

ON THE TREATMENT OF TRAUMATIC MEMORIES OF DID PATIENTS: ALWAYS? NEVER? SOMETIMES? NOW? LATER?

Richard P. Kluft, M.D.

Richard P. Kluft, M.D., is Clinical Professor of Psychiatry at the Temple University School of Medicine in Philadelphia, Pennsylvania, and practices psychiatry and psychoanalysis in Bala Cynwyd, Pennsylvania.

For reprints write Richard P. Kluft, M.D., 111 Presidential Boulevard - Suite 231, Bala Cynwyd, PA 19004.

ABSTRACT

Patients with Dissociative Identity Disorder (DID) have been overwhelmed by early life events. However, their recollections of those events may become distorted in the course of their registration, retention, and retrieval of those events, and the processing of those recalled events may itself prove so difficult that efforts to do so risk retraumatizing them rather facilitating their growth. The integration of the DID patient's identity appears to require the working through his or her traumatic memories, however flawed with respect to historical accuracy and however emotionally unsettling work with such memories may be. Drawing upon a stage-oriented view of the treatment process and data from DTMI (Dimensions of Therapeutic Movement Instrument) research, I will offer pragmatic guidelines with which to address the questions posed to me by the organizers of the Amsterdam Congress: Should we treat the traumatic memories of DID patients - Always? Never? Sometimes? Now? Later?

OVERVIEW

The treatment of traumatic memories is one of the most central aspects of the successful psychotherapy of Dissociative Identity Disorder (DID) and allied forms of Dissociative Disorder Not Otherwise Specified (DDNOS). Notwithstanding its importance, it is extremely difficult and has become the subject of considerable concern and controversy. Accounts of the successful treatment of DID and DDNOS (hereafter DID) invariably describe painful and often arduous efforts to work with and detoxify these materials. A phase of detoxifying and metabolizing traumatic memories is included in every major outline of the stages of the treatment of DID (e.g., Braun, 1986; Fine, 1991; Kluft, 1991; Putnam, 1989; Ross, 1989; Turkus, 1991).

Characteristically textbooks and professional articles describe ideal or complete strategies and/or courses of psychotherapy that lead to the maximal improvement of the

patient and the maximal elimination of the target psychopathology. Thereby they may inadvertently give the impression that these and other authorities are advising that all treatments of all DID patients should involve the exploration and processing of traumatic memories. This most certainly is not the case. Should such an understanding universally inform clinical practice, the results would be devastating. While these publications describe appropriate sequences of concerns, they all proceed on the assumption that the goals of one stage are to be achieved more or less successfully before the treatment progresses to address those of the next. A treatment that does not achieve the goals of the stages prior to the stage of working with traumatic memories generally should not attempt to move forward into work with traumatic memories. If it were to do so, the circumstances of the individual patient might be disregarded, and both the patient and the therapeutic venture might be imperiled.

To date, all accounts of the successful treatment of DID to the point of integration, in both the scientific and the lay literature, describe work with traumatic memories as an essential ingredient of the treatment process. As of this writing, there is no basis on which to assume that the full and stable integration of DID can occur without dealing with the DID patient's unfortunate experiences, their representation in autobiographical memory and personal narratives, and their impact on his or her adaptation and attitude toward the world. Therefore, a DID patient's potential to achieve and maintain integration is very highly correlated with that patient's capacity to undertake the often strenuous efforts to recover the representation of the past in the patient's mind and metabolize them so that they cease to be vital and compelling determinants of the patient's contemporary life and adaptation. If a DID patient cannot access this material, withstand the painful therapeutic work necessary to palliate its impact, and both tolerate and resolve the delayed post-traumatic symptom complexes that often accompany the unearthing of long-buried traumata, his or her DID may become less dysfunctional (which is a satisfactory adaptationist outcome [Kluft, 1993a]), but a full integration appears to be unlikely, if not impossible.

The Spectrum of DID Patients

As theoretically desirable as it may be to undertake and complete the processing of traumatic memories in order to facilitate the total cure of the DID, many patients who suffer this condition appear to be unable to follow this theoretically ideal course of action. It is not uncommon for clinicians to find that some DID patients decline to work on past traumata. They either are too apprehensive to do so, or they fear the consequences. Many are virtually phobic about approaching painful materials and/or reexperiencing intense affect. Typical considerations with regard to possible deleterious consequences include fears of decompensation, apprehension that their revelations may be harmful in some magical way to themselves and/or others, and concern that the individuals and/or the alters who have threatened dire consequences for such revelations may injure if not destroy them.

Still other DID patients make it clear from their reactions and behaviors that despite their willingness to do the trauma work, indeed, despite their ardor to do it, the consequences of any efforts to do so are likely to prove unacceptable. All too often such endeavors in vulnerable DID patients are followed by chaotic switching, crises, decompensations, inability to function, hospitalizations, suicidal and parasuicidal behaviors, and dysfunction in the major alters charged with handling day to day affairs and work. The deterioration of a fully functional individual into a disabled, miserable, and overwhelmed one can occur under these circumstances. Although no doubt many of these declines in function would have been inevitable (e.g., the patient is encountered in a phase characterized by the precipitous and/or continuous spontaneous recovery of traumatic material, and this process eludes the therapist's efforts to contain it), it seems that some are the consequences of the patient's incapacity to manage this aspect of therapy.

Yet other DID patients appear to become fascinated and masochistically preoccupied with trauma work. Instead of seeing the trauma work as a means to the end of recovery, they mistakenly come to perceive it as an end in itself. While at times the therapist's focus on and preoccupation with trauma is a factor in a patient's making this assumption explicitly or implicitly, in consultation I often encounter patients who have come to this stance in spite of their therapists' efforts to redirect the therapy. However they have come to this stance, throwing aside considerations of function and coping, they force themselves into the material over and over again, perhaps factitiously augmenting their traumatic histories in the process. Such patients may become totally immersed in their inner worlds to the detriment of their coping with external reality, and make themselves psychological cripples in the process.

Some experienced clinician-investigators have attempted to describe different subgroups of DID patients. Interestingly, implicit in the distinctions they have drawn are

the patients' capacities to deal with traumatic materials. Horevitz and Loewenstein (1994) described three groups:

1. High-Functioning MPD Patients

Patients in this group have significant psychological, interpersonal, social, vocational, and financial resources. High-functioning patients present with very little personality disorder comorbidity and significant capacity to master affect, control dysphoria, and participate in a productive therapeutic alliance. They generally experience positive outcomes in outpatient treatment and pose relatively fewer significant therapeutic management problems.

2. Complicated Cases With Comorbid Conditions

The clinical picture is complicated by the coexistence of symptoms that meet the *DSM-III-R* symptoms for Borderline Personality Disorder. Other complicating factors may include organic brain damage, severe medical illness, severe substance abuse, and eating disorders... this "complicated" category should be reserved for patients who have been in treatment for a significant period of time with little evidence of treatment gain, and who exhibit personality characteristics (i.e., dependency, low autonomy, external locus of control, blaming, and self-preoccupation) associated with poor therapeutic outcome (e.g., older and more severe family, marital, and medical problems; complex PTSD symptoms refractory to treatment; severe memory problems; affect dysregulation). With this group of patients, treatment is of necessity much slower, the potential for gain is less certain, and the ideal goal of full fusion and integration may not be attainable.

3. Enmeshed Patients

The group of patients that is the most recalcitrant to treatment tend to remain in abusive relationships, have a "dissociative" lifestyle, and actively participate in self-destructive and/or antisocial behaviors and habits....Not surprisingly, they have a poor therapeutic prognosis and can be treated most effectively when therapy is geared toward symptom stabilization and crisis management rather than the uncovering integration of alters (cf. Turkus, 1991). (Horevitz & Loewenstein, 1994, pp. 291-292)

Kluft described several different groups of DID patients impressionistically in 1984. Later, using more objective findings from preliminary research with the Dimensions of Therapeutic Movement Instrument (DTMI), Kluft (1994a, 1994b) delineated three groups of DID patients with regard to treatment response. The DTMI evaluates 12 categories of behavior in therapy (Table 1), allowing each to be scored from zero to five (potential range of DTMI scores: 0-60). He

TABLE 1
Dimensions of Therapeutic Movement

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. Intersession Contacts
12. Subjective Well-Being

found that within a year his patients could be divided into three groups. The first consisted of those whose scores increased and/or stayed high. They moved rapidly to integration and recovery. A second group had scores that improved moderately, and made intermediate progress. A third had scores that improved little if at all. They constituted the high, intermediate, and low trajectory subgroupings of DID patients. The intermediate group could be further subdivided into a "slow and gradual," an "up-and-down," and a "slight improvements followed by long plateaus" subgroups.

The high trajectory group rapidly formed a therapeutic alliance or moved to improve it. Often complaining every step of the way, they "got the hang of therapy" and went about doing what had to be done. More and more alters joined the therapeutic process. These patients identified with the work ego of the therapist and rapidly appreciated that therapy was a partnership in which their hard work was essential. They enjoyed the support of the therapist, but were not preoccupied with pursuing it. They ruled out suicide and self-destruction as appropriate options. They were able to take a rational approach to dealing with those they alleged had abused them in the past.

In contrast, the low trajectory patients were preoccupied with the pursuit of nurture and support. The therapist's approval and the minutiae of the therapist's behavior vis-a-vis the patient was and remained a central concern. Regardless of their objective strengths and assets, they seemed to conceptualize help only in terms of external supplies and resources. They frequently protested that although they

were working very hard, their efforts were not appreciated. Their concept of the therapeutic alliance was often of compliance with the therapist or control of the therapist rather than of partnership. This type of compliance was often with the letter rather than the spirit of what the therapist had requested. Often such patients were litigious and/or legalistic in their complaints. Characterologic issues often were prominent and problematic. Their alter systems were often sadomasochistic, and/or dominated by children, and/or lacked a robust host. Safety remained an unresolved issue for long periods, and past traumata were commonly reenacted within the alter system. Many remained enmeshed with allegedly abusive families.

The intermediate group was so diverse it was difficult to characterize. Borderline traits, affective disorders, and eating disorders were commonly present. Access to alters often was problematic. Co-consciousness often was difficult to achieve. Often instability led to ups and downs, with much distress on that account.

High trajectory patients generally held or rose to DTMI scores of 40 or more with therapeutic alliance scores of 4 or 5, or at least a two-point jump per year until that level was attained. Middle trajectory patients generally held DTMI scores from the high 30s to the low 40s, and showed a rise in scores of over 10 points their first year and over 5 per year thereafter. Their therapeutic alliances were usually 3, or had risen at least one point over the last year. Low trajectory patients' scores were generally below 35 and had showed less than a five-point gain over the last year. Therapeutic alliance scores of 2 or less were common, with a tendency not to rise much over time. Since the trajectory is more an overall trend than a score, these are generalizations rather than ratings that can be used to determine a trajectory numerically in a precise manner.

Ross and Dua (1993) and Fraser and Raine (1992) also found three groups of DID patients. While it is not clear to what extent these groups parallel the above descriptions, it appears that all investigators characterize groups that are responsive to treatment, minimally responsive or unresponsive to treatment, and somewhat responsive to treatment. Because successful treatment with a goal of integration involves work with traumatic memories, there are perforce, groups that can manage traumatic materials, groups that cannot, and groups that can only do so somewhat, or with extreme difficulty.

Memories of Trauma

As important as work with traumatic memories may be to work with DID patients, the importance of this work for recovery is not necessarily correlated with the historical accuracy of the remembered materials. Although there are occasional reports of DID patients' dealing with a traumatic recollection simply by being shown it was unlikely to be accurate (Ganaway, 1994), more often than not either it is

not possible to demonstrate whether a recollection is true or false, or the patient does not respond favorably to such attempts. Although work with children and adolescents with DID demonstrates that abuse can be documented in 95% of such cases (Hornstein & Putnam, 1992; Coons, 1994), the memories reported by adults with DID may have undergone a metamorphosis (Kluft, 1994c), and may have either a greater or lesser resemblance to the actual historical traumatic occurrences. The clinician usually is in the position of not knowing whether an alleged abuse has occurred, or whether a memory of a documented abuse is truly a memory, an imagined reconstruction from any of several potential sources mistaken as recollection, or an event that has occurred within the "third reality" of the inner world of the alter personalities (Kluft, 1995, 1998).

Notwithstanding these concerns and still others related to the vicissitudes of memory, and reviewed in detail in recent publications (Brown, 1995; Hammond et al., 1995) and treated encyclopedically (Brown, Schefflin, & Hammond, 1997), the patient's subjective reality must be addressed. It is not that the historical truth does not matter. Rather, it is that the patient's need for relief from the pain associated with what the patient's mind has registered, retained, and recalled as autobiographical memory must be acknowledged, and efforts to bring about that relief almost inevitably will involve working within the idiom of the patient's memories, however flawed they may be.

Furthermore, without the integration of memory, despite its potential imperfection, trauma theorists feel it is not possible for the trauma victim to regain and rehabilitate his or her identity. It is necessary to acknowledge what is believed to have occurred, and to deal with the impact of that alleged experience upon one's self in order to find one's own truth, and one's own voice (Herman, 1992).

DETERMINING WHETHER TO PURSUE WORK WITH TRAUMATIC MEMORIES - I: BASIC CONSIDERATIONS

Several approaches are available to the clinician attempting to determine whether it is appropriate to pursue work with traumatic memories with a particular DID patient. With these considerations in mind, it is possible to make a clinically sound decision in the majority of cases, although some instances will not lend themselves to evaluation by these criteria. The circumstances of many DID patients can be determined readily. However, some patients who appear to be quite unstable may be unstable precisely because they cannot regain their balance until some traumatic memories are abreacted or otherwise detoxified. Therefore, I will first discuss general issues, and then return to consider the unstable patient.

TABLE 2
Stages of the Therapy of DID
(From Kluft, 1991)

1. Establishing the Psychotherapy
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 and Working Through
9. Follow-up

General Considerations

Dimensions relevant to determining whether to proceed include: 1) the patient's voluntary cooperation; 2) the patient's motivation; 3) the patient's life circumstances (stressors, crises, and supports); 4) the status of comorbid conditions; 5) ego strengths; 6) the achievement of the goals of phases 1-3 of therapy (Table 2); 7) progress on the DTMI; 8) the therapist's readiness to undertake this stage of treatment; and 9) logistics.

The patient's *voluntary cooperation* is essential. Under no circumstances is it advisable to pursue such work without the patient's willingness to do so. If this is attempted, the therapy holds the potential to become an assaultive sado-masochistic enterprise, and the patient will either defend against it, masochistically submit to it, or fluctuate between these responses.

Beyond cooperation is the patient's *motivation*. Work with traumatic materials is demanding, and best pursued when the patient is inclined to do so in the hopes of achieving relief. Initially, less than enthusiastic motivation is acceptable, because often the initial work, however painful, makes the patient hopeful of ultimate relief, and enhances his or her interest in the therapy. If motivation does not increase, or cannot be sustained, such work should be suspended until motivation is restored.

It is essential to assess the *patient's life circumstances* with great care, noting intercurrent and/or potential stressors,

crises, and supports. If the patient is going to be able to address traumatic material successfully and safely, he or she must have the emotional resources to do so. It often is best to defer such work if the patient's life is so stressful that he or she is barely able to keep up with what he or she has to do. If crises are in process or over the horizon, adding still more stress (such as dealing with traumatic memories) is more likely to lead to decompensation than to progress. If supports are not available, or are withdrawing from the patient, it is wise to defer trauma work until supports are available, or both therapist and patient are confident that the patient can proceed with safety given what is available. Often it is necessary to help the patient appreciate that support is not available, but that the work can be done regardless due to the patient's own inner resources. Many traumatized people simply are without the type of support the therapist and the patient would wish to be present. With such patients it is essential to use techniques that control the trauma work as meticulously as possible (e.g., see the section on fractionated abreactions below).

Comorbid conditions should be assessed and treated to as full an extent as possible before proceeding. Otherwise they may compromise the resources that the patient can bring to the trauma work, and may prove to be impediments to the work, or enough of and additional burden to push the patient to the point of decompensation. The author recently declined to do trauma work with a DID patient whose phobic responses to medication made her decline to allow him to control her major depression adequately. He feared that the undertreated affective disorder plus the pain of the trauma work might overwhelm the patient and bring her to a point at which she would be unable to function adequately, and perhaps consider suicide. When she finally allowed her depression to be treated to the point of remission, he agreed to go forward. It is especially unwise to proceed to trauma work with patients who continue to abuse substances or whose sobriety is fragile. The anodyne of the substances all too often will prove an irresistible temptation, and the social connections associated with substance abuse offer still further incentives and pose still further hazards to the uncomfortable DID patient.

I suggest the *assessment of ego strengths* in depth, according to an ego psychological framework (e.g., Waldhorn, 1967). Although it is tempting to assess the DID patient exclusively in the language of DID, an overall whole-person assessment is very useful as well, and often offers a helpful perspective. For example, assessing anxiety tolerance and the quality of object relationships can alert the therapist to problems that might be overlooked in an evaluation restricted to symptoms, phenomenology, and the workings of the alter system; i.e., the patient may have a pattern of impulsivity when overwhelmed, and of running from relationships in which the anxiety level increases. Such a patient might look very ready to work in DID terms, but might flee therapy abruptly

when the trauma work begins.

It usually is premature, as well as pointless and potentially dangerous to do work with traumatic memories until the patient has achieved *the goals of the first three stages of therapy* (Table 2), establishing the therapy, preliminary interventions, and history-gathering and mapping. These phases are equivalent to the phase of safety and symptom reduction discussed recently by Herman (1992), but first by Janet (van der Hart, Brown, & van der Kolk, 1989). As noted in earlier publications by Kluft (1988, 1989, 1993b) and Fine (1991, 1993), it is essential to stabilize and strengthen the patient, equipping the patient with the tools to manage the anticipated distress and difficulties, before moving into dangerous material. Failing this, the patient will encounter the material that proved overwhelming in the past with little more than the passage of years to assist in its management. Under these circumstances, dealing with and attempting to abreact traumatic material is more likely to lead to retraumatization than to mastery. Severe and prolonged distress, if not overt decompensation, is very likely to occur. Furthermore, it is dangerous to begin trauma work without mapping and doing considerable history gathering. A therapy in which this is not done runs the risk of initiating work on traumatic material that may trigger the unintended upset of many alters and the emergence of many related memories in short order. The material that might have proven manageable by itself may prove to bring with it unanticipated additional material that may be too much for even a very strong patient to tolerate. Proceeding before achieving the goals of stage 3 is a potentially dangerous endeavor except under the circumstances described below with regard to the unstable patient.

As noted, the treatment of DID is a post-traumatic therapy, and as such follows the triphasic model first noted by Janet (see van der Hart, Brown & van der Kolk, 1989), but most recently elaborated and popularized by Herman (1992). Herman found that in successful post-traumatic therapy, a phase of establishing safety is followed by one of remembrance and mourning. The final phase is one of reconnection. In the nine stages of DID treatment described by Kluft (1991; see Table 2), Herman's stage of safety consists of stages 1 - 3, remembrance and mourning is stage 4, and reconnection is associated with stages 5 - 9. A failure to respect the *considerations of stage-oriented treatment* with the traumatized exposes the already injured patient to the risk of further harm.

Progress on the *DTMI indices* is an indication that the patient is achieving better control and enhanced cooperation with the therapy. It is useful to use this relatively objective measure because therapists typically overestimate the progress of DID patients and their readiness to progress to trauma work (Kluft, 1994a, 1994b). The therapists of DID patients work long and hard, and are eager to find signs that their efforts have led to change. DID patients often are eager to please their therapists. Both pressures can lead to an

overemphasis on the positive that may catapult the patient prematurely into perilous waters. All too often estimates of progress are made on the basis of the circumstances of a few alters rather than the whole person. The DTMI scoring protocol insists on conservative scoring. It is very unusual for the DTMI score to confirm the estimates of therapists who have not seen several DID patients through to integration, but quite commonly the DTMI mirrors the impressions of more experienced and battle-hardened DID therapists.

A typical DTMI item, therapeutic alliance, is illustrated as Table 3. It is very difficult for a DID patient who is not well-contained and cooperative to score well on it. Excepting the circumstances of the unstable patient, trauma work is not generally safe at all unless the therapeutic alliance can be rated three or more. At three, occasional circumscribed trauma work may be possible, but it is not possible to work on trauma in a sustained fashion. At four or five, sustained trauma work can be considered for a patient with good ratings in other areas as well. When with a strong patient, it should not be thought that the capacity to do trauma work indicates that this can or should be the focus of every session. Trauma work should be paced, and exploration and abreaction should be followed by processing, not necessarily by further exploration and abreaction. In the absence of generally good ratings, only intermittent and clinically unavoidable trauma work should be considered.

The use of DTMI ratings to determine readiness will be illustrated with several vignettes.

Patient One

This patient is a mental health professional who entered therapy amidst terrible external stress. He rapidly achieved high ratings on the DTMI. When, after about ten months of treatment, his circumstances improved, he proceeded rapidly to the abreaction of traumata and integration.

Patient Two

This patient is an 18-year-old hospitalized adolescent. She was transferred to the author after three years of unsuccessful inpatient treatment with a colleague. She has gradually developed the capacity to do occasional bits of trauma work. Although her final scores resemble the beginning scores of the more highly functioning Patient One, it is clear that she is on her way to a high trajectory, with gains of 19 points in seven months and a therapeutic alliance score of three. With such a patient, despite her low overall score, her trajectory allows the occasional attempt to deal with intrusive traumatic material.

Patient Three

This patient represents a low trajectory patient who has had a prolonged and stormy course of over a decade. Attempts to work with traumatic material earlier in her therapy inevitably led to decompensation and self-harm. Since

TABLE 3

Sample DTMI Item:
Therapeutic Alliance

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 are either 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

1989 the focus has been on strengthening the patient. She is now a much more stable individual, and is nearly ready to attempt to work with traumatic material on an occasional basis.

Patient Four

This patient illustrates the important pattern of the low trajectory patient who makes a leap forward. After years of

making little apparent progress, this patient suddenly "got the hang of therapy" after a particular piece of work, and began her work with traumatic material only within the last three months. She is abreacting her traumata on an outpatient basis, and integrating alters on a rather regular basis. Most of her symptoms have remitted.

Patient Five

This patient is a middle trajectory patient. She has made slow, undramatic progress, with little integration, but has strengthened herself so that she is poised to do more work with trauma without regression, in the pursuit of integration. She began therapy in 1990, and was not ready to do any real work with traumata until 1994. Only late in 1994 did it become possible to attempt to do such work on an ongoing basis, with much resultant integration.

It appears that DTMI measurements can offer a useful tool for the assessment of readiness for trauma work.

The *therapist's readiness to work with traumatic material* is another consideration of consequence. Unless the therapist has the skills and resilience to do this type of work, it is likely that proceeding with it will jeopardize the therapy and hold the potential to place the patient in harm's way.

Logistics must be adequate to sustain the treatment. Sessions must be sufficient in duration and frequency to support the patient through the process, and the patient must have reasonable access to the therapist or alternative effective intervention between sessions in order to assure that problematic incidents and difficulties can be attended to rapidly, without their being allowed to escalate into major crises.

The Unstable Patient

An occasional DID patient will enter treatment with traumatic material intruding into awareness, and unresponsive to containment techniques. At times one will encounter a DID patient who has abruptly begun to do poorly in connection with intrusive symptoms which appear to relate to traumatic experiences. In still other situations, one may find a DID patient who simply cannot gain control of traumatic material and who is suffering deeply due to the intrusive post-traumatic symptomatology, but whose DID is otherwise not chaotic. In these and similar circumstances the clinician is confronted with DID patients who do not appear to fit the general criteria for beginning work with traumatic material, but who either appear capable of benefiting from a direct approach to the traumatic material nonetheless, or whose traumatic material must be approached because it is clinically disruptive and there is no way around it.

All such endeavors are calculated risks, and must be discussed as such with the patient, who should be able to give informed consent to proceeding with a potentially problematic intervention. In such cases the therapist should either

be an expert or highly experienced, or should involve an expert or highly experienced colleague as a consultant or supervisor. The logistics must be appropriate, and the assessment of the patient's ego strengths must convince the therapist that the patient is likely to rebound in short order from any temporary regression. The patient must choose such an approach freely, and have excellent motivation, and a fair degree of courage. All comorbid conditions must be addressed simultaneously. In the author's experience, it is most useful to be skilled in hypnosis to do this work, because the adroit application of hypnotic techniques (Kluft, 1988b, 1989, 1992) can often mitigate the absence of early phase work and supply a prosthesis for the patient's beleaguered ego functions.

The situations in which such out-of-phase or DTMI-incongruent interventions might be applied are too varied to discuss in detail. Two illustrations will demonstrate this type of approach.

Patient One

A basically strong mental health professional with a history of severe child abuse entered treatment for DID. After two months of once-weekly sessions, during which only the most gentle preparatory work was in progress, she evaluated a young girl who had had experiences similar to her own. She became flooded with flashbacks, and they did not respond to cognitive and hypnotic efforts to contain them. She began to get panic attacks, her sleep became disrupted, and she found herself unable to practice, because as soon as she worked with an abuse victim she herself became deluged with flashbacks.

After alternative treatment approaches and their potential benefits and drawbacks were discussed, the patient elected to try to abreact the intrusive material. The therapist explored hypnotically and found that the intrusive material was from two child alters, whose experiences and affects were infiltrating the other alters. Each alter was helped to abreact its experiences and taught to go to a safe place. Thereafter each agreed to take a long nap in its safe place, experiencing only pleasant dreamless sleep until it was time to enter the therapy in a more engaged fashion. Then the patient's other alters were given permissive amnesia for the material that had intruded. That achieved, the therapy returned to considerations appropriate to the phases of establishing the therapy and preliminary interventions. The traumata of those child alters were not revisited for nine months.

Patient Two

A physician with DID had returned to practice after years of disability. The treatment was focused on helping the alter system retain stability in the face of the considerable stress of practicing medicine, with the goal of turning toward a more definitive therapy once the physician's stability was well-established. Long estranged from her family, she received a

call from a sister on the occasion of her birthday. Their conversation precipitated the recovery of traumatic scenarios and the emergence of associated alters that could not be contained, and flooded her or intruded upon her continuously, even impairing her professional activities. With her informed consent, focused trauma work was done on the material that could not be contained, which was associated with the disruptive alters, and she was able to stabilize. Therapy was then redirected toward supporting her in her return to practice.

It is important to note that in such instances the successful completion of a piece of trauma work is not an indication to proceed with more of the same. Instead, it is the opportunity to put the therapy back on track by returning to a focus on stage-appropriate objectives.

DETERMINING WHETHER TO PURSUE WORK WITH TRAUMATIC MEMORIES - II: PRAGMATIC DECISION-MAKING

If the dimensions discussed above are kept in mind, the decision about whether to proceed should be both self-evident and time-limited. It should be self-evident because in the majority of instances, all nine dimensions should favor the decision to go forward. It should be time-limited because it is clear both from clinical experience and recent DTMI research that many patients who are not good candidates for such work will become able to undertake it at a later date, and making a permanent decision against doing such work may condemn a patient capable of full recovery from DID to a lifetime of compromised mental health. Furthermore, the decision to proceed with trauma work should be subject to ongoing re-evaluation. It should not be regarded as an irrevocable decision. For example, a strong and determined DID patient had done all the necessary work preparatory to beginning trauma work. We had actually begun to work with the first alter whose traumata were to be processed, but had not begun the actual processing, when she learned that her teen-aged son had been diagnosed with leukemia. Although she protested that she could deal with both this stressor and the trauma, I argued that she had not yet absorbed the meaning of the news about her son, and that she would need her full emotional resources to deal with his illness and its impact upon her and the family. With some reluctance, she agreed. We did not return to trauma work for two years, during which we worked on containment so she could support her son, which she did with tenderness and strength. Four years later, when we were well along in her trauma work, she contracted Lyme disease, and suffered severe consequences. Trauma work was curtailed, except for working with material that broke into awareness and could not be contained with hypnotic and other strategies.

It is self-evident that the patient's voluntary cooperation and motivation is essential, along with the skill of the ther-

apist and the adequacy of logistics. It is not permissible to proceed with comorbid conditions uncontrolled unless they are believed to be epiphenomena of the traumata and perceived to be likely to be resolved by the trauma work. If the patient's life circumstances are either acceptably stable or are at a level of chronic uproar to which the patient has adapted, such work may be possible. If there has been adaptation to chronic uproar, any trauma work should be intermittent, and never preoccupy more than two consecutive sessions. The patient's ego strengths must be deemed adequate to manage at least occasional trauma work without regression, and may determine how frequently it will be feasible to do trauma work. For some patients a relatively consistent trauma focus (which still does not mean focusing on trauma in every session) can be considered, while for others it may be advisable to do deliberate trauma work no more than once a month, and to process that material gradually between focused trauma sessions.

If the goals of stages one through three have not been attained, the focus should remain supportive. In fact, with the exceptions noted above, it will be essential not to proceed to stage three if the first two stages are not managed, because taking the history presupposes the ability to shut down any strong feelings and material that may emerge (Fine, 1991, 1993; Kluft, 1993). Likewise, the failure to attain DTMI scores of over 30 precludes most trauma work. The failure to achieve a therapeutic alliance score of three or more prohibits deliberately-induced trauma work. A score of three may sustain occasional non-sustained work on trauma, but sustained focused trauma work necessitates a therapeutic alliance score of four or more, and a profile with high scores in dimensions related to safety and impulsivity.

Patients who have been assessed in this manner and found unready for work on trauma can be prepared for trauma work by therapeutic efforts that focus on providing them with the assets necessary to advance toward this goal. The therapist who comes to a realization that his or her patient is not a candidate for trauma work is less likely to succumb to countertransference therapeutic ambitiousness and push the patient to engage in a countertherapeutic situation. If a patient never achieves the strengths necessary to proceed, the treatment must retain a supportive focus, although it may have to address intrusive traumatic material from time to time.

Models of Therapy and Trauma Work

When considering how to approach the patient who is able to do work on trauma, and the patient who is not, it is useful to consider which treatment models are appropriate for the various endeavors. In earlier communications (e.g., Kluft, 1988, 1993a) I have attempted to classify current stances toward the treatment of DID. Here I will demonstrate how those stances affect the subject at hand.

Strategic integrationalism "focuses on rendering the dis-

TABLE 4
Dimensions Suitable for Fractionation in
Fractionated Abreactions

- A. Temporal Sequences
- B. Percentage Titrations
 - 1. Rheostat Metaphor
 - 2. Control Panel
 - 3. VCR Metaphor
 - 4. Slow-Leak Variants
 - 5. Mountain Metaphor
 - 6. Library Technique Variant
- C. Input Subdivision
 - 1. BASK Dimensions
- D. Alter Participants
 - 1. Number of Participants
 - 2. Sequential Spill-over
 - 3. Branching or Waterfall Overflow
 - 4. +/- Protective/Anesthetic Alters as Companions or in Temporary Blendings

sociative defenses and the structures that sustain [DID] less viable, so that the condition in essence collapses from within. Its ideal goal is the integration of the personality in the course of the overall resolution of the patient's symptoms and difficulties in living" (Kluft, 1988). This is consistent with the psychoanalytic tradition of the analysis and resolution of pathological defenses. Although this approach, which values process over the use of techniques, might seem to be quite safe because it does little that is intrusive, this appearance is deceptive. It is best applied to the patient with very high ego strength, much as is psychoanalysis. If it is used with a DID patient unready for trauma work, it may loosen defenses that are very much needed to keep the traumatic material in check, and encourage regression and decompensation. This model is only safe with less stable DID patients if it is ineffective. The fact that few people who use it with DID are skilled with DID makes it, ironically, a relatively safe approach under those circumstances because it is not a powerful technique in their hands. Well-applied, it is not appropriate for patients who are not prepared to face traumatic material with

considerable ego strength.

Tactical integrationism also focuses on integration, but attempts to achieve it with a predominant focus on tactics and discrete interventions that serve as adroit devices to accomplish a series of objectives. Planful and deliberate, such a focus can be used with any DID patient, and the techniques applied either to dilute the intensity of the treatment in the interests of safety, or to pursue a titrated approach to traumatic materials. It is always a relatively safe approach if used with skill, because the steps it takes are small and gradual, and respectful of the dissociative defenses until late in the treatment process.

Personality-focused treatments proceed as if they were a family therapy of the self or a diplomacy designed to bring about the more facile cooperation of the alters; integration may be pursued if desired. This approach is very valuable when it is important to avoid traumatic material, but nevertheless to achieve symptomatic relief and better function. It is extremely useful for supportive work when the alters are in evidence and can be accessed without destabilizing the patient.

Adaptationalist approaches prioritize the management of life activities and the maintenance and improvement of function. Integration is considered an option, and a luxurious one at that. It is most useful when the patient is symptomatic, but working with the alters directly might be destabilizing. It certainly can be used when the alters can be accessed without difficulty, but is without distinct advantages over other approaches under those circumstances. By its very nature it is an incomplete therapy, and more a combination of therapy and symptom management approaches. It is most suitable for the compromised or low trajectory DID patient, the patient whose motivation for more definitive treatment is uncertain, or for the patient who is being maintained while an overall treatment strategy is being decided upon.

Although any therapy almost inevitably is a combination of all or most of the above stances as clinical circumstance change over time, the above considerations may be useful in considering how to approach the patient who is not ready for trauma work. When trauma work is a focus, inevitably strategic integrationist or tactical integrationist stances must be brought to bear, and the adaptationalist stance is contraindicated. When the focus is supportive, the strategic integrationist stance should be avoided, while all of the other stances may play useful roles.

Techniques that Protect the Patient During Trauma Work

When doing work with traumatic materials, it is useful to select techniques and interventions that are "user friendly" with respect to the patient's psychological resources. The fractionated abreaction approach developed by Kluft (1988, 1989, in press) and discussed in depth by Fine (1991) is one of the most powerful methods available to make the processing of traumatic memories more tolerable. Dimensions

of fractionation are outlined in Table 4.

In essence, fractionation replaces traditional abreaction's pursuing the abreactive process vigorously to its completion with an approach that allows the abreaction to be done piecemeal and a controlled manner. Its goal is to bring the patient to a posture of mastery over what has befallen him or her. In this manner a desensitization is undertaken, and the patient is protected from being confronted with overwhelming memories and affects at a level of intensity that is likely to lead to countertherapeutic disorganization and discomfort. When used with hypnotic temporizing techniques (Kluft, 1989), this combination is associated with a great deal of safety and control. In fifteen years of using fractionation techniques, the author has only had one patient leave a session in a badly overwhelmed state. That patient had not followed the instructions that were given. In her zeal to recover quickly, despite agreeing to work with a single alter, she had tried to work with several alters simultaneously. Stunned by the outcome of her misadventure, she never repeated this type of mistake, and concluded a successful therapy two years later.

Fractionation invites the patient to collaborate with the therapist in determining how much pain will be worked with in a given session. Active planning toward mastery replaces the feared passive helplessness that was characteristic of the trauma, and which the patient does not wish to reexperience. Traumatic incidents are broken down into small steps, dysphoria is presented in increasing percentages of its original intensity, the BASK dimensions (behavior, affect, sensation, knowledge) (Braun, 1988) can be presented in isolation from one another, and the alters associated with a trauma can be worked with one at a time if this seems wise. Also, it can be arranged for vulnerable alters to do their trauma work in combination with stronger and more stable ones.

In this manner, the therapist conversant with fractionated abreaction methodology and associated hypnotic interventions can usually approach trauma work in a manner less likely to overwhelm the patient's resources and disrupt the course of his or her life.

CONCLUSION

Let us now address the questions that were posed at the start by the organizers of the Amsterdam Conference with regard to the treatment of traumatic memories: Do we work with them "Always? Never? Sometimes? Now? Later?"

Always? Of course not. Some patients will never be ready to do the trauma work. Virtually all patients, even the most strong, gifted, and resourceful, are incapable of maintaining a continuous focus on trauma work. Trauma work should be titrated with compassion and kindness, and when there is doubt as to whether it is safe to pursue it, it should not be done.

Never? Sometimes! There are patients who will never be

able to do the trauma work, but a premature decision that a patient can rarely do the trauma work is potentially harmful. It may condemn a patient who could gradually gain the strength to face traumatic material and integrate to a life without prospects of full recovery. The decision to defer trauma work should rarely be permanent, and should be reassessed periodically. The attempt to strengthen the patient should never be abandoned.

Sometimes? Yes, also, in the sense that this is the most reasonable stance. Yes, also, in the sense that every DID patient should be expected to do trauma work at some point in the therapy, because it is virtually impossible to remove trauma, its impacts, and its intrusions into the therapy of a DID patient, no matter what strategy is elected by the therapist and patient. We can count on life to provide a sufficient number of triggering stimuli to force each DID therapy to address trauma, if only infrequently or intermittently.

Now? The answer is affirmative only if all nine considerations noted above are appropriately attended to (with the possible exception of the DTMI indices, since this instrument is not widely known or used), or if it seems appropriate to use trauma work to restabilize an unstable patient with basically good strengths, or a patient in whom the trauma work simple cannot be avoided, despite intentions to the contrary. In the latter case, "now" becomes "no" as soon as one has done enough work to effect restabilization.

Later? When in doubt, this is always the best approach to consider.

A FINAL OBSERVATION ON THE TREATMENT OF TRAUMATIC MEMORIES IN DID PATIENTS

It is a matter of choice rather than oversight that this paper has not addressed the subject of whether the traumatic memories considered for processing are or are not accurate, although this has been noted in passing throughout the text. This is a clinical paper with a specific focus on whether it is appropriate to proceed with the treatment of traumatic memories. Trauma therapy, like therapy in general, is dedicated to helping the patient deal with what is important to the patient, and with what appears to have had and to be having an impact on the patient. In clinical circumstances, it is rarely possible to ascertain the accuracy of allegations and given historical material, and often it would not be appropriate to attempt to do so. It is clear that DID patients may present memories that prove accurate and memories that prove inaccurate, and memories that contain admixtures of accuracy and inaccuracy (Kluft, 1984). Furthermore, in DID treatment, as in most therapies, most allegations made remain neither proven nor disproven (Kluft, 1995, 1998). Most therapies of all sorts spend most of their time and effort discussing or addressing matters that are of uncertain accuracy, but which are important to individual patients. For a more scholarly approach to memory in therapy, the reader

is advised to consult the encyclopedic *Memory, Trauma Treatment, and the Law* (Brown, Schefflin, & Hammond, 1997). ■

REFERENCES

- Braun, B.G. (1986). Issues in the psychotherapy of multiple personality disorder. In B.G. Braun (Ed.), *Treatment of multiple personality disorder* (pp.1-28). Washington, DC: American Psychiatric Press.
- Braun, B.G. (1988a). The BASK (Behavior, Affect, Sensation, Knowledge) model of dissociation. *DISSOCIATION*, 1(1), 4-24.
- Brown, D. (1995). Pseudomemories: The standard of science and the standard of care in trauma treatment. *American Journal of Clinical Hypnosis*, 37, 1-24.
- Brown, D., Schefflin, A., & Hammond, D.C. (1997). *Memory, trauma treatment, and the law*. New York: Norton.
- Coons, P.M. (1994). Confirmation of childhood abuse in child and adolescent cases of multiple personality disorder and dissociative disorder not otherwise specified. *Journal of Nervous and Mental Disease*, 182, 461-464.
- Fine, C.G. (1991). Treatment stabilization and crisis prevention: Pacing the therapy of the multiple personality disorder patient. *Psychiatric Clinics of North America*, 14, 661-675.
- Fine, C.G. (1993). A tactical integrationalist perspective on the treatment of multiple personality disorder. In R.P. Kluft & C.G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 135-153). Washington, DC: American Psychiatric Press.
- Fraser, G.A., & Raine, D. *Cost analysis of the treatment of MPD*. (1992, November). Paper presented at the Ninth International Conference on Multiple Personality and Dissociation, Chicago, IL.
- Hammond, D.C., Garver, R.G., Mutter, C.B., Crasilneck, H.B., Frischholz, E.J., Gravitz, M.A., Hibler, N.S., Olson, J., Schefflin, A., Spiegel, H., & Wester, W. (1995). *Clinical hypnosis and memory: Guidelines for clinicians and for forensic hypnosis*. Seattle: American Society of Clinical Hypnosis Press.
- Herman, J.L. (1992). *Trauma and recovery*. New York: Basic Books.
- Horevitz, R.P., & Loewenstein, R.J. (1994). The rational treatment of multiple personality disorder. In S.J. Lynn & J.W. Rhue (Eds.), *Dissociation: Clinical and theoretical perspectives* (pp. 289-316). New York: Guilford.
- Hornstein, N.L., & Putnam, F.W. (1992). Clinical phenomenology of child and adolescent multiple personality disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 31, 1055-1077.
- Kluft, R.P. (1984). Treatment of multiple personality disorder. *Psychiatric Clinics of North America*, 7, 9-29.
- Kluft, R.P. (1988a). On the treatment of the older patient with multiple personality disorder: "Race against time" or "make haste slowly?" *American Journal of Clinical Hypnosis*, 30, 257-266.
- Kluft, R.P. (1988b). Editorial: Today's therapeutic pluralism. *DISSOCIATION*, 1(4), 1-2.
- Kluft, R.P. (1989). Playing for time: Temporizing techniques in the treatment of multiple personality disorder. *American Journal of Clinical Hypnosis*, 32, 90-98.
- Kluft, R.P. (1991). Multiple personality disorder. In A. Tasman & S.M. Goldfinger (Eds.), *American Psychiatric Press annual review of psychiatry* (Vol. 10, pp. 161-188). Washington, DC: American Psychiatric Press.
- Kluft, R.P. (1992b). Hypnosis with multiple personality disorder. *American Journal of Preventive Psychiatry and Neurology*, 3, 19-27.
- Kluft, R.P. (1993a). The treatment of dissociative disorder patients: An overview of discoveries, successes, and failures. *DISSOCIATION*, 6, 87-101.
- Kluft, R.P. (1993b). The initial stages of psychotherapy in the treatment of multiple personality disorder patients. *DISSOCIATION*, 6, 145-161.
- Kluft, R.P. (1994a). Treatment trajectories in multiple personality disorder. *DISSOCIATION*, 7, 1, 63-76.
- Kluft, R.P. (1994b). Clinical observations on the CSDS Dimensions of Therapeutic Movement Instrument (DTMI). *DISSOCIATION*, 7(4), 272-283.
- Kluft, R.P. (1994c). Ruminations on metamorphoses. *DISSOCIATION*, 7(3), 135-137.
- Kluft, R.P. (1995). The confirmation and disconfirmation of memories of abuse in dissociative identity disorder patients: A naturalistic clinical study. *DISSOCIATION*, 8, 253-258.
- Kluft, R.P. (1998). Reflections upon the traumatic memories of dissociative identity disorder patients. In S.J. Lynn and K. M. McConkey (Eds.), *Truth in memory* (pp. 304-322). New York: Guilford.
- Kluft, R.P. (in press). The management of abreactions. In J. Turkus & B. Cohen (Eds.), *Multiple personality disorder: Continuum of care*. New York: Jason Aronson.
- Putnam, F.W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: Guilford.
- Ross, C.A. (1989). *Multiple personality disorder: Clinical phenomenology, diagnosis, and treatment*. New York: Wiley.
- Ross, C.A., & Dua, V. (1993). Psychiatric care costs of multiple personality disorder. *American Journal of Psychotherapy*, 47, 103-112.
- Turkus, J.A. (1991). Psychotherapy and case management for multiple personality disorder: Synthesis for continuity of care. *Psychiatric Clinics of North America*, 14, 649-660.
- van der Hart, O., Brown, P., & van der Kolk, P.A. (1989). Pierre Janet's treatment of post-traumatic stress. *Journal of Traumatic Stress Studies*, 2, 379-395.
- Waldhorn, H.T. (Reporter). (1967). Indications for psychoanalysis. In E.D. Josephs (Ed.), *Monograph II: Monograph series of the Kris Study Group of the New York Psychoanalytic Institute* (pp. 3-51). New York: International Universities Press.