CLINICAL OBSERVATIONS ON THE USE OF THE CSDS DIMENSIONS OF THERAPEUTIC MOVEMENT INSTRUMENT (DTMI)

Richard P. Kluft, M.D.

Richard P. Kluft, M.D., practices psychiatry and psychoanalysis in Philadelphia, PA, where he is Director of the Dissociative Disorders Program at The Institute of Pennsylvania Hospital and Clinical Professor of Psychiatry at Temple University. School of Medicine.

For reprints write Richard P. Kluft, M.D., Director, Dissociative Disorders Program, The Institute of Pennsylvania Hospital, 111 North 49th Street, Philadelphia, PA 19139.

ABSTRACT

The CSDS Dimensions of Therapeutic Movement Instrument (DMTI) is a 12-item instrument designed to allow therapists to follow the progress of the treatments of patients with Dissociative Identity Disorder (formerly Multiple Personality Disorder) and allied forms of Dissociative Disorder Not Otherwise Specified (DDNOS.) The current communication will illustrate its clinical applications and offer guidelines with regard to the frequency of its use, the meaning of its scores, and the implications of the of the treatment trajectories that it demonstrates.

INTRODUCTION

Dissociative Identity Disorder (DID) and allied forms of Dissociative Disorder Not Otherwise Specified (DDNOS) are diagnosed and treated with increasing frequency in the North America (Putnam, 1993) and elsewhere (van der Hart, 1993). Although the overtness and disruptiveness of the condition often waxes and wanes it appears that DID/DDNOS (hereafter DID) patients do not improve spontaneously (Kluft, 1985, 1991). Nor do they achieve the resolution of their difficulties in treatments that take efforts to discourage or choose not to address the DID phenomena. Although they may cease to manifest their conditions in the presence of their therapists, and/or decline to make report of the manifestations of the DID to therapists who clearly are pleased not to hear about them, this hardly constitutes remission. Non-specific general therapy that acknowledges but fails to address the DID may help DID patients in general, but resolves the DID itself in only 2-3% of such treatments (Kluft, 1985, 1993a).

In contrast, specific treatment is often quite successful. Treatments of private practice patients by therapists with great experience with DID is often remarkably successful within a period of several years (Kluft, 1984, 1986, 1993a). Treatments of state hospital clinic patients by trainees and therapists new to DID is far less successful (Coons, 1986). Nonetheless, taking into account the findings of the studies cited above, it appears that specific treatment efforts with state hospital clinic patients by neophytes (often under the supervision of or in consultation with a therapist experienced in the treatment of dissociative disorders) is more effective than the non-specific treatment of private practice or clinic patients by more experienced mental health professionals (Kluft, 1993a, 1994, unpublished data).

Despite the above findings, much remains unknown. There are no substantive data that speak to the fate of the average DID patient in treatment with an average therapist with a reasonable degree of knowledge and skill in the treatment of DID. In all likelihood it will be difficult if not impossible to explore these concerns without extensive multicenter studies. Although some are being planned, it is not likely that they can be brought to their successful completion in this century.

Meanwhile, therapists working with DID patients have very little information to draw upon in order to assess their work and better appreciate the progress of the treatments that they actually are conducting. Not only is the treatment of DID potentially demanding for patient and therapist alike, but all too often both participants experience the therapy as a journey through a confusing and uncharted landscape in which there are few if any reliable landmarks, in which apparent trails abruptly come to an end or swerve in unanticipated directions, in which hazards appear with little warning, and in which things rarely prove to be what they seem. This can be perplexing, disorienting, and demoralizing. Uncertainty can be corrosive to the confidence and competence of the therapist. It is not uncommon for a cycle of mutual projective identification to occur in which therapist and patient create a Type B field (Langs, 1980) and pass their distress, discouragement, disillusionment back and forth in a sharing that has unfortunate implications for the fate of the psychotherapeutic venture.

This is all the more likely to occur because getting better and feeling better rarely occur simultaneously in the treatment of DID. As a DID patient comes to grips with increasing amounts of difficult material and involves the more problematic alters in the therapy, treatment may be progressing very well, but the intensification of distress is not uncommon. Consequently, both the patient who is working well in treatment and the patient who is doing poorly may be feeling increasingly miserable, and both may complain vociferously on the basis of their subjective feeling states and the absence of tangible signs of improvement that the treat-

ment is "going nowhere" and/or that they were better off before they entered therapy. As the patient protests that the treatment is not helping, and may even insist that it is causing a deterioration, it becomes difficult for the therapist to remain confident that progress is actually occurring. Even the experienced therapist who has seen many DID patients through such valleys of despair may be unable to convince him- or herself that matters are progressing in a satisfactory manner, let alone offer meaningful reassurances to the patient.

Conversely, all too often treatments in which the patient feels very well and has a positive regard for both the therapist and the therapy may not be making progress. It is not uncommon for consultation to be sought because a therapist and patient who feel very good about one another appreciate that little is happening in the their work together. "I really like the patient, and there is a very positive transference," a therapist may say, "but after six years of work I am not sure much has really changed." "Dr. B. is very nice, and I would hate to have to leave her," a patient might observe, "but I am not sure I am any better after all this time." Frequently such treatments have proceeded under the influence of what I have described as a quasi-positive submissive transference; that is, the patient behaves toward the therapist as if he or she were a person who both abused the patient and insisted upon being told he or she was loved and respected. In other cases the therapist has responded or been perceived as responding to the patient's need for nurture and support, and this had been such a decisive force in the treatment that no work on other areas has been able to take place. Consequently, the absence of difficult material from the therapy is responsible for the general atmosphere of good feeling. In still other situations a positive transference constellation has become a transference of resistance, or the real relationship between the therapist and patient has overwhelmed the treatment. In both cases, close inspection reveals the absence of a viable therapeutic alliance, which seems to be highly correlated with progress in treatment (Kluft, 1994).

Furthermore, it is always difficult to assess one's work objectively. The therapist is too intimately involved in the therapeutic process to be able to view it with complete dispassion. Countertransference may influence perception. The therapist's identity and self-esteem may be invested in the success of his or her practice; therefore judging progress of the therapeutic work may become a test of the therapist's own worth and/or efficacy. There is a well-known tendency to see in a welter of material that which is consistent with and tends to support one's opinion and orientation — confirmatory bias (Baron, Beattie, & Hershey, 1988). If one embraces a particular theoretical model or clinical approach one will tend to see that which seems to uphold or demonstrate them as the most relevant data; there is a risk of paradigm-driven myopia with the repudiation of information that would lead to cognitive dissonance (Festinger, 1957), with consequent self-deception. These are only a few of the factors that may compromise the objectivity of the clinician.

However, the therapist's lack of this type of objectivity generally is not a shortcoming. Therapy is an intense and intimate engagement. The distance and detachment necessary for the most effective assessment is inconsistent with the stance of the involved therapist. Any experienced supervisor of student psychotherapists can not only point to situations in which the neophyte therapist's naivete was detrimental to a treatment, but also to instances in which a beginner accomplished a remarkable result, perhaps in part because the beginner did not know what more experienced clinicians knew — that it could not be done.

The Dimensions of Therapeutic Movement Instrument

The CSDS (Center for the Study of Dissociative States) Dimensions of Therapeutic Movement Instrument (DTMI) (Kluft, 1994) was developed to serve certain specific purposes. In the course of my consultation to colleagues and my supervision of residents and other trainees I frequently would find that the clinicians discussing DID patients with me were genuinely uncertain about how to understand whether the course of treatment was progressing, stalemated, or deteriorating. All too often the clinician was attempting to gauge the state of the therapy by considering whether or not there were crises or self-injuries, whether alters were accessible and/or cooperative, whether the patient's anger was problematic, whether the patient tended to agree more often than not with the therapist's observations, whether the patient was willing and able to do abreactive work, whether the relationship between therapist and patient was perceived as positive in tone, etc. Some used very idiosyncratic or highly subjective criteria (e.g., "how I feel things are going," "my gut feel"), and others were (sometimes unwittingly) using countertransference reactions as their guides.

I came to think that I needed a more formal way of demonstrating, discussing, and teaching about treatment progress in work with DID patients. I also appreciated that clinicians working with DID patients needed to have some instrument that they could use to monitor their patients' responses, an instrument that that would be much more objective than their subjective and impressionistic estimations alone. As noted elsewhere (Kluft, 19994), I also was interested in exploring and understanding the significant and thought-provoking discrepancies between my own studies of treatment progress and those of Coons (1986).

The DTMI is a clinician-scored instrument that allows the assessment of 12 dimensions of clinical progress, each on a 0-5 scale. Therefore, the minimum score is zero, and the maximum score is 60. The dimensions are listed in Table 1.

The DTMI has not been assessed for reliability or validity, although such studies are in progress. It is an admittedly preliminary measure. It was published in its current form in response to literally hundreds of requests that it be made available. It has proven extremely useful and reliable in the author's hands, and in the hands of those he has trained in its use.

Preliminary results indicate that DID patients scored monthly or more frequently on the DTMI for six months to a year demonstrate one of three basic treatment trajectories, and that follow-up indicates that these initial trajecto-

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

ry patterns hold steady for the next several years in virtually all cases newly entered into treatment, while patients who have established a treatment trajectory over a period of years occasionally jump to a higher trajectory, and rarely drop into a lower one. In these cases, moving to a higher trajectory is associated with therapeutic breakthroughs, while moving lower is associated with a negative therapeutic reaction, intercurrent upsetting events, or the impact of comorbidity (Kluft, 1994; unpublished research findings).

DTMI-DERIVED TREATMENT TRAJECTORIES

Initial explorations have indicated that within a year or less DID patients assort themselves into one of three treatment trajectories: 1) a group of patients whose DTMI scores increase and/or stay high, and who rapidly move toward integration and recovery; 2) an intermediate group whose scores improve moderately from the beginning of the year to the end; and 3) a group whose scores improve slightly if at all over the year. These are the high, intermediate, and low trajectory groups. The intermediate group is further subdivided into three subgroups. The first shows slow but gradual improvement; the second shows ups and downs but averages out to slow improvement; the third makes one or two improvements and plateaus, making no further gains for months.

In this context it is significant that Ross and Dua (1993) and Fraser and Raine (1992) also found three groups of DID patients in terms of their responses to treatment and consumption of mental health care resources. However, it remains unclear to what extent the three groups described by these authors and Kluft (1994) are comparable. It seems clear that all authors found one group of DID patients that responded rapidly to treatment and one that did not, but their intermediate groups are difficult to reconcile on the basis of information published to date.

The high trajectory group either moves toward attaining or continues to merit superior scores on the DTMI. Such patients "get the hang of therapy" and, often complaining every step of the way, go about doing what has to be done. They rapidly form a good therapeutic alliance or move toward its improvement. Even if their systems are large and complex, the therapeutic alliance rapidly involves more and more of the alters. They commit themselves to the treatment process and identify with the work ego of the therapist. They appreciate that therapy is a partnership and appreciate the need to do hard work. Although they value the support of the therapist, they are not preoccupied with pursuing it. They take satisfaction in their accomplishments in therapy. Suicide and self-injury is rapidly ruled out as an appropriate option, however tempting such pursuits might be. They are able to take a rationale approach to dealing with those they allege have abused them in the past, but no particular strategy in their dealing with their families predominates.

Low trajectory patients often are characterized by their prioritization of the pursuit of nurture and support, and their seeking the therapist's approval. They seem to perceive their source of help as external to themselves, as is their sense of locus of control. They frequently protest that they are trying very hard, and/or that it is not appreciated how much effort they are putting into the treatment. Frequent low trajectory patient preoccupations are: "Do you like me?" "Are you angry at me?" "She [an alter] can't take the pressure." Their idea of participation in the therapeutic alliance is often compliance and/or submission rather than partnership; less frequently they are preoccupied with controlling the therapist. Legalistic wrangling is very frequent. Characterologic issues are often prominent. Not infrequently, the alter systems are highly complex, and/or extremely sadomasochistic, and/or dominated by child alters, and/or noteworthy for the absence of a robust host or the frequent of prolonged abdication of the alter with the patient's legal name. The inner worlds often recapitulate the patient's alleged traumata. Issues of self-injury and suicidality are rarely resolved in a definitive manner. Allegations of bizarre multiperpetrator abuse are very common in this group. Many remain enmeshed with the families that they allege have abused them.

Intermediate trajectory patients have proven such a varied lot that generalizations have proven difficult. Often they appear borderline in many respects, and simply take longer that the high trajectory group to begin to move forward. Several such patients had major affective and/or eating disorders that complicated their treatments. Some were very hard workers, but accessing and dealing with their alters systems simply took quite a long time. Often co-consciousness was difficult to achieve, and/or denial of the reality of the diagnosis persisted, and/or a major alter tried to rationalize not dealing with the others for months or years on end. Impulsiveness and catastrophic reactions to crises were common, and often led to complications that made treatment

extremely difficult. This group included a successful suicide and several patients who self-injured and made suicide attempts. Such risks were most characteristic of that subgroup whose scores bounded up and down. It is my impression that these patients, who experienced improvement and then felt it was snatched away from them, who knew hope only to experience it as a cruel deceiver, were more prone to suicide than the low-trajectory patients who had accommodated to chronic misery and often clung to life, but not to hope. These few examples and observations do not do justice to the complexity of this group.

With regard to DTMI scores for DID patients in their first year of therapy, in general high trajectory patients held or rose to overall scores of over 40 and held therapeutic alliance scores of four or five or increased their therapeutic alliance score two points or more. Middle trajectory patients were difficult to characterize in their global score, but generally either held a DTMI score in the high 30s or low 40s, or showed an increase of over 10 points in their first year and over five points per year in subsequent years. Their therapeutic alliances fluctuated, but averaged about three, or had made a gain of one point or more in the prior year. Low trajectory patients generally held scores below 35, and showed a gain of five points or less in the course of a year. Their therapeutic alliances generally were two or below, but, as noted, they tended to protest that they were working very hard in treatment. They often made no gains in their therapeutic alliance scores for years on end.

Naturally, these generalizations cannot encompass all possible situations, especially because what is significant is an overall trend, and/or a level that is held with consistency.

FREQUENTLY-ASKED QUESTIONS ABOUT THE DTMI

As increasing numbers of clinicians have become familiar with the DTMI in workshop settings, a number of issues of recurrent concern have been identified. The answers given here are based on five years' experience with the DTMI, and the feedback of dozens of colleagues.

Why are the DTMI scores to be used by the therapist and not shared with the patient? Does this not recapitulate pathological secrecy and infantilize the patient?

Experiences with DID patients learning about their being scored have proven complications in treatment. Early efforts to use the DTMI to educate patients about their treatments have proven counterproductive. Therapeutic endeavors are guided by the Hippocratic axion, "First, do no harm." DID patients tolerate painful confrontations poorly, and there is no reason to complicate their treatment in this manner.

Many therapists appear to forget that a major goal of the treatment is to help the patient distinguish between the present and the past, and that an element of similarity does not mean an equivalence has been established. There also, in this era of consumerism and "empowerment," is a tendency to forget that learning too much too early can be traumatic.

Imagine the plight of a patient newly entered into treatment who is scored and told that treatment will be measured by repeating this measure. A year later the patient has defined him/herself as a low trajectory patient, and is now told that he or she has made a four point improvement on the DTMI, or has made none at all. He or she inquires as to the meaning of this, and is told that it probably indicates a long treatment with slow progress. Has this helped or traumatized the patient? Will it help the patient to repeat this ritual of humiliation on a periodic basis? Would it not be more humane to have not shared the score, and to tell the patient, should the patient ask, that the treatment is progressing reasonably, and that it will be advisable for the treatment to address problems in a systematic manner, step by step? I have received numerous telephone calls from DID patients whose therapists (against my advice) have shared DTMI scores. Some have wept and begged me to assure them that they were treatable, or to change the scale so all their "hard work" would be reflected in the scores, etc. Some have been enraged that their intense abreactive efforts did not show up in the DTMI score (even if they were totally decompensated). Some feared their therapists would abandon their care because they were not improving rapidly enough.

Nor is it only the less than optimal scores that can be upsetting. One patient whose materials were used in a workshop (with her informed consent) obtained a tape of the workshop in which she was able to infer which vignette, although disguised, referred to her. She heard me express my admiration for her courage and character, and state how impressed I was with her bravery and determination. Her response was typical for the DID patient confronted with praise (Kluft, 1993b). She was upset not with the fact that I had used her materials, but that I seemed to have misunderstood her so completely. Could I not appreciate that she was a moral reprobate and coward? How could she be helped by a therapist who was incapable of seeing what she really was?

In sum, the idea of being completely open with the patient with regard to the therapist's assessment of how the treatment is progressing is a flagrant boundary violation, not a helpful bit of information. It is inconsistent with the fact that we are to share with our patients not everything we think, but everything that will advance the patient's recovery. For example, most interpretations made by an analyst are silent, and never verbalized. Not everything that advances the analyst's understanding will assist the analysis and the patient's healing. The DID patient does not need additional opportunities to experience shame and mortification. For patients exquisitely sensitive to being judged and rejected, the cost/benefit ratio of sharing DTMI scores is unacceptable. Tact and compassion dictate that the scores be used for the therapist's better understanding of the therapeutic process.

Lest the reader think that I am making too strong a case, and conclude that it will be alright to share DTMI scores with patients who are doing well and not with those who are not, let me point out that the "DID underground" will soon bring news of your use of this test in patients you have praised to the ears of patients to whom you have said nothing of the

DTMI. Those who have not heard will immediately deduce the situation, to the detriment of their recovery.

Why is there no scale to describe function? Is this not an important dimension of how well the patient is progressing?

Here we come to a fascinating issue indeed. I specifically omitted a function scale after considering my experience and that of several colleagues with DID patients who spent years prioritizing function, but did so by suppressing alters and avoiding difficult issues they felt might destabilize their patients. Although they continued to function, their DID was reinforced in the process, and they often did very poor jobs in their marital and parental roles (while maintaining all was well). Therefore, I have seen ample evidence that function is not necessarily associated with improvement, and, as such, cannot be a realistic dimension of therapeutic movement. An ancillary Function scale is an appendix to this article, and can be used if the patient enters treatment in a decompensated state.

Why is there no scale to describe abreaction and/or the recovery of memories? Are these not important dimensions of treatment progress?

Unfortunately, as important as memory work and abreaction may be in the treatment of DID, there is no reason to assume that the presence of intense abreactive work is associated with improvement. Sometimes it is an indication of a treatment careening out of control. Also, there are problems with assuming that memory work per se is an indication of treatment progress, because of the problematic nature of memory. Many patients on very low treatment trajectories spend years doing work on the abreaction of memories without improving, and some patients persist in doing abreactive work and seeking out more and more traumatic materials of uncertain veracity, and which may be developed in the course of a defensive process that avoids coming to grips with more mundane difficulties. At times the therapists in these situations are not encouraging the strenuous abreactions and memory retrival processes that go on, and in fact are trying to bring them under control. Because abreaction and memory work is only meaningful in the context of a planful and circumspect therapy, separate dimensions for their assessment did not seem appropriate. If a patient is doing the sort of abreactive and memory work that is consistent with good therapeutic process, it is picked up in the therapeutic alliance dimension (e.g., for a score of five, "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" (Kluft, 1994, p. 71).

Why is there no dimension that addresses psychotic features?

I struggled with this problem, and decided to leave the DTMI without a specific psychosis scale, but with items that pick up psychotic levels of function indirectly. There are many reasons for this decision. It may be difficult to distinguish between features that have long been considered indices of psychosis, but are common in dissociative patients (Kluft, 1987). It may be possible to reduce apparent psychotic manifestations with hypnosis if the therapist has the prerequisite skills (Kluft, 1992). Often the presence and persistence of psychotic features is a commentary on the therapist more than the patient or the therapy. Also, since there may be a concomitant affective disorder capable of psychotic manifestations, it is often difficult at a given moment to assign the symptom to the correct disorder, and the DTMI is not designed to address comorbidity. Finally, many DID patients and not a few therapists perpetuate the convention of the so-called "psychotic alter," which I consider a conceptual error. In sum, adding up the pluses and minuses of adding a dimension to address psychotic manifestations, I decided that the pluses were far less impressive than the minuses.

Can the DTMI be used with dissociative disorder not otherwise specified (DDNOS)?

Since most DID patients fluctuate between manifestations best described as DID and DDNOS (Kluft, 1985, 1991), the DTMI is designed for such usages. Therefore, if the patient has a form of DDNOS that has the structure of DID, there should be no difficulty. In scoring DDNOS patients, it is important to appreciate that access to an alter need not mean its full emergence, but only that it is possible to communicate with the alter in a manner that allows the therapy to proceed.

Why does the DTMI insist that if there is uncertainty as to which of two scores should be given, the lower of the two should be used?

The reason is very pragmatic and based on clinical experience. In consultation with over a thousand clinicians and the supervision of many dozens of trainees, it is my experience that with the exception of those who sought my advice for situations that were not going well, virtually every one of them overestimated the progress being made by the DID patient in question. I have come to think that many therapists think things are going well until it is too late to correct what has gone wrong with a relatively simple series of interventions. Therefore, the "default" setting of the DTMI is the lower of the two scores.

What is the relationship of the DTMI to the various therapeutic stances toward DID that are discussed in the literature?

Elsewhere I have attempted to describe several therapeutic stances toward the treatment of DID (Kluft, 1993a): strategic integrationalism, tactical integrationalism, adaptationalism, and personality-oriented. The DTMI was specifically designed for use in treatments that work toward integration. However, adaptational and personality-oriented treatments can easily be followed with the DTMI, but will not be terribly concerned with the dimension of integration. In such situations the integration dimension should be scored nonetheless, because it may alert the therapist to developments that they might not otherwise be considering, and which may be an important insight into the process of therapy, and the patient's motivation. As John G. Watkins (personal communication, 1991) has observed, some patients treated by ego-state therapy may be very motivated to integrate, and may pursue this even though it is not an essen-

tial dimension of the ego-state therapy approach.

Can a DTMI dimension be scored on the basis of the behavior of a particular personality?

This question is usually asked by a therapist who has a DID patient who usually is very cooperative, but the disruptive behavior of an alter, even though it was brief and not representative of the patient's typical behavior, would argue for a lower score. The therapist thinks the trend rather than the exception should be scored. Here the situation is easily resolved. This concern speaks to the above-mentioned DTMI convention that mandates the use of the lower of two scores in marginal situations. Since the DID patient is a single human being, if a behavior occurs, it is reflected in the DTMI score. Therefore, if one major alter is very contained, and another that makes brief appearances is disruptive, the total human being has been generally cooperative, but occasionally not so. This must be reflected in the score, because a single dangerous behavior may prove fatal, even in the face of generally excellent behavior. Since the scoring should never be shared, there is no need to be concerned that the alter that is very cooperative will be upset by how the therapist scores the situation. Conversely, if the therapist is encouraged to score by disregarding apparently aberrant behaviors, the inflated DTMI score can create a false sense of security about how the treatment is progressing. The alteration of interpretations by disregarding this convention can elevate a DTMI score by five or more points, depending on the nature of the exceptional behaviors. In this connection, it is important to appreciate that one of the dimensions, 10., Resolution of Transference Phenomena, is scored on the preponderance of behavior, because it is unreasonable to think any patient can be sensitive to and raise for discussion all transference phenomena all of the time. Clinical judgement and common sense applies here.

What is the use of the DTMI in supervision and consultation?

It is important to appreciate that the DTMI is an imperfect and preliminary instrument. Nonetheless, it has already proven exceptionally helpful in my own consultation and supervision. I emphasize that the DTMI cannot be used to grade the therapist, but can serve a useful alerting function about what is happening and what is possible in the therapeutic dyad under study. Once it is possible to ascertain the patient's baseline and/or the type of trajectory that is declaring itself, the therapist is given a useful picture of where the patient begins, and of the patient's ability to use the therapy. The DTMI baseline and first few sequential scores often offer a valuable perspective on the ego strength that the patient can bring to the therapeutic process, and suggest how the therapy should proceed with regard to structure, adopting a supportive versus expressive focus, and the implementation of various therapeutic interventions and techniques.

It is often useful to see whether very direct approaches to the patient's areas of apparent weakness can correct them, or whether they constitute more difficult problems. This is a major focus of the preliminary interventions stage of the psychotherapy (Kluft, 1993b). If correction is possible by simple means, the patient may prove to be a potential high trajectory patient who simply was not appropriately socialized to therapy, or who was transiently overwhelmed but can restabilize gradually. If this is not possible, the therapist will appreciate that the initial stages of treatment will take longer to accomplish, and that more than modest expectations of the patient may prove counterproductive.

Another application of the DTMI is the prevention of demoralization. Not uncommonly therapists do not appreciate what they are contending with when they treat DID. So much is happening, yet so little improvement is apparent. They may conclude that they are failing their patients. Shortly after I began to use the DTMI in consultations, two very competent psychologists asked me to review their work with their DID patients. It happened that I saw them both during the same week. Both cried as they outlined their efforts and the total failure of everything that they attempted. It was apparent that these two individuals were not only competent, but exceptional. I asked each if they would help me help them by telling me which of six statements about the 12 dimensions was most applicable to the patient being presented. One therapist's patient scored 21, which is a score most commonly found in decompensated inpatients; the other's patient scored 23. I was able to demonstrate that neither patient was working in treatment, and that both patients were of a type associated with an extremely low trajectory. Both patients were backing away from the interventions that were being attempted. In each case I advised the therapists to take a more supportive focus, and defer deliberate efforts to access and work on traumatic material until the patient was much stronger. The therapists left these consultations feeling validated and supported, and with fresh ideas for the treatment of their extremely demanding patients.

This approach has also been useful for student therapists under supervision, who may have unrealistically high expectations of themselves and their patients. At times, however, it has been helpful in encouraging learners to ask more of themselves and their patients, because a patient's superficial chaos may disguise a deeper underlying strength. For example, a much-traveled patient treated for 20 years as a schizophrenic was discovered to have DID and assigned by rotation to an inexperienced resident. I was able to demonstrate that at every assessment her DTMI score was rising rapidly, and that the resident was not "stuck" with a burnt-out case, but had an exciting opportunity to work with a very strong although deeply hurt human being literally straining at the leash to be allowed to get better. Thus encouraged, the resident decided to follow the patient throughout her four years of training, and the patient's progress has been astonishing.

Many psychoanalytically-oriented colleagues have seen the DTMI as quite comparable to the type of assessments done in determining analyzability, and have found its ideas very congenial. This is not surprising, because the inspiration for the DTMI was a monograph on analyzabilty from the Kris Study Group (Waldhorn, 1967). Its orientation is basically ego psychological.

Should I use the DTMI in my discussion of my patients with managed care companies?

This question is difficult to answer in a general manner. Although it speaks to many issues at the heart of the treatment of DID, it may or may not address the concerns that preoccupy the reviewers for such enterprises. In my negotiations with managed care companies, I have often agreed with the reviewers to follow certain parameters, always behaviorally defined, in a systematic fashion, using criteria upon which we can reach a mutual understanding. I have found this more effective than referring to the DTMI. However, I have found it useful to point out changes in DTMI dimensions to sophisticated reviewers, without referring to their being part of an assessment instrument. Using DTMI scores may be counterproductive, because they may do no more than demonstrate that the treatment is likely to be slow and take a long time. One would hate to be put in the position of "producing" a certain number of change points per unit of time in order to justify the treatment, especially given the heterogeneity of DID patients.

THE MEANING OF DTMI SCORES

Although the scores are less important than the trajectory that they define, it may be useful to indicate something of the range of the scores encountered in different settings. Unpublished data indicates that the average patient admitted to the Dissociative Disorders Program of the Institute of Pennsylvania Hospital has an baseline DTMI score between 18 and 25. On occasion a patient with a much higher score may be hospitalized. For example, a high-trajectory patient whose scores were usually between 48 and 54 acutely decom-

FIGURE 1 – Case 1: A High Trajectory Patient
THE INSTITUTE OF PENNSYLVANIA HOSPITAL (DDU)
CSDS Dimensions of Therapeutic Movement Instrument Score Sheet

DIMENSIONS	Dates of Assessments 12/92	1/93	2/93	3/93	4/93	5/93	6/93	7/93	8/93	9/93		
1. Therapeutic Alliance	3-4	3-4	4	5	5	5	5	4-5	5	5		
2. Integration	1	1	2	3	3	3	3	3	3	4		
3. Capacity for Adaptive Change	1	1	1	2	2	2	3	3	4	4		
4. Management of Life Stressors	1	1	1-2	2	2	3	3	3-4	3-4	4		
5. Alter's Responsibility for Self-Management	2	3	4	4	5	5	5	5	5	5		
6. Restraint from Self-Endangerment	3	3	3	3	3	3-4	3-4	4	4	4		
7. Quality of Interpersonal Relationships	1	1	2	2	3	3	3	3	4	4		
8. Need for Medication	5	5	5	5	5	5	5	5	5	5		
9. Need for Hospital Care	4	4	5	5	5	5	5	4	5	5		
10. Resolution of Transference Phenomena	2	3	3	3	4	4	4-5	4-5	5	5		
11. Intercessions Contacts	5	5	5	5	5	5	5	5	5	5		
12. Subjective Well-Being	0	0	0	0	1	1	1	2	3	4		
TOTAL SCORE:	28.5	30.5	33.5	39	43	44.5	46	46.5	51.5	54		
Average Score/Dimension:												
Change from Last Assessment:	0	2	3	6	4	1.5	1.5	0.5	5	3.5		
Average Change/Dimension:												

pensated when an incident from her past became public knowledge. Usually an inpatient who is discharged back to outpatient status improves by approximately one dozen points. However, this is not a straightforward finding, because the inpatient therapist cannot assume that what he or she encounters is typical of the patient's behavior with a therapist with whom he or she is familiar. Therefore the "improvement" may simply indicate that the patient has learned to work with the inpatient therapist and is no longer suicidal.

A series of outpatients I took into treatment and did not hospitalize averaged between 28 and 38 at baseline. However, there is reason to believe that patients who come to me under such circumstances are differentially high-functioning. My assessments of over a dozen DID outpatients referred to residents in a clinic setting revealed no patient with a baseline of over 25. Many were hospitalized early in their treatment.

THE FREQUENCY OF DTMI ASSESSMENTS

The DTMI was designed for use every two weeks for inpatients and every month for outpatients and patients in partial hospital programs. After the first year of outpatient assessments, it may be appropriate to make determinations every quarter year, reserving more frequent usages for special situations, such as when a patient seems to be going against his or her trajectory. In these latter circumstances frequent reappraisal is encouraged. Should the patient begin to improve, a breakthrough may be in progress, and it may be crucial to capitalize upon it, offering appropriate encouragement and opportunities to test the patient's readiness to approach material and issues that the therapy had been unable to address (although this is often exactly what occurs spontaneously at such junctures). Conversely, a dropping DTMI is a clinical

FIGURE 2 – Case 2: A Decompensating Patient
THE INSTITUTE OF PENNSYLVANIA HOSPITAL (DDU)
CSDS Dimensions of Therapeutic Movement Instrument Score Sheet

DIMENSIONS	Dates of Assessments: 1/93	2/93	3/93	4/93	5/93	6/93	7/93	8/93				
1. Therapeutic Alliance	5	4	3	2	2	1	1	0				
2. Integration	1	1	1	1	1	1	1	1				
3. Capacity for Adaptive Change	0	0	0	0	0	0	0	0				
4. Management of Life Stressors	5	4	3	3	3	3	3	3				
5. Alter's Responsibility for Self-Management	5	4	3-4	2	2	2	1	1				
6. Restraint from Self-Endangerment	4	3	2	2	2	2	2	2				
7. Quality of Interpersonal Relationships	1	1	1	1	1	1	1	1				
8. Need for Medication	1	1	1	1	1	1	1	1				
9. Need for Hospital Care	4	4	4	4	4	4	4	4				
10. Resolution of Transference Phenomena	5	4	3	3-2	2	2	2	2				
11. Intercessions Contacts	5	4	3	3	5	5	5	5				
12. Subjective Well-Being	2	2	1	1	0	0	0	0				
TOTAL SCORE:	38	32	24.5	22.5	23	22	21	20				
Average Score/Dimension:												
Change from Last Assessment:	0	-6	-7.5	-2	0.5	-1	-1	-1				
Average Change/Dimension:												

emergency. Thus far, every DID patient who has lost 20 points or more has dropped out of treatment and/or required hospital care for a serious suicide attempt or the prevention of the same. Average change scores, currently used for research only, are omitted in all examples.

Case 1: A High Trajectory Patient

This 50-year-old counselor with an extensive history of addiction and professional underachievement entered treatment in the context of a painful divorce. His divorcing spouse was a favorite of their mutual employer, who gave him less and less support, and finally made it clear he would lose his job. He was profoundly depressed and without supports other than 12 step programs and some rather isolated fellow hobbyists. He was therefore all the more joyful when a dissociative disorder and finally DID was diagnosed. He worked in therapy with constant complaints about its pain, slowness, and incapacity to relieve pain. His alters, however, were delighted to have a chance to be relieved of their burden, and rapidly developed a pattern of revelation, abreaction, and integration. His life was indeed difficult and became worse. Often therapy had to address situational factors for months on end. Now after three years of treatment, his system appears over 90% integrated, and is motivated to complete the treatment in order to have more flexibility in pursuing personal and professional objectives. He has mourned his marriage and his idealized image of his ex-wife. He has a full and prosperous private practice. The first ten months of his DTMI scores are illustrated in Figure 1. The remainder of his DTMI scores were over 50.

Case 2: A Treatment Demonstrating Deterioration and Failure

FIGURE 3 – Case 3: A Middle Trajectory Patient
THE INSTITUTE OF PENNSYLVANIA HOSPITAL (DDU)
CSDS Dimensions of Therapeutic Movement Instrument Score Sheet

			Dates of Assessments										
DIMENSIONS		8/92	9/92	10/92	11/92	12/92	1/93	2/93	3/93	4/93	5/93	6/93	7/93
1.	Therapeutic Alliance	4	4	5	5	5	5	5	5	5	5	5	5
2.	Integration	1	1	1	1	1	1	1	1	1	1	1	1
3.	Capacity for Adaptive Change	2	2	2	2	2	2	3	3	3	3	4	4
4.	Management of Life Stressors	0	0	0	0	0	1	1	1	1	2	2	2
5.	Alter's Responsibility for Self-Management	5	5	5	5	3	3	3	3	3	3	4	4
6.	Restraint from Self-Endangerment	3	3	3	3	3	3	3	3	3	3	3	3
7.	Quality of Interpersonal Relationships	0	0	0	0	0	1	1	1	1	2	2	2
8.	Need for Medication	1	1	1	1	2	2	2	3	3	2	2	3
9.	Need for Hospital Care	3	1	1	1	1	1	1	1	1	1	1	1
10.	Resolution of Transference Phenomena	0	0	1	1	2	2	3	3	3	4	4	4
11.	Intercessions Contacts	5	5	4	4	3	3	2	2	2	2	1	2
12.	Subjective Well-Being	0	0	0	0	0	1	1	1	2	2	2	3
TOTAL SCORE:		24	22	23	22	24	25	26	26	30	30	29	34
Average Score/Dimension:													
Change from Last Assessment:		0	-2	1	-1	2	1	1	0	4	0	-1	5
Average-Change/Dimension:													

This 58-year-old consultant initially made superlative gains in the first three years of her treatment, identifying and integrating 408 alters down to five. However, her ailing parents became an increasing concern, and she began to dedicate her every hour to their care. She was especially gratified by the attention her mother paid her, and the approval she received from her family and neighbors, who long had criticized her or been indifferent to her. She began to refuse access to her alters and to deny her DID. She began to cut appointments, and then insisted on reducing their frequency. She became very depressed, and attributed this to her exhaustion, her anticipation of her parents' deaths, and to what she perceived as the indifference of the therapist. The therapist tried to point out how depleted the patient was by her now-neglected inner turmoil, which she declined to address, and by her burdensome efforts on behalf of her parents despite her own cardiovascular disease. The patient minimized but acknowledged this, and declared that she finally had the relationship with her parents that she desired, and would not forfeit it. When the therapist confronted her about the risks to herself inherent in her stance, she initiated a series of activities that culminated in her leaving treatment. Her next therapist informed the author that she had endured another major heart attack, but resumed her parents' care as soon as she left the hospital. Her future survival is considered precarious.

Case 3: A Middle Trajectory Patient

This 39-year-old woman was transferred from another institution among whose programs she had spent the last six years. She rapidly formed an idealizing and mirror transference with her therapist, and although isolative and

FIGURE 4 – Case 4: A Low Trajectory Patient
THE INSTITUTE OF PENNSYLVANIA HOSPITAL (DDU)
CSDS Dimensions of Therapeutic Movement Instrument Score Sheet

DIMENSIONS	Dates of Assessments 8/93	9/93	10/93	11/93	12/93	1/94	2/94	3/94	4/94	5/94	6/94	7/94
1. Therapeutic Alliance	4	2	2	2	2	2	2	2	2	3	3	3
2. Integration	1	1	1	1	1	1	1	1	1	1	1	1
3. Capacity for Adaptive Change	2	2	2	2	2	2	2	2	2	2	2	2
4. Management of Life Stressors	4	1	1	1	1	1	1	1	1	1	2	2
5. Alter's Responsibility for Self-Management	5	0	0	0	0	0	0	0	0	0	0	1
6. Restraint from Self-Endangerment	4	3	3	3	3	3	3	3	3	3	3	3
7. Quality of Interpersonal Relationships	3	0	0	0	0	1	1	1	1	1	1	1
8. Need for Medication	3	1	1	1	1	1	1	1	1	1	1	1
9. Need for Hospital Care	5	5	5	5	5	5	5	5	5	5	5	5
10. Resolution of Transference Phenomena	3	0	0	0	0	1	1	1	1	1	1	1
11. Intercessions Contacts	4	4	4	4	4	4	4	4	4	4	4	4
12. Subjective Well-Being	4	2	2	2	2	2	2	2	2	2	2	2
TOTAL SCORE:	42	21	21	21	21	23	23	23	23	24	25	26
Average Score/Dimension:												
Change from Last Assessment:	0	-21	0	0	0	2	0	0	0	1	1	1
Average Change/Dimension:												

avoidant, was slowly coaxed into active participation in the remainder of the program. Despite her long history of violence toward staff and regression, she has been in the main a cooperative patient, although quite sensitive to actual and perceived slights. There have been many advances in therapy with the contacting of over two hundred alters, and the abreaction of many alters' issues. There has been no integration because the alters have said that all related alters will want to integrate at one time, and no one group has concluded its work. Although the patient remains very ill, her family states that she has already been restored to the level at which they knew her best, and are astonished by the changes that have been achieved. The illustrated period of time describes her first year of care, and includes the first, third, every second subsequent DTMI score (she was scored every two weeks).

Case 4: A Low Trajectory Patient

This young man, a former athlete, was referred for definitive DID treatment. He initially approached each session with eager enthusiasm, and did all he was asked with impressive obedience and aclarity. He pronounced himself ready to work in all alters, and encouraged his psychiatrist to push him further and faster. However, after initial apparent progress in mapping and establishing a history, the first efforts to deal with painful material led to massive regression and disavowal of all he had revealed. Furthermore, he began to oversleep therapy sessions and to arrive late at crucial appointments. He began to reveal a characterological stance toward the world of being an incapable little baby unable to fend for himself. After many efforts to mobilize him toward the achievement of discrete goals, it became clear that his goal was regressive dependency. Plans were made to undertake a gentle supportive treatment that acknowledged his limitations and pursued only what was possible. Figure 4 illustrates a year of his treatment. On most recent follow-up his DTMI was 28. Clearly, his treatment will be long and progress will be very gradual unless he makes a breakthrough.

CONCLUSION

The DTMI remains a new and unproven instrument, but one with considerable promise as a rough and preliminary rather than as a sophisticated and definitive contribution. The remarks above are an effort to clarify some aspects of its clinical application. As further experience is gained with the DTMI, additional communications will be submitted for publication. ■

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APPENDIX
Ancillary DTMI Dimension 13 — Function

Note: This is to be used only for monitoring the recovery of a DID patient who has decompensated in function. It is not a "bonus" for the DID patient who continues to function, and/or who acts in ways that are detrimental to his or her ultimate recovery in the interests of function.

5 - The patient functions competently in all major life areas without undue effort or discomfort.

4 - The patient functions competently in all major life areas albeit at the cost of great effort and/or with considerable discomfort.

3 - The patient functions competently in most major life areas, albeit with considerable effort and discomfort.

2 - The patient functions competently in some major life areas, but has abdicated and/or proven unable to function competently in many major life areas.

1 - The patient functions competently in a small number of major life areas, but has abdicated and/or proven unable to function competently in the majority.

0 - The patient has abdicated and/or proven unable to function competently in virtually all major life areas.

Clinical illustrations:
The major life areas in consideration here are: employment (or student function, or volunteer position or satisfying life routine if physically disabled or retired), friendship, self-care (shopping, hygiene, getting appropriate medical, psychiatric, and social care), roles with significant others (spouse, parent, child, etc.), appropriate leisure time use and avocations, etc.

1. A woman is unable to work and is very isolated. She can do volunteer work for one or two periods of a few hours per week, and does so adequately. She has no friends. She is able to play cards with a small number of older women on occasion. She is able to comply with complex and demanding medical procedures necessary for the assessment and treatment of medical conditions, and does so with grace and determination. She comports herself well in her relationships with her sister and the sister's children, but virtually every contact with her family precipitates a crisis call to her psychiatrist, who is one of the few males to whom she can relate.

   Score: 1., verging on 2. The DTMI convention is always to score at the lower of two levels if in doubt or if the situation is marginal.

2. A man functions very well at his professional work, and is involved actively in a few solitary hobbies. He has a number of friends, and dines with one or more at least twice weekly. He attends professional gatherings with interest and enthusiasm. He is terrified of women. He is uncomfortable with female colleagues, but can work effectively with them. As much as he yearns for female companionship, he feels cannot bring himself to pursue dating until he has worked through some particularly difficult material.

   Score: 3.