

TREATMENT TRAJECTORIES IN MULTIPLE PERSONALITY DISORDER

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ABSTRACT

Despite rapid recent advances in the study of multiple personality disorder (MPD), many basic concerns remain unexplored or incompletely understood. One of these regards expectations about progress in treatment. The literature contains little that allows the clinician to estimate how a particular patient's response to therapy compares to that of other patients. Without such baselines confusion, exasperation, or complacency with respect to progress cannot be monitored and, if necessary, corrected, in a reasonable manner. In order to study treatment progress 31 MPD patients in ongoing treatment with the author as of July 31, 1990, were monitored along 12 dimensions through August 1, 1991. The progress of the 10 MPD patients most recently taken into treatment by the author and seen for at least three months was monitored as well. The results suggest that although steady stepwise improvement is quite unusual, many patients show indices of improvement on a year-by-year basis. MPD patients can be distributed into several subgroups by virtue of the trajectories of their treatment, and that reasonable expectations for progress vary widely according to the trajectory subgroup to which a given patient proves to belong.

Multiple personality disorder (MPD) has made the transition from the realm of rare exotica to the domain of the clinically commonplace in under a dozen years. Large series of MPD patients have been studied (see Kluft, 1991, for listings). Both North American (Ross, 1991) and European (Vanderlinden, Van Dyck, Vandereyken, & Vertommen, 1991) epidemiological studies have demonstrated that dissociative phenomena with the severity of diagnosable dissociative disorders are endorsed by 3% or more of the non-clinical population. Ross, Anderson, Fleisher, and Norton (1991) found

that 3.3% of sequentially admitted psychiatric inpatients (excluding known dissociative disorder patients and patients with organic mental syndromes) suffered previously undiagnosed MPD, a finding recently confirmed by Saxe et al. (1993) who found that 4% of the patients in Massachusetts Mental Health Center had previously unsuspected MPD. Boon and Draijer (1993) report a Dutch study in which 5% of hospitalized psychiatric patients were found to have previously undiagnosed MPD.

Increasing numbers of clinicians are involved in the treatment of MPD. The literature now includes several useful outlines of its psychotherapy and management (Braun, 1986; Kluft, 1991; Putnam, 1989; Ross, 1989). Workshops and training opportunities for the acquisition and refinement of relevant clinical skills, once uncommon, now are readily available. As a rule, the information shared in these publications and educational settings have been upbeat and optimistic. Very recently, however, increasing numbers of clinicians in the field have been taking a more guarded view of the prognosis of MPD. They have found themselves unable to duplicate, or even to approach, the type of results that were first reported in the literature, or described by teachers and workshop leaders. This concern is slowly being reflected in a more moderate, and even rather somber and disillusioned stance, in which it is emphasized that not all MPD patients are treatable.

In the absence of any available data base that defines the characteristics of the course of treatment for MPD over time, it is quite possible for clinicians and patients alike to become confused, exasperated, despondent, or complacent about the treatment process, and unable either to guide themselves or correct their perceptions by referring to some reference point or accumulated clinical findings. Efforts to generalize from published follow-up series (Coons, 1986; Kluft, 1982, 1984, 1986) can be distressing and demoralizing.

Coons (1986) studied 20 MPD patients an average of 39 months (range: 3 to 129 months) after intake. Sixty-seven percent of them were reported as moderately to greatly improved, and 25% had integrated completely. Kluft (1982, 1984, 1986) followed a growing series of integrated patients through sequential reassessments. They had achieved integration in an average of 21.6 months of treatment. He found that approximately 90% of the patients who remained in treatment achieved integration, and that all but two of the integrated patients were doing very much better in life. Comparing just these aspects of the Coons and Kluft stud-

ies, it is difficult to reconcile their findings. Kluft's data would appear to offer a glowing prognosis for MPD patients, while Coons' seem to argue for more modest expectations.

However, further exploration suggest some clues to these studies' discrepancies. Coons' series was acquired in a state hospital setting. His patients' educational attainment averaged less than high school graduation. They were seen by twenty different therapists, many of whom were trainees. Nineteen of the 20 therapists were working with their first MPD patient. Most saw their patient only once a week, which is below the recommended intensity for this condition (Kluft, 1991, in press a; Wilbur & Kluft, 1988).

In contrast, Kluft's series was seen in the private sector. Incomplete data is available about their education, but very few had failed to complete high school, and many were college graduates. All but a few of the patients who entered the series were seen by Kluft, who had brought 20 MPD patients to successful integration before initiating the series. All cases that were followed up had been treated solely by Kluft. The intensity of treatments averaged about two sessions per week, which means that many treatments were intense indeed.

Furthermore, other commentators on Kluft's data have neglected a crucial consideration. Kluft's research began in the early 1970s before the modern upsurge in interest in MPD. His papers were designed to establish the feasibility of bringing MPD to a successful and stable integration. Their focus was related to demonstrating the attainment and retention of this goal. Kluft's series started with 171 MPD patients; he followed the treatments of 123. In the 1984 report forty patients (33%) had not reached integration, and 50 (41%) had reached integration but had not fulfilled requirements for entry into the study of the stability of integration. A cohort of patients still under active treatment had been excluded lest their being reported in the literature influence their ongoing psychotherapies. The reported study dealt with only 33 patients, constituting 27% of the treatment group. In his 1986 paper, 19 additional patients who previously had not fulfilled criteria for stable integration now could be included in the updated study, which consisted of 52 (42%) of the patients whose treatments had been monitored. Still more patients were integrated but did not fulfill criteria for stable integration. As of this writing 103 of the 123 patients whose treatments were followed have achieved stable integration. Six remain in active treatment. Four continue to have active MPD, one has severe DDNOS, and one has mild DDNOS.

Viewed from this perspective, it is possible to speculate that the Coons and Kluft studies, despite their major differences with regard to the source of their subjects, the patients' education, the therapists' experience, and the intensity of treatments rendered, might differ on yet another dimension. Could it be possible that the MPD patient subgroups Kluft encountered but excluded a priori from the main focus of his study were more highly represented in the Coons cohort, which would have no reason to exclude them? If so, it might prove to be the case that MPD patients are not a homogeneous group, but rather consist of two or more diverse subgroups that have different characteristic treatment trajectories. If this were to be demonstrated, it might be possible

to reconcile some aspects of the differences in the Coons and Kluft data, and, more importantly, afford the clinician a more realistic perspective on the assessment of the treatment progress of MPD patients.

METHODS

The charts of all MPD patients in treatment with the author for over three months as of July 31, 1990 were reviewed to study their course of treatment between that date and August 1, 1991. Thirty-two charts were available.

Relevant entries most proximate to these dates were studied to gauge the patients' status with *The CSDS Dimensions of Therapeutic Movement Instrument (DTMI)*. The DTMI addresses 12 dimensions of therapeutic progress developed by the author on the basis of his clinical experience and taking into consideration issues raised by Coons (1986). Their descriptions and scoring guides are included as an appendix to this article. These dimensions are quite preliminary in their current form, and further modifications are anticipated. The dimensions are: 1) Therapeutic Alliance; 2) Integration; 3) Capacity for Adaptive Change; 4) Management of Life Stressors; 5) Alters' Responsibility for Self-Management; 6) Restraint from Self-Endangerment; 7) Quality of Interpersonal Relationships; 8) Need for Medication; 9) Need for Hospital Care; 10) Resolution of Transference Phenomena; 11) Intercession Contacts; 12) Subjective Well-Being. Each dimension was scored from zero to five. Hence a patient's total score could range from zero to sixty.

In order to compare the treatment of patients who are in the midst of a long-term therapy with those who are just beginning treatment, the same measures were applied to the ten MPD patients in the author's practice whose treatment had most recently begun, but who had been seen for at least three months. For those patients the dimensions were studied from the onset of treatment to their therapeutic contact closest to December 31, 1991.

FINDINGS

General Observations

One woman among the 32 established patients being followed died of a cerebrovascular accident in the study's first month. Her baseline scores were excluded from further calculations. In the last month of the study one patient died from the cardiovascular complications of a suicide attempt. Her data were retained. Over the study year two patients reached final integration (6%), and three achieved what they hoped was final integration only to discover there were further alters in previously undiscovered layers. One (3%) reached a stable resolution and declined to work for fusion. One patient (3%) discontinued treatment due to relocation and the minimal level of her residual symptomatology; one (3%) dropped out of therapy for several months for financial reasons. One patient's treatment (3%) was regarded as a failure, and was discontinued. Only five (16%) reported uninterrupted steady progress; the remainder experienced their progress as going up and down. Conversely, only five

TABLE 1
Changes in Therapeutic Movement Scores in Two Groups of Multiple
Personality Disorder Patients

Score Range	Group of 31 (Established)#/%	Group of 10 (New)#/%
>31	1 (3.2%)	2 (20%)
26-30	1 (3.2%)	1 (10%)
21-25	3 (9.7%)	2 (20%)
16-20	4 (12.9%)	2 (20%)
11-15	5 (16.1%)	2 (20%)
6-10	4 (12.9%)	-
1-5	5 (16.1%)	1 (10%)
0	3 (9.7%)	-
(-)1 - (-)5	2 (6.5%)	-
(-)6 - (-)10	2 (6.5%)	-
(-)11 - (-)23	1 (3.2%)	-

(16%) reported sustained rather than brief episodes of decreased function and diminished subjective well-being. The remainder, 84%, stated that they believed that they were improving in their function and subjective well-being.

Therapeutic Movement Scores

Table 1 demonstrates changes in therapeutic movement scores for both the established group of 31 patients and the ten new patients. Overall improvement scores in the former group averaged 9.3 change points, while members of the new group averaged 21.8. An inspection of the table reveals an impressive range of scores in the established group. A small group of patients made mercurial gains, a significant number made impressive gains, some made moderate gains, some made minimal gains, and some made no apparent headway, or are lost ground. Clearly, a diversity of treatment trajectories can be demonstrated.

In contrast, of the new patients, seven made impressive gains (16 points or more), two made moderate gains (between 6 and 15 points), and one made minimal (under 6 points) change. This seemed to indicate that many new patients made a very rapid adaptation to this type of treatment, and moved ahead rapidly. However, it might indicate that there is a "honeymoon factor," or that most gains can be made on this scale when a patient is initially highly symptomatic, and begins to show improvement. An inspection of Tables 2 and 3, however, while not ruling out a "honeymoon factor," reveals that the latter explanation would be difficult to sustain. For many dimensions the baseline measures of

the two groups are quite comparable, but the degree of improvement among the new patients is equal or more impressive. Also, the dimensions do not rate the type of symptoms that are most likely to respond to the initiation of treatment. Instead, most measure ways of behaving in treatment.

It seems possible that even in the first few months of treatment the new patients are assorting in a manner that suggests that most of them will do quite well quite rapidly, consistent with that cohort that yielded Kluff's optimistic (1984, 1986) findings, and that a smaller group will become the more difficult and slow to respond type of patients that were not yet at integration in Kluff's earlier series, and accumulated in his practice to form the cohort from which many of the 31 established patients were drawn. In short, some patients "get the hang" of this sort of treatment and move right ahead, while some either do not, fight it, or their progress is influenced adversely by other factors.

Table 2 displays the change in each dimension over the course of a year in the 31 established MPD patients.

Table 3 shows the same for the ten new MPD patients. It is impressive that every dimension shows more substantial change on the average for the new patients. The established patients are following a number of different trajectories, while the majority of the new patients are on similar trajectories. The lower averages in the established groups hide the diversity of their trajectories, which can be appreciated more readily in Tables 4a and 5a. These tables correlate the reassessment ratings of the therapeutic alliance and overall change scores and the change in the therapeutic alliance and overall change scores respectively. Tables 4b and 5b do so for the ten new MPD patients. The therapeutic alliance dimension alone is discussed in this communication. The established patients who maintain a high quality therapeutic alliance are clearly making more predictable and positive changes, and those who improve their therapeutic alliance are able to make impressive leaps, even after years of slow or apparently stalemated therapies. Among new patients, those who enhance their therapeutic alliances make the most impressive gains.

It is important to realize that the gains that an MPD patient makes may not be consistent with that patient's perception of his or her circumstances. I long have urged my MPD patients to appreciate the difference between getting better and feeling better, and have tried to educate them to comprehend that they do not necessarily occur simultaneously. Dimension 12, Subjective Well-Being, does show improvement, but it starts as one of the most problematic dimensions, and remains so. It appears highly correlated with

Management of Life Stressors, Capacity for Adaptive Change and Alters' Responsibility for Self-Management. These appear to be related to a vulnerability to being overwhelmed, which often cannot be addressed definitively as long as the individual maintains an MPD adaptation.

Although Therapeutic Alliance has been used as an illustration, some preliminary observations about other dimensions may be in order. Integration, one would think, would be a major focus of the therapy of the MPD patient. Indeed it is for those patients with a rapid trajectory, but for others there is a reluctance to deal with this subject, and a preoccupation with other concerns so intense that this dimension infrequently becomes a priority. It is impressive to note that the established patients' average Integration rating was 2.87, below the 3.5 average of the new patients, eight of whom were undergoing integrations within months of beginning therapy.

The dimension of Capacity for Adaptive Change again illustrates the impact of the high trajectory patients among the new group. They started lower than the established group, and finished higher, demonstrating the capacity for rapid mobilization. In contrast, the established group floundered. Lower trajectory patients, it appears, have a hard time achieving self-efficacy. With regard to Management of Life Stressors, both groups made changes. However, nine of the ten new patients contributed to the group's change score, while only 74% of the established patients did so. A significant minority remained unchanged or regressed.

Alters' Responsibility for Self-Management improved in both groups, but again the new group addressed this concern more predictably. Among the established group, many continued to profess a lack of control and/or wounded innocence in this connection. Restraint from Self-Endangerment improved in both groups, but did so more predictably and more generally in the new group. This is especially impressive because many of the new group (60%) had severe suicidal concerns, and several had entered my practice as inpatients on this account. The new group also was more successful in improving Quality of Interpersonal Relationships, despite the fact that most had severe difficulties in this area. They were more willing to take risks in this connection than the established group.

TABLE 2
Changes in 31 MPD Patients 7/90 - 8/1/91

Dimensions (total/average)	7/90	8/91	Change
1. Therapeutic Alliance	73/2.35	96/3.1	23/.74
2. Integration	75/2.42	89/2.87	12/.39
3. Capacity for Adaptive Change	55/1.77	89/2.87	34/1.10
4. Management of Life Stressors	65/2.10	94/3.03	29/.94
5. Alters' Responsibility for Self-Management	64/2.06	102/3.29	38/1.23
6. Restraint from Self-Endangerment	85/2.74	111/3.58	26/.84
7. Quality of Interpersonal Relationships	61/1.97	95/3.06	34/1.10
8. Need for Medication	97/3.13	106/3.42	9/.29
9. Need for Hospital Care	110/3.55	137/4.42	27/.87
10. Resolution of Transference Phenomena	67/2.16	86/2.77	19/.61
11. Intersession Contacts	99/3.19	107/3.45	8/.26
12. Subjective Well-Being	55/1.77	84/2.71	29/.94

The new group was much more ready to find alternatives to the Need for Medication than the established group, despite the fact that its members universally entered treatment in acute distress. They were glad to put medications aside, while most of the established patients were panic-stricken when such a reduction of medications was proposed. Both groups were rather comparable with regard to Need for Hospital Care, but this is misleading. Many new patients were referred for hospital care, and discharged after short stays. Many established patients had come to perceive hospitalization as part of their lives, and insisted that certain topics in their therapies could only be addressed in a hospital setting.

The findings with regard to the Resolution of Transference Phenomena were striking. The new group rapidly began to work with rather than act upon transference perceptions, while many established patients continued to find this an area of extreme difficulty. The same was the case for Intersession Contacts, for which the new groups almost immediately reduced their calls to legitimate occasions, while a subgroup of the established patients who abused the therapist's availability continued to do so.

TABLE 3
Changes on Follow-Up in Ten New MPD Patients

Dimensions (total/average)	Baseline	Review	Change
1. Therapeutic Alliance	24/2.4	44/4.4	20/2.0
2. Integration	10/1.0	35/3.5	25/2.5
3. Capacity for Adaptive Change	12/1.2	34/3.4	22/2.2
4. Management of Life Stressors	22/2.2	38/3.8	16/1.6
5. Alters' Responsibility for Self-Management	11/1.1	39/3.9	28/2.8
6. Restraint from Self-Endangerment	21/2.1	38/3.8	17/1.7
7. Quality of Interpersonal Relationships	19/1.9	39/3.9	20/2.0
8. Need for Medication	28/2.8	40/4.0	12/1.2
9. Need for Hospital Care	30/3.0	40/4.0	10/1.0
10. Resolution of Transference Phenomena	22/2.2	40/4.0	18/1.8
11. Intersession Contacts	27/2.7	39/3.9	12/1.2
12. Subjective Well-Being	11/1.1	29/2.9	18/1.8

In view of clinicians' concerns over the impact of allegations of ritual abuse on treatment progress in this patient groups, I explored this factor. Of the patients making such allegations in the group of 31, many did very poorly but some made excellent breakthroughs in the course of the study year. Their dramatic changes disguised the fact that they had been refractory, stalemated, and regressive for years. Working with additional unpublished data, it was possible to prorate their progress per year over a longer period of observation. They appear to progress quite unevenly and unpredictably over the short run, and about half as rapidly as patients who have never made such allegations. This is consistent with either the hypothesis that those alleging ritual abuse experiences are a more traumatized population that requires more time and effort to treat, or the hypothesis that MPD patients who make such allegations have an additional aspect to their psychopathology that causes them to see themselves as the victims of such experiences and/or to express their personal pain within this terrifying frame of reference. In the latter case, this hypothesized additional aspect of psychopathology would be understood to make

them more refractory to treatment.

DISCUSSION

The findings of this study, although preliminary and necessarily less than comprehensive because of the short periods of follow-up and observation, seem to be consistent with the hypothesis that MPD patients are far from uniform in their response to treatment, even when the nature, orientation, and experience of the therapist are kept as relative constants. Furthermore, it seems that the early indications of these trajectories can be inferred from the behavior of MPD patients in their first year of treatment. In the context of these observations, Kluft's optimistic outcome studies (1984, 1986) are the natural outcome of his experimental design's requiring a preponderance of rapid recovery patients in his subject group. His studies perforce described in the main patients from the most optimistic trajectory group, and relegated those from most other trajectory groups to subgroups that were not the focus of his articles' concern. Coons' (1986) twenty patients clearly came from a greater diversity of trajectory groups, including some of the most rapid recoverers among them. It is likely that the nature of these two authors'

referral streams made it less likely for Kluft to see many of the poorer prognosis patients seen by Coons, and less likely for Coons and his colleagues to see more of the excellent prognosis patients described by Kluft.

Follow-up indicates that the initial treatment trajectories of the ten new patients have proven accurate predictors of treatment progress. As of the publication of this paper three of the ten new patients are integrated, one after 34 months despite a long history of prior treatment failure and years of hospital care, another in 24 months despite eighteen years of unsuccessful prior treatment, and the third after four months of treatment by the author and two years more work with the referring therapist. A fourth is virtually integrated after 30 months; this patient had a 20-plus year history of prior treatment including several hospitalizations. A fifth, who had over three decades of prior treatment and the lowest score of the new group of ten, leapt to a high trajectory in her second year of therapy, and has decided to conclude her therapeutic work with what she considers a successful resolution. She is in the termination phase of treat

TABLE 4a
Therapeutic Alliance and Overall Change
Correlations with Therapeutic Alliance Ratings at
Reassessment Group of 31 MPD Patients

TA Rating	# Patients	Average Change & Range
5	7	19.9 (9-41)
4	9	12.1 (0-26)
3	7	7.1 (0-14)
2	1	18.0
1	2	1.5 1-2)
0	5	-7.2 (0 - -23)

TABLE 4b
Therapeutic Alliance and Overall Change
Correlations with Therapeutic Alliance Ratings at
Reassessment Group of Ten New MPD Patients

TA Rating	# Patients	Average Change & Range
5	5	23 (13-38)
4	4	21.8 (5-38)
3	1	20
2		
1		
0		

TABLE 5a
Correlation of Change in Therapeutic Alliance
and Overall Change at Reassessments in
31 MPD Patients

TA Rating	# Patients	Average Change & Range
+5		
+4	1	41.0
+3	4	19.3 (10-24)
+2	7	12.7 (9-26)
+1	6	13.5 (5-18)
0	6	2.8 (0-6)
-1	4	-3.3 (-6 - 0)
-2	2	0.5 (0-1)
-3		
-4		
-5	1	-23.0

TABLE 5b
Correlation of Change in Therapeutic Alliance
and Overall Change at Reassessments in
Ten New MPD Patients

TA Rating	# Patients	Average Change & Range
+5	1	38.0
+4	1	38.0
+3	1	23.0
+2	2	23.0 (19-27)
+1	4	17.3 (12-22)
0	1	5.0
-1		
-2		
-3		
-4		
-5		

ment. A sixth, the highly suicidal veteran of over twenty years of treatment, had the second lowest score in the new group. She fought treatment tooth and nail, her score declining and hospitalization being required. She was the only patient among the ten to be hospitalized except for hospitalizations involved in the referral of these patients to the author. A seventh has made excellent progress and improved her life considerably. This is despite the fact that her circumstances have made it impossible for her to have more than one long session per month. An eighth patient was doing well until being stricken with serious and life-endangering medical problems. Coping with her physical illness has become the focus of treatment. The remaining two patients were referred back to their own therapists after a long hospital treatment and a short hospital stay followed by a period of outpatient treatment by the author. Both are reported to be doing well, and to have integrated some alters.

Consequently, 30% are integrated, and 90% are much improved above their mental health baselines, although one patient is miserable due to medical difficulties. Only one patient is proving to be slow and refractory in treatment.

ADDITIONAL OBSERVATIONS

The use of a clinical instrument to provide a consistent yardstick for studying MPD patients' treatment progress may succeed in resolving many of the uncertainties that continue to surround the psychotherapy of this condition. One of the incidental findings of this study was that drop-outs, treatment failures, and serious suicide attempts were highly correlated with falling global treatment change scores. Perhaps the routine use of such measures might encourage more rapid identification of patients at risk and prompt more successful interventions in such circumstances.

The findings of this study strongly suggest that if a patient's behavior along the twelve indicated dimensions is monitored systematically, the patient will define his or her trajectory of treatment within one year if not earlier. Once the nature of that trajectory is appreciated, the therapist can establish reasonable expectations with that trajectory in mind, and target for work particular areas that, if modified, may make the patient capable of entering a higher (more rapid) trajectory. If those areas prove to be incapable of being modified by such focused efforts, the therapist can accept the likelihood that the treatment will have to take place at a modest pace, and conduct it without putting undue and unrealistic pressure on the him/herself, the patient, or the treatment process.

Although the findings are consistent with a number of hypotheses, I would like to note two because they are consistent with a number of observations that I perceive to be relevant. The first is related to the fact that victimized persons often perceive themselves as incapable of achieving mastery, self-efficacy (Bandura, 1977), and an internal locus of control. It appears that those patients who begin early in therapy to perceive themselves as able to act in such a way as to improve their circumstances become mobilized quickly, identify with the therapist's expertise and power, and achieve

a rapid trajectory as they improve in ways that challenge their baseline perception of their victim stance. Those who do not behave in this manner continue to manifest aspects of learned helplessness (Seligman, 1975) and the "sitting duck syndrome" (Kluft, 1990). It is the author's observation that developing a high trajectory is highly correlated with the patient's success in attaining the goals of the initial phases of therapy, which are designed to strengthen the patient and build in the skills and resilience that will make the remainder of the treatment tolerable and relatively free of decompensation. An extensive discussion of these phases is available (Kluft, 1993b).

The second hypothesis is that not only can we look at MPD as a heterogeneous condition, but that we may need to begin considering whether we are dealing with separate conditions that fulfill the diagnostic criteria for MPD; i.e., "multiple personality disorders." The author is currently involved in a series of projects designed to answer this question. Suffice it to say, it is possible that the high trajectory patients are very different from the low trajectory patients, despite their common MPD phenomena.

CONCLUDING COMMENTS

As of this writing, the monitoring of the treatment of MPD patients is largely a matter of clinical wisdom. However, if this study can be improved, replicated, and confirmed, it may be possible to use the findings of such assessments as an agenda for addressing ongoing difficulties in therapy. Perhaps the candid identification and discussion of problem areas such as those described here may serve as a vehicle for bringing more MPD patients toward a more positive treatment trajectory. Certainly, this study's confirmation of the clinical axiom that the treatment of the MPD patient is only as good as the quality of the therapeutic alliance may prove to be a first step in this direction.

CAUTIONS

This paper introduces a new clinical instrument which appears to be promising. However, it has not yet been studied in depth, nor has it been applied by objective observers uninvolved in the treatment process. The author, who was the therapist of all of the patients in the series, may have brought his or her own biases and blind spots to the scoring process. Confirmatory bias may be a problem.

This instrument was designed to measure treatment progress as a guide to the therapist, and secondarily to assist in a larger study that will attempt to study the homogeneity and heterogeneity of MPD populations. This instrument was not designed to help MPD patients assess their own progress in treatment, nor was it designed so that its results could be shared with MPD patients. In fact, it omits many areas of consideration that MPD patients might see as important, and focuses on considerations that often are experienced by MPD patients as criticisms.

Preliminary experiences with MPD patients' responses to learning about their scores over time has been universally negative. Sharing

the findings from this instrument with MPD patients is regarded as absolutely contraindicated by the author. Details of this experience and illustrations of the clinical application of this instrument will be the subject of another communication (Kluft, in press.) ■

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APPENDIX

The CSDS Dimensions of Therapeutic Movement Instrument (DTMI)

The following examples for scores are illustrative usages. One or more features at each level (or their equivalent) may be the basis of a given score. It is understood that each patient will start from a completely unique baseline and have his or her own specific features. Likewise, each treatment proceeds under its own particular and irreproducible circumstances. The crucial features are that a score of 5 (maximum) indicates that that dimension is fulfilled in a manner consistent with excellent progress consistent with the examples given. The user should record any criteria that are being used in the monitoring of a particular case. Only dimension 12 should be scored on purely on the patient's subjective considerations. Whenever the precise score is in doubt, use the lower of the two scores being considered. Always score on the basis of the total human being – never on the basis of a single alter or a group of like alters.

1. Therapeutic Alliance

- 5 - The patient consistently acknowledges his/her circumstances, allows access to all alters, and will work on all necessary issues, even if painful, at least 80% of sessions. The patient obeys the rules of therapy.
- 4 - The patient usually acknowledges his/her circumstances, allows access to most alters, or all with reluctance, and will work on most necessary issues, even if painful, at least 60% of sessions. Breaches of the rules of therapy are infrequent and minor.
- 3 - The patient denies his/her circumstances over 25% of sessions, denies access to several alters, will work on some, but avoids some necessary issues, and attempts to evade the work of therapy in many sessions. Breaches of the rules of therapy either are frequent, or are occasionally moderate to severe.
- 2 - The patient denies his/her circumstances frequently, denies access to many alters, and avoids dealing with many crucial topics. Breaches of the rules of therapy are significant and/or quite frequent.
- 1 - The patient's denial is frequent and intense. Access to alters is intermittent and unreliable. The patient often refuses to deal with important topics for protracted periods. Breaches of the rules of therapy are severe and sustained.
- 0 - Generalized therapeutic stalemate due to major manifestations of problems enumerated above.

2. Integration

- 5 - The patient achieves or sustains final integration, integrates over 25% of the known remaining alters, or integrates two or more alters that play major roles in day to day life. Any additional alters found are related to layering, not the formation of new alters.
- 4 - The patient integrates over 10% but under 25% of the known remaining alters, or integrates one alter that plays a major role in day-to-day life. Any additional alters found are related to layering, not the formation of new alters.
- 3 - The patient integrates more than one but under 10% of the known remaining alters. Any additional alters found are related to layering, not the formation of new alters. Or, there has been fulfillment of integration criteria for 4, but at least one new alter has been formed.
- 2 - The patient integrates one alter. Any additional alters found are related to layering, not the formation of new alters. Or, fulfillment of integration criteria for 3, but at least one new alter has been formed.
- 1 - The patient integrates no alters. Any additional alters found are related to layering, not the formation of new alters. Or, fulfillment of integration criteria for 2, but at least one new alter has been formed.
- 0 - The patient integrates no alters and forms new personalities and/or reactivates previously integrated alters.

3. Capacity for Adaptive Change

- 5- The patient is able to learn new adaptational strategies and carry them into action with facility.
- 4- The patient is able to learn new adaptational strategies and carry them into action, but with difficulty, and at the cost of considerable effort.
- 3- The patient can learn some new adaptational strategies and gradually achieves some degree of success in implementing them.
- 2- The patient can make minimal use of most suggested new adaptational strategies, but occasionally can employ one or more with modest success.
- 1- The patient is unable to use new adaptational strategies.
- 0- The patient actively and successfully opposes efforts to teach new adaptational strategies.

4. Management of Life Stressors

- 5- The patient handles life stressors without regression, withdrawing, dysfunctional switching, the triggering of misperceptions of the present for the past, or the intrusion of the features of post-traumatic stress.
- 4- The patient handles life stressors well in general, but has occasional episodes of transient regression, withdrawal, dysfunctional switching, misperceptions of the present for the past, or the intrusion of the features of post-traumatic stress.
- 3- The patient handles life stressors with a moderate degree of success, but has experienced several or severe episodes of regression, withdrawal, dysfunctional switching, misperceptions of the present for the past, or the intrusion of the features of post-traumatic stress.
- 2- The patient handles life stressors with an inconsistent and frequently problematic degree of success, and has experienced many or severe episodes of regression, withdrawal, dysfunctional switching, misperceptions of the present for the past, or the intrusion of the features of post-traumatic stress.
- 1- The patient has minimal success in handling life stressors and usually responds by regression, dysfunctional switching, misperception of the present for the past, or the intrusion of the features of post-traumatic stress.
- 0- The patient predictably handles life stressors by regressing, withdrawing, dysfunctional switching, and misperceiving the present for the past. Post-traumatic stress features are prevalent.

5. Alters' Responsibility for Self-Management

- 5- The alters willingly cooperate by engaging in no behavior that is counterproductive. They can contract for this.
- 4- The alters cooperate by engaging in no behavior that is counterproductive, but this is not freely given, and largely due to the therapist's active pursuit of such control and containment. They can contract for this, but with some alters expressing reluctance.
- 3- Most alters are cooperative but one or more occasionally refuse to contract or are determined to act irresponsibly.
- 2- Several alters decline to contract or are determined to act irresponsibly, or one such alter engages in major disruptive behavior.
- 1- Many alters decline to contract or are determined to act irresponsibly, or several such alters engage in major disruptive behavior.

- 0 - Many alters act on their impulses without consideration for the total human being. Contracting is refused or negated.

6. Restraint from Self-Endangerment

- 5 - Neither incidents nor impulses toward self-harm are encountered.
- 4 - There has been no self-harm, but the patient occasionally feels pressured toward self-harm.
- 3 - There has been one episode of mild self-harm or chronic or recurrent severe impulses toward self-harm.
- 2 - There have been two incidents of self-harm, one suicide attempt, or a hospitalization to prevent such episodes.
- 1 - There have been three or more incidents of self-mutilation, two or more suicide attempts, or two or more hospitalizations to prevent such episodes.
- 0 - Chronic, recurrent, severe self-harm behaviors, or hospitalizations to prevent these.

7. Quality of Interpersonal Relationships

- 5 - The patient maintains and/or makes healthy relationships and avoids counter-therapeutic relationships.
- 4 - The patient is having some success in attempting to maintain and/or make healthy relationships, and to avoid counter-therapeutic relationships. However, he/she is having some difficulty in the selection of companions, and/or is having some difficulty breaking from old problem relationships and enmeshments.
- 3 - The patient is both moving toward new and positive relationships and making some efforts to change, but for the main part is retaining pathological ones, or vice versa. There may be some poor judgment in new affiliations. There may be avoidance and/or withdrawal.
- 2 - The patient is unable to change relationship patterns in a positive way, but is moving toward loosening some dysfunctional ties, or vice versa.
- 1 - The patient is defiant, disinterested in changing, or is terrified by the prospect of changing his/her affiliations.
- 0 - The patient is oppositional, massively withdrawn, and/or retains and makes only pathological relationships.

8. Need for Medication

- 5 - The patient requires no medication for target symptoms associated with his/her MPD, but may require medication for co-morbid psychopathology. No medication abuse.
- 4 - The patient requires medication for target symptoms associated with his/her MPD, but the usage is short-term and crisis-oriented only. No medication abuse.
- 3 - The patient requires medication for target symptoms associated with his/her MPD on an ongoing basis. Rare and/or mild misuse of medications.
- 2 - The patient requires the addition of additional medications to an ongoing regimen in order to cope. Occasional and/or moderate misuse of medications.

- 1 - The patient requires many adjustments of medications to address symptoms that elude control. Frequent or major misuse of medications. Use of illicit substances.
- 0 - Sustained and/or major misuse of prescribed medications and/or illicit substances.

9. Need for Hospital Care

- 5 - The issue of hospitalizing the patient does not arise.
- 4 - The patient need not be hospitalized, but the issue must be considered at least once.
- 3 - The patient must be hospitalized once, and is cooperative with this.
- 2 - The patient either must be hospitalized more than once, or must be committed against his/her will.
- 1 - The patient spends over a month in a hospital.
- 0 - The patient exhausts his/her resources and/or must be transferred to a long-term public facility.

10. Resolution of Transference Phenomena

- 5 - The patient listens to and works with transference materials productively, and initiates exploration of the transference.
- 4 - The patient listens to and works with transference materials productively, and but does not initiate exploration of the transference.
- 3 - The patient is reluctant to explore many transference phenomena and may challenge such interpretations.
- 2 - The patient will explore some transference issues with reluctance, but insists that others represent true perceptions. He/she may act on them in minor ways. However, he/she does not make major decisions or take major actions on their basis.
- 1 - The patient will discuss transference somewhat, but usually does not seem to see its "as if" quality. He/she may act on transference misperceptions in many ways, some of which are major.
- 0 - The patient regularly mistakes transference for contemporary reality and acts on the basis of such misperceptions.

11. Intersession Contacts

- 5 - The patient has made no intersession contacts.
- 4 - In the therapist's opinion, the patient has made no inappropriate intersession contacts.
- 3 - The patient has made one inappropriate intersession contact.
- 2 - The patient has made several inappropriate intersession contacts; redirection has been required.
- 1 - The patient has been extremely intrusive with respect to inappropriate intersession contacts; redirection and mild limit-setting have been required.
- 0 - The patient's intersession behavior has required very assertive and/or repetitive interventions and redirections by the therapist.

12. Subjective Well-Being

The patient is asked to assess his/her sense of subjective well-being across all alters for the proceeding month, and asked to describe what represents the average of the good, bad, and intermediate feeling states, in accord with the general model and language below. The patient is not given these sentences to choose among.

- 5 - I generally feel well most days except just before, during, and after therapy sessions.
- 4 - More of my days are good or neutral than bad except just before, during, and after therapy sessions..
- 3 - About half of my days are good or neutral except just before, during, and after therapy sessions.
- 2 - Some of my days are good or neutral.
- 1 - I rarely have a good or neutral day.
- 0 - I have had no neutral or good days in the last month.

**THE INSTITUTE OF PENNSYLVANIA HOSPITAL (DDU)
CSDS Dimensions of Therapeutic Movement Instrument Score Sheet**

Dates of Assessments

DIMENSIONS																				
1. Therapeutic Alliance																				
2. Integration																				
3. Capacity for Adaptive Change																				
4. Management of Life Stressors																				
5. Alter's Responsibility for Self-Management																				
6. Restraint from Self-Endangerment																				
7. Quality of Interpersonal Relationships																				
8. Need for Medication																				
9. Need for Hospital Care																				
10. Resolution of Transference Phenomena																				
11. Intercessions Contacts																				
12. Subjective Well-Being																				
TOTAL SCORE:																				
Average Score/Dimension:																				
Change from Last Assessment:																				
Average-Change/Dimension:																				

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