients, averaging 8.5 years of age, recovered unity within 15 or fewer sessions. (p. 94)

Again, the author would hypothesize that the reason for quicker success is because the cases were identified and treated before or during the early stages of adolescence. Following this line of thought, it is important that researchers and clinicians continue to develop measures that assess childhood dissociativity and DID, though several new measures have been published of late (Putnam, Helmer, & Trickett, 1993; Smith & Carlson, 1996).

In terms of assessing those who present for treatment, one might assume that a patient presenting with DID was traumatized between ages 2 and 8, while a patient presenting with a DID/borderline personality presentation was traumatized at the lower end of this continuum or prior to age 2. A patient presenting with DDNOS may have been traumatized during the same time as

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the DID patient but possesses a low capacity for imaginative involvement, or was traumatized after 8 but before adolescence. Patients who present with PTSD were traumatized during or after adolescence and may have a prior trauma history that is feeding into their distress, while patients presenting with acute stress disorder are responding to the severity of the current trauma and are relatively well-adjusted in terms of trauma-related pathology. Schizodissociative presentations suggest very early and continued trauma. All of this may impact how one proceeds with a patient and needs to be followed up with future research.

In terms of treatment approach, the theory fits with typical models of treating DID, which emphasize correcting cognitive distortions that perpetuate separateness and developing a sense of flexibility and ownership of previously unrecognized thoughts and feelings. Knowing which types of alters dominate the system may shed light on what sorts of experiences the patient had as a child and which feelings he or she has the light on what sorts of experiences the patient had as a child and which feelings he or she has the most difficulty integrating and incorporating into the sense of self. For example, if persecutor and frightened-child alters dominate the system, one might hypothesize that this is a very frightened individual who probably experienced severe abuse as a child, blames himself or herself for the abuse, and feels useless, helpless, and deserving of punishment. Likewise, a patient dominated by sexual alters was probably sexually abused and has never integrated these experiences. The theory also argues for an educative approach to treating DID, where the therapist explains how the patient's symptoms developed, taking some of the mystery away from the disorder.

In closing it is important to note that as with any theory, there are definite shortcomings and limitations. For example, the theory does not address issues of coconsciousness, nor does it adequately explain why some personalities develop an understanding of the system, while others remain unaware that other personalities exist. There may be other shaping experiences as well that occur in between the stages that have a significant impact on the personality system and the course of development in other trauma-related disorders. In addition, the theory does not discuss developmental issues after young adulthood. Nevertheless, the theory does raise some interesting questions, and by emphasizing the role of adolescence, may spur others to address this period in alter personality development and other trauma-related disorders with more rigor. Whether it is Putnam's state-transition model or Barach's theory of reactive detachment, when, how, and why alters become invested in their separateness is an issue that needs to be addressed. It is the opinion of this author that this cannot be done without mention of adolescence.

References


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