THE TREATMENT OF TRAUMATIC MEMORIES IN DID: INDICATIONS AND CONTRA-INDICATIONS

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This is a revised manuscript of a plenary presentation presented at the Fifth Annual Spring Conference of the ISSD, in Amsterdam, on May 10-13, 1995

The author would like to thank Onno van der Hart, Ph.D., for his valuable comments on an earlier draft and continuous support as a colleague.

ABSTRACT

A treatment model with a focus on trauma treatment and subsequent integration is widely accepted as the most successful among therapists treating DID. However, this model may not be the best option for all DID patients. Lower functioning patients often do not have the strength or therapeutic potential and/or opportunity to endure this kind of treatment. This article discusses indications and contra-indications for entering into the second phase in the treatment of DID patients: the treatment of traumatic memories. A checklist was developed to evaluate the treatment process and make a well-founded decision about the transition from phase I, stabilization and symptom reduction, to phase II, treatment of traumatic memories. Criteria that influence a decision to focus on phase I only, without proceeding to phase II, will be discussed. Clinical examples will demonstrate the use of the checklist.

The standard of care for the treatment of severe dissociative disorders consists of a stage-oriented treatment model as first described by Pierre Janet (van der Hart, Brown, & van der Kolk, 1989) and more recently by contemporary clinicians (Brown, Scheflin, & Hammond, 1998; Herman, 1992; Kluft, 1993a; Horewitz & Loewenstein, 1994). This model consists of three stages of treatment: 1) stabilization and symptom reduction (Herman [1992] speaks of establishing safety); 2) treatment of traumatic memories (part of which is mourning the associated losses); and 3) integration and rehabilitation. Although controlled outcome studies on the psychotherapy of DID have not yet been conducted, a vast majority of successful treatments have been associated with a model focusing on integration (Kluft, 1984; 1986 and 1993b). This approach is also the basis of the official guidelines for the treatment of MPD/DID of the International Society for the Study of Dissociation (1994, 1997).

Effective treatment for DID can never start with extensive exploration of the traumata. On the contrary, as highlighted in the works of Kluft, Fine, and many other authors in the field, trauma-work can only be done after sufficient groundwork has been completed (Fine, 1991, 1993; Kluft, 1986, 1991, 1993a, b & c). Over the last several years, there has been a growing realization that not all DID patients are capable of integrating their traumatic memories (Boon, 1994, 1995; Boon & van der Hart, 1995, 1996; Kluft, 1993a &b; 1994; Horewitz & Loewenstein, 1994). In some cases treatment techniques focusing on stabilization and symptom reduction are the only feasible option. The aim is, essentially, to help the patient to use dissociation as a more effective coping style. This approach falls into Kluft's category of adaptationalism (Kluft, 1988b, 1993b). An important feature of this approach is pragmatism. The priority is on maintenance and management of life functions, and improvement of the patients' functioning. Kluft (1988b) mentions several reasons for therapists to prefer this model: 1) cost containment; 2) minimization of the value of psychotherapy; and 3) burn-out symptoms in the therapist. I would like to add another very important reason for this stance: a considerable group of patients is unable to achieve the goal of integration. Severe attachment problems, a lack of ego strength, a lack of the essential therapeutic potential to proceed due to concomitant psychiatric problems or a lack of motivation may be among the reasons that these patients are unable to bear an intensive treatment geared towards the treatment of traumatic memories and the achievement of integration.

In this paper I will discuss factors that may influence a decision toward maintaining a focus on stabilization. I will present a checklist to evaluate the treatment process and make a well-founded decision about whether it is appropriate to make a transition from phase I concerns, stabilization and symptom reduction, to phase II issues, the treatment of traumatic memories. Clinical examples will illustrate the use of the checklist.

Prognosis and Treatment Goals

Initially there was an optimistic stance among therapists about treatment prognosis of DID (Kluft, 1984, 1986a). Although treatment approaches differed with regard to many aspects (Kluft, 1993a), successful treatment was primarily focused on integration, a goal that was considered as achievable by most patients. In the pioneering years the literature, with few exceptions (e.g., Caul, 1988; Kluft, 1984), gave little attention to the complexity of concomitant personality disorders and severe attachment problems. The indications or possible contraindications for a treatment approach focusing on trauma treatment and integration were not discussed widely in the literature, and unfortunately the ISSD guidelines do not mention this subject, not even in their most recent revision. Gradually the realization that DID patients are a very heterogeneous group with different capacities to undertake definitive treatment has been appreciated (Kluft, 1993; Horewitz & Loewenstein, 1994; Groenendijk & van der Hart, 1995).

An overview of the literature shows that several authors have mentioned factors associated with treatment impasses, failures or a bad prognosis. Kluft (1984) described 10 patients (out of a study group of 117 treated by the author) whose treatment failed. These patients had not succeeded in establishing a therapeutic alliance despite years of effort and some of the following features were present: They had severe ego weaknesses, they were often enmeshed with "traumatizers"; there was a prolonged "warfare" among the personalities; there was substance abuse or sociopathic behavior. However the vast majority of the patients in this early study responded very favorably to treatment.

More recently Kluft (1993c, 1994a) compared the patients he had treated with a patient cohort from an outcome study described by Coons (1986). Kluft's patients had done much better, 75% of his series had rapidly integrated. Only 25% of the patients from Coons's series responded in the same positive way to treatment. Patients in the two studies were from very different backgrounds, however. Kluft's patients were almost all treated in private practice and had much more education. Coons's patients were from a state hospital setting. One of Kluft's conclusions was that MPD/DID is a very heterogeneous condition with a few subtypes with different prognostic implications: 1) a group of high-functioning DID patients who respond positively to therapy and improve quickly; 2) a group of lower functioning DID patients with comorbid Axis II conditions whose response to treatment is less positive (treatment is necessarily much slower and full integration may not be attained); and 3) DID patients who are unable to make use of a therapeutic relationship; they have a dissociative lifestyle and can not change self-destructive and/or antisocial behaviors. Horewitz and Loewenstein (1994) also describe three different subtypes of DID patients comparable to the groups mentioned by Kluft.

The fact that groups of DID patients may differ widely with regard to treatment setting and level of education is also confirmed by comparing data from a survey of current treatment practices conducted by Putnam and Loewenstein (1993) with data of a clinical investigation of 71 Dutch MPD patients (Boon & Draijer, 1993). Eighty-one percent of the patients in Putnam and Loewenstein's cohort [N=305] were treated in private practice, and 43.5% had graduate degrees. Only 12% of the Dutch patient cohort had a degree comparable to an American graduate degree. A minority (21%) was treated in private practice, 54% were treated in an outpatient psychiatric service, 14% in an inpatient psychiatric service, and 10% in a psychiatric day hospital. Only 15% of the Dutch patients were employed. These data suggest that a majority of this Dutch patient cohort had characteristics of a "lower functioning" group of patients.

David Caul (1988), one of the first to discuss treatment prognosis, mentioned a list of factors influencing prognosis which included: 1) length of (previous) treatment following DID diagnosis; 2) number of therapists that have treated the patient since the diagnosis was made; 3) narcissistic investment in the separateness of alters; 4) preoccupation with uncovering again and again "new trauma material" instead of focusing towards resolution; 5) prolonged presence of a violent attitude; 6) the degree of confabulation; 7) persistence of issues of control or attempts to dominate the course of therapy; and 8) little or no emotional commitment to change.

Putnam (as cited by Comstock & Vickery, 1992) estimated that one third of DID patients are not treatable. Some of the reasons that these DID patients were not treatable included the extent, length, and intensity of the patients' trauma; their propensity towards reenactment in adult life; the coexistence of medical and psychiatric conditions; their tendency towards secondary gain; their incapacity to attend to stimuli without cognitive or affective distortion; their compromised intellectual capacity; and their lack of motivation to overcome the past.

It is certain that clinical experience with a low-functioning patient cohort has influenced my thinking about prognosis, indications, and contraindications for a treatment model focusing on trauma work and integration. This had lead to the idea that treatment following the "integration model" is not always feasible and sometimes an "adaptationalism stance" is the best there is to offer. Not every patient is best helped following a model of intensive therapy focusing on integration and not every patient has enough "strength," even after a prolonged stabilization phase, to complete the very demanding stage of the treatment of traumatic memories, a necessary step in order to move towards integration. Moreover, sometimes, if intensive treatment has been started with a patient who is unable to endure this kind of psychotherapy, he or she can easily deteriorate and more damage can be done if this type of treatment is continued. Given the fact that the current "standard of treatment" is

intensive psychotherapy with "a minimum recommended frequency of sessions twice a week" (ISSD Guidelines, 1994, 1997), it is not so easy to change the focus of treatment (or frequency of sessions) without inevitable feelings of abandonment, anger, and of "being a treatment failure" on the side of the patient, and strong countertransferential feelings on the side of the therapist.

With a considerable group of low-functioning patients the focus of therapy should be, as a rule, limited to crisis management, stabilization, and symptom reduction.The aim is essentially to help the patient to use dissociation as a more effective coping style. Boon and van der Hart (1994, 1995, 1996) described eight types of interventions aimed at stabilization and symptom-reduction in the first treatment phase of DID and five factors important in making the choice to remain focused on these treatment goals only. Electing limited treatment goals for those patients who seem to be unable to work toward processing trauma and integration has the disadvantage that there will be always an unstable equilibrium easily disturbed by stressful situations or other difficult life events. However the cost of treatment with a focus on trauma may be too high emotionally and may lead to chronic decompensation or worse.

CRITERIA THAT INFLUENCE A DECISION FOR A LIMITED TREATMENT FOCUS

The first phase in the treatment of DID is always focused on stabilization, establishing personal safety, and self-care. Moreover it is very important to work on the establishment of a therapeutic alliance. The length of this first phase may differ considerably from patient to patient. Pacing the therapy is essential (Fine, 1991; Kluft, 1993b). During this phase, the following treatment strategies are applied (Boon & van der Hart, 1994, 1995):

a. General applicable supportive interventions, useful in the care of many other clients in crisis as well;

b. Psychoeducation with regard to dissociation, DID, and PTSD, which may heighten a sense of control and which lower feelings of anxiety and shame; also psychoeducation also with regard to attachment problems;

c. Teaching coping and containment techniques with regard to traumatic memories (Brown & Fromm, 1986; van der Hart, Boon & van Everdingen, 1990); i.e., teaching a constructive use of dissociative abilities;

d. Teaching cooperation between various identities, in particular between those adult identities which are unaware of the traumatic past and who function mainly in daily life (Kluft, 1993c);

e. Developing positive contact between the therapist and identities which are aggressive or self-destructive (often so-called "perpetrator-introjects"), and subsequently between these identities and other identities;

f. Cognitive therapy, aimed at correcting faulty cognitions and basic assumptions of various identities (Fine, 1988, 1992; Ross, 1989);

g. Marital or family therapy with the patient, her/his partner, and the current family (Panos, Panos & Alfred, 1990; Sachs, Frischholz & Wood, 1988);

h. Developing a protocol for crisis intervention, including short-term inpatient treatment.

It is my clinical experience that mapping all personalities during the first treatment phase is not desirable, because that may trigger traumatic material and overwhelming feelings the patient can not (yet) tolerate. For an alternative perspective see Fine (1991) and Kluft (1991). During this phase I prefer to work with identities which actively participate in daily life, cognitive observer identities and, if possible, the so-called "perpetrator-introjects." They are often responsible for a lot of chaos and self-destruction but may become very good therapeutic allies once they decide that therapy is not going to harm them or other identities and that they will not lose their "function."

When working with lower functioning patients it is not always easy to make a decision whether or/and when to proceed to the second treatment phase, the treatment of traumatic memories.

In my clinical approach to the decision for a treatment focusing on stabilization only or a more encompassing treatment approach, the following factors are taken into account (Boon & van der Hart, 1994, 1995, 1996; van der Hart, van der Kolk, & Boon, 1997):

1. ***The Patient's Current Personal and Professional Functioning***

DID patients differ widely in their ways of functioning in daily life. Some patients are able to maintain jobs; some study, have hobbies, friends, and a good social support system. Others, however, have not had much education and/or are unable to do any kind of work. Some have long psychiatric histories; they are unable to maintain stable relationships or do not seem to succeed in eliciting any support at all from external sources. Often there are other Axis I diagnoses, such as episodes of severe depression or anorexia that need to be addressed.

In the first treatment phase, one of the goals should be the improvement of personal functioning. This may include helping the patient: 1) to find meaningful activities during the day; 2) to form supportive relationships with significant others; 3) to learn to abide by contrac-

tual arrangements with respect to the therapy; 4) to control impulses; and 5) to improve his or her general capacity for self-care.

In general high functioning patients do not have many problems in the above-mentioned areas. Never-theless, their treatment should proceed very slowly (Kluft, 1986b, 1993a). Early exploration and treatment of traumatic memories, without having first established the capacity for re-stabilization, can seriously disrupt the patient's functioning. Some of the lower functioning patients manage to improve gradually with respect to personal functioning during the first stage of therapy; others do not. If there is not any improvement in functioning over time and the patient remains isolated, unable to undertake any kind of daily activities, unable to organize some social support, unable to learn to relate to others (including the therapist) in a more stable way, a therapy focusing on treatment of the treatment of traumatic memories is not feasible.

2. ***The Presence of an Axis II Disorder***

Many DID patients have concomitant axis-II disorders. Often they meet criteria on a descriptive level for one or even more *DSM-IV* personality disorders. Research among 71 Dutch patients has shown that 38% met full (five or more out of nine) criteria for borderline personality disorder (BPD) and 65% met four or more criteria (Boon & Draijer, 1993). However some of the so-called personality disorder criteria may be misunderstood posttraumatic symptoms and disappear during treatment. On the other hand if all personalities of the DID patient have the same rather rigid behavior pattern associated with a certain personality disorder then treatment may be seriously complicated. Patients with comorbid Axis II conditions have much more difficulty forming an attachment to the therapist. They often engage in pathological self-soothing behaviors, have poor judgment in their interpersonal relationships, and tend to reenact former traumatic attachments. Testing and some acting-out behavior in the beginning of therapy with DID patients can be considered "normal," but if it is impossible to control this in the course of the stabilization phase it is not wise to proceed with the treatment of traumatic memories.

Severe Axis II problems may also cause a lack of motivation or a lack of willingness to take the responsibility to get better.

3. ***Patient's Life Cycle Phase And/Or External Life Crises***

Sometimes the patient's life cycle phase seriously limits therapeutic possibilities. For female DID patients, pregnancy and the raising of very small children can be very demanding. In general the focus of therapy should be on stabilization, in particular when the patient has little support from a partner and/or significant others. With older patients the factor of age may also play a role in determining the focus of therapy. Many older people show diminished ego strength. Subsequently it is more difficult for them to endure demanding therapy. Kluft (1988c) stressed the importance of going very slowly with the older DID patient. I think that in many cases older DID patients may be helped best by a therapy focusing on stabilization only.

External life crises also limit the possibility of doing trauma work. These crises may differ widely, but always need to be addressed first. Finally, factors such as severe physical infirmity or terminal illness in the patient or a close family member are contraindications for proceeding to the next phase.

4. ***Substance Abuse***

Many DID patients have personalities in their system that are alcohol and/or substance abusers. Generally this behavior is considered as a form of self-medication associated with the management of painful traumatic memories and feelings. Some clinicians argue that the addiction of alcohol and/or drugs will disappear after trauma work has been done. Others stress the importance of addressing alcohol and/or substance abuse as a separate problem. I think that alcohol or drug addiction should be addressed in the initial stages of the treatment. Patients (or specific personalities) need to learn new coping techniques to replace harming the body through alcohol, drugs, or excessive amounts of medication. If they have not learned other coping techniques there is a risk that they will abuse substances even more in the second phase, when confronted with feelings that they can not tolerate. If there is no motivation to give up alcohol or drug abuse, I consider the treatment of traumatic memories to be premature.

5. ***Ongoing Abuse***

It is clear that in cases where there is ongoing abuse, the only focus of the treatment can be to help the patient to stop or remove himself/herself from the abuse. It is my experience that in some cases a prolonged episode in a psychiatric hospital has enabled the patient to end an abusive relationship. In many parts of the world, this option is not available.

In conclusion, it is usually not one of these factors, but a combination of these factors that may lead to the decision for therapy focusing on stabilization only. It is often impossible to make a well-founded decision early in treatment. In some cases, treatment of traumatic memories becomes possible after a prolonged stabilization phase or when the patient has entered another life phase.

Checklist for the Evaluation of the Treatment Process

Kluft (1994 a&b) was the first to develop an instrument, the Dimensions of Therapeutic Movement Instrument (DTMI), to measure therapeutic progress of DID patients. This instrument was specifically designed for use in treatments that work towards integration (Kluft, 1994b) and addresses 12 dimensions of therapeutic progress. Kluft has described three different groups of patients based on DTMI scores achieved by different DID patients: High, Middle and Low Trajectory patients. Although the instrument can be used in adaptational treatments, it is clearly designed for a treatment trajectory with a focus on integration. For instance, a scale to describe function (Dimension 13), is optional.

Because my personal experience – both with most of the patients I have treated as well as in many consultations and supervisions – has been primarily with middle or low-functioning patients, I felt a need to develop a checklist which may enable the clinician to make a well-founded decision either for phase I only, or for a more encompassing treatment model. This checklist differs from the DTMI in that is has been designed from an adaptationalist stance. The focus is primarily on the first phase of treatment; there is no dimension concerned with integration. Using this checklist, the following areas can be systematically evaluated: diagnostic assessment; psychiatric history and prior treatment; trauma history; ongoing abusive relationships; acceptance of diagnosis; current functioning; life-cycle phase and interaction with current functioning; other problem areas interacting with current functioning (for instance, financial problems; general health problems); acceptance of treatment frame and boundaries; extent of cooperation with the therapist; specific problem areas in therapeutic relationship; and crises during treatment.

The therapist evaluates each area at the beginning of treatment. Further evaluations can be done as often as necessary; I prefer to evaluate once every half year. Most areas can be scored in the following way: 1) absent; 2) present; 3) seldom (present) 4) recurrently (present) 5) frequently (present) 8) not clear. There are no "subscores" for the different parts of the list nor a "total score." The instrument was designed for clinical practice, not as a research instrument. Decisions based on the checklist may also vary from patient to patient and from therapist to therapist depending on the personal experience and the therapeutic skills of the therapist. However, in general I believe that the transition from phase I to phase II can only be made if a patient is functioning without major problems in the areas VI-XIV and if there are no major somatic or psychiatric comorbid conditions that complicate the situation.

I have used this checklist in the following ways: 1) to evaluate my own patients and discuss patients with colleagues, in order to make a decision based on the checklist whether a transition towards the next phase is appropriate at that time; 2) to motivate individual patients, particularly when the patient wanted "more and faster" therapy or was not taking enough responsibility for her own treatment. In those cases, using the checklist in the session was helpful to motivate the patient to make necessary changes in phase I of the treatment. In other cases it did help the patient to accept the fact that "more and faster" was not a wise treatment strategy at that point in time. Moreover, psychoeducation about the problems of comorbid conditions and attachment problems helped these patients to understand that they were not "treatment failures," and needed their own time and pace to get further in therapy. It is also useful 3) as an instrument during supervision or consultations.

To illustrate the use of this checklist the therapy process of several patients will be described.

Patient One

Agnes was 28 years old when she was referred to our psychiatric department in an acute crisis. After her boyfriend had left her, she smashed her apartment to pieces, took her one-and-a-half year old son, and went to her mother's house. There she barricaded herself in her old bedroom. The fire brigade had to break in through a window. She refused food and water, and a request was made to hospitalize her against her will. This did not occur, because by the time a second psychiatrist had come to judge her situation she was eating again. She did not want to speak or make any contact, however. After a few days, all of a sudden she left her mother's home with her child and went back to her apartment.

She was referred to the author for outpatient therapy. In the first session she said she did not need therapy for her past problems; that she only wanted to talk about the present. However, it became clear that she had severe dissociative symptoms (for instance, almost total amnesia for the past crisis). The diagnosis DDNOS was made, and DID was suspected.

Using the checklist, the following picture of her baseline presentation during the first months of therapy can be given. Agnes presented with a "classical" (see Kluft, 1985) DID picture, i.e., a depressed host, very defensive and secretive about the dissociative symptoms. She did not present with other psychiatric problems on Axis I; the diagnosis on Axis II was not clear. There had been some prior outpatient therapy, but no hospitalizations. Apart from recurrent severe headaches, she did not mention other somatic complaints. Her current functioning was very problematic. She was a nurse, but did not have a job because she had to take care of her young child. She had financial problems; the rent of her house was too high for her to afford without the support of her former boyfriend. After he had left her, he did not take any responsibility for their child. She had no social support system and had a very ambivalent relationship with her mother and half-brothers and sisters. At times she had problems with proper self-care and with the care of her child. Although she felt sometimes very suicidal, she was able to

control her feelings and not act upon them. She reported some eating problems, mainly bingeing and vomiting. There was no alcohol or substance abuse. Although several other personalities had written letters to the therapist in the course of the year and DID was confirmed, Agnes was ambivalent about this diagnosis.

However, she did accept the treatment frame and boundaries, and she showed willingness to cooperate with the therapist to improve her situation. She was motivated to learn techniques of self-hypnosis for containment of reactivated traumatic memories, building ego strength, etc. After one year Agnes was functioning much better. She had found a day-care center for her child, she passed exams and entered university, and she found a cheaper apartment. Also, she had become more open about her dissociative symptoms and had accepted the diagnosis of DID. However, she was still without social support. She often engaged in rather destructive interactions with her former boyfriend and with her mother, which at times severely threatened her stability. Now her attachment problems became a main focus of therapy. By the end of the third year of therapy, she began to learn to keep more distance and disengage (most of the time) from destructive interactions. At the same time she made some new friends. She functioned much better in all areas of the checklist and a sufficiently strong therapeutic alliance was built. It was then that the therapist and Agnes could make a decision about making the transition to phase II, the treatment of traumatic memories. This choice has proven the right one. Agnes is now, about five years later, fully integrated.

Patient Two

Marianne, when referred for a first diagnostic consultation, was a 34-year-old woman, who had been in psychiatric care for the past five years, after her divorce. She did not have children. The first treatment setting was a psychotherapeutic clinic for patients with severe personality disorders, with group therapy treatment focusing on exploration and the past. In response to this treatment regime she totally decompensated and rapidly became worse. She then was referred to an inpatient setting for more chronic, lower-functioning patients, with an individual treatment focus on the here and now. During her stay there DID was suspected. A consultation by the author confirmed the diagnosis and a treatment plan was made to help this patient to get out of the hospital and live on her own again. Four years after this consultation she was referred to the first author again for a supportive therapy. She then lived in a "half-way" home for chronic patients. Her profile on the checklist was as follows: In addition to the Axis I diagnosis of DID, she received an Axis II diagnosis, Borderline Personality Disorder. She had reported a history of severe abuse by an organized perpetrator network. Although she did not report enmeshment with the original perpetrator network, she was constantly reenacting the trauma by letting herself get picked up, beaten up, and abused. She was very self-destructive in other ways as well, such as recurrent deep cutting and other suicidal behaviors leading to many visits to emergency rooms. She was frequently hospitalized and demanded lots of medication. During hospitalizations she regressed into child-alters or other dissociative states which had resulted in her getting hours of attention by staff nurses to "get her back" to the here and now. She had very few daily activities and no support system. She had many difficulties in accepting the treatment frame and boundaries. There were frequent crises. She was able to involve and split many different therapists, and agencies became conflicted and argued heatedly about her treatment. In her individual therapy sessions she switched rapidly from one alter into another, which made therapeutic work difficult. Although she claimed that she was willing to do therapeutic work, she in fact undermined any attempt of the therapist to help her achieve more stabilization. She constantly tried to bring traumatic material into the session and she stopped this behavior only after she was explicitly told that therapy would end if she were to continue doing this. It took two years – with very severe limit-setting – to educate Marianne how to take minimal responsibility for her own treatment. At the end of these two years, I decided to show her the checklist and score it together. I explained to her what work had to be done before she ever could get to the next phase of therapy, which she claimed she wanted to enter. There were very few positive scores in most of the areas of the checklist at that time. After this confrontation, Marianne suddenly and amazingly started to change her behavior. She stopped the cutting, the "emergency calls and visits" diminished greatly, and she found herself a job. She also started to learn new strategies to cope with her feelings, flashbacks, etc. Marianne is currently in her fourth year of therapy and is now making plans to leave the "half-way home" and live on her own again. She has managed to keep her job in the last year and is starting to make some friends. She also has achieved much more control over her self-destructive behaviors, except for the overeating. In the therapy, her attachment problems were addressed. Marianne has done better after an extensive period of tough and continuous limit-setting (which had not been done before she was referred to me), a lot of psychoeducation, and finally a "confrontation" with the checklist. Although the work is still in phase I and more time is needed to work through attachment problems before proceeding to the phase of treatment of traumatic memories, this option now can be considered.

Patient Three

Sandra is an attractive 30-year-old woman, who had had previous psychotherapeutic treatment for six years. During this therapy the diagnosis of DID was made. She was referred to me after she moved to another city. After her divorce, she lived alone and had a job as an administrator. Every week-

end she uses hard drugs and after this lets herself get abused by men. She is constantly at high risk for HIV-AIDS or other sexually-transmitted diseases. In her therapy sessions she is punctual, always present, polite, and at times very seductive. Superficially, she is very cooperative, but in truth, nothing changes whatever I try. When she came to treatment Sandra had very little memory at all about her childhood, but at times she had very bad dreams or flashback-like experiences about abuse by both her parents and a network of other people. Although she reports these experiences, she is very reluctant to consider the possibility that things like that might have happened in the past. She is unable or unwilling to work to achieve more control with regard to the drug abuse. She promises herself week after week to stop the drug abuse and the abuse by many different men, but is unable to give up these behaviors. She does not allow access to the alters that are involved in the drugs and abusive relationships. So far it has not been possible to teach Sandra either other coping mechanisms or any containment techniques. Sandra scores very low in many areas of the checklist and after many years of therapy it has been very difficult to achieve any changes. In this situation a transition to another phase cannot be considered at all. The major goal is to preserve current functioning and to try to prevent deterioration (for instance the possibility that she might lose her job).

Patient Four

Grace is a 44-year-old woman, married with grown-up children. She came with her therapist for a consultation. She wanted to move on towards phase II and do trauma work, but her therapist was not sure whether that would be the right decision. Grace had been in therapy with her current therapist for about four years with the diagnosis DID. Before that she had had outpatient therapy for several years. During this earlier therapy the diagnosis DID had been made. This treatment was broken off after a crisis and admission to a psychiatric hospital. In the previous years Grace had managed to pick up her life again and she functioned rather well. She worked in the business of her husband, whom she described as very supportive. She had a good supportive network and there were no problems in most areas of the checklist except one major and important one. Although Grace had allowed access to many alters and had worked very hard and successfully with hypnotic techniques for containment and safe places, she was still phobic for "inside communication" and terrified of the "angry ones," in particular a part she called "the father." During the consultation she dissociated into an alter who told me that "he ['the father'] had to disappear." I used the checklist and explained to Grace and her therapist that I thought that trauma work would be possible in the future provided that she would allow contact with the "angry ones." I could also explain that trauma work without the permission and cooperation of the "angry ones" was impossible and bound to fail, because those parts had kept the angry feelings. Finally I was able to "talk through" and relabel the "angry parts" as helpers. Grace could accept this explanation, and both she and her therapist made a plan to try to improve communication with those parts that had not yet participated in the treatment.

DISCUSSION

I have described several cases to illustrate the use of the checklist and the considerations that are important when making a decision for a transition from phase I to phase II, the treatment of traumatic memories. All four patients were treated in a psychiatric outpatient department and were probably, in Kluft's terms, "middle" or "low trajectory" patients. The first patient achieved stable integration after about eight years of treatment. The others have been in treatment for DID for between four and eight years, and a transition to phase II cannot yet be considered because of the complexity of their pathology. Although low-functioning DID patients clearly follow a different pathway, another factor that may determine their treatment progress should be considered.

In addition to patient factors, there are also therapist factors that influence treatment outcome. In the Netherlands the diagnosis and treatment of DID have received considerable attention compared to other European countries in the past ten years (van der Hart & Boon, 1990), but there are still very few "experienced" therapists. Although intensive training has been made available in the past years, many therapists are treating their first DID patient. Moreover, the therapists are often from very different backgrounds, some with considerable basic psychotherapeutic training, others with less extensive training. Therefore, in most of the consultations I did in the past years there was a combination of factors that influenced the treatment situation of a given patient. Almost all patients were complex, with substantial Axis II problems, many of the therapists were inexperienced with regard to the treatment of severe personality disorders and attachment problems, as well as with regard to specific DID treatment techniques (for instance, how to address "the angry ones," and how to help a patient overcome a phobia for these parts, as was the case in the last vignette).

Treatment frame problems were very common with patients deteriorating in regressive dependency, in need of hospitalization, and while working with burned-out, over-involved therapists struggling with strong countertransferential feelings. Patients with powerful attachment problems were seen two or three times a week by therapists who had problems setting limits in the treatment frame and difficulty in handling transference/countertransference issues. Do we have to blame these therapists? Is this a typical Dutch problem? I do not think so at all. I think this a typical pitfall in the treatment of DID, in particular with complex, lower-functioning patients. A great deal of experience is necessary to set firm boundaries and handle strong transference and coun-

tertransference issues and to prevent deterioration in low-functioning DID patients. From that point of view, too much emphasis on intensive treatment (with sessions twice a week) and a focus on integration as "the only (and best) treatment pathway" can create unrealistic expectations in both patients and therapists, and eventually can do harm. In my opinion, future revisions of the ISSD treatment guidelines should address these problems and pay more attention to considering alternative treatment pathways. This may prevent extra traumatization in patients (and their therapists) who believe that they are treatment failures, because they are unable to follow the pathway toward integration.

In training and supervision, I currently advise therapists to start with a weekly session, in particular when the patient has complex Axis II problems and the therapist is relatively inexperienced. It is easier to change the frequency of sessions from once a week to twice a week than the other way around. In cases where a focus on stabilization clearly seems to be the only realistic pathway from the beginning, the frequency of sessions may be even fewer than once a week to prevent regressive dependency.

When working with patients I have found the checklist very helpful in explaining to them different pathways and reasons why a focus on stabilization was the best current option at that time. Kluft (1994) has described his reasons for not sharing the scores of the DTMI with his patients. He was mainly worried about a negative effect on those patients that did not do well. I think that there could be such an effect when the only way is a pathway towards treatment of traumatic memories and integration. I have had very different experiences. When scoring the checklist with a patient I always give a great deal of explanation and psychoeducation about the problems we encounter. I have found that if I can explain with empathy the reasons for a focus on stabilization, patients' reactions were positive, and their feelings of being a "bad patient" or "a treatment failure" could be prevented. Sometimes, if I think that a patient clearly can do better and should take more responsibility, the confrontation with the checklist is helpful to motivate a patient. But even then the timing of when to score the list with the patient is very important. This is illustrated by the second case history. Marianne was a very complicated patient who had previous treatment that had fostered major regression. It took several years to correct the impact of the previous treatment and set limits, a task that would have been difficult for a therapist without experience with complex DID. But once these boundaries were established, the use of the checklist was helpful in motivating her to make further steps.

CONCLUDING REMARKS

DID patients differ widely with respect to ego strengths and therapeutic potential. Although recent approaches in the treatment of DID pay much more attention to pacing the therapy, building ego strengths and assessing the individual vulnerability of DID patients, integration can not be achieved in the treatment of many patients. Prognosis should get more attention and controlled treatment studies are needed to enable us to make better decisions about what kind of treatment is best when and for which patients.

The exploration and treatment of traumatic events should only start when certain conditions are met: some stabilization and symptom reduction must be reached; patients must master certain skills such as functioning in daily life, maintaining some supportive relationships, and having some control on self-destructive behaviors; patients must have established some cooperation among alter personalities and have established a firm working alliance with the therapist. This also includes a working alliance with the inner perpetrators. Unless these conditions are fulfilled, attempts at trauma work should be discouraged.

The checklist I presented can be seen as a preliminary contribution to the clinical decisions concerning a transition from phase I to phase II in the treatment of complex dissociative disorders. With a focus on phase I and the patient's current functioning, it may be a supplement to Kluft's DTMI. ■

REFERENCES

Boon, S. (1995, May). *Treatment of traumatic memories: Always, never, sometimes, now, later?* Paper presented at the Fifth ISSD Annual Spring Conference, Amsterdam, The Netherlands.

Boon, S., & Draijer, N. (1993). Multiple personality disorder in the Netherlands: A clinical investigation of 71 patients. *American Journal of Psychiatry, 150,* 489-494.

Boon, S., & van der Hart, O. (1994). Supportive psychotherapy for MPD patients. In B.G. Braun & K.L. Robins, (Eds.) (1994). *Proceedings of the 11th International Conference on Dissociative States.* Chicago: Rush.

Boon, S., & van der Hart, O. (1995). De behandeling van de multiple persoonlijkheidsstoornis [Treatment of multiple personality disorder]. In O. van der Hart (Ed.), *Trauma, dissociatie en hypnose* (pp. 165-186). Lisse: Swets & Zeitlinger.

Boon, S., & van der Hart, O. (1996). Stabilisatie en symptoomreductie in de behandeling van patiënten met een dissociatieve identiteitsstoornis [Stabilization and symptom reduction in the treatment of patients with a dissociative identity disorder]. *Tijdschrift voor Psychiatrie, 38,* 159-172.

Brown, D., & Fromm, E. (1986). *Hypnotherapy and hypnoanalysis.* Erlbaum, Hillsdale, NY

Brown, D., Scheflin, A.W., & Hammond, C.D. (1998). *Memory, trauma treatment, and the law.* New York: W.W. Norton.

Caul, D. (1988). Determining prognosis in the treatment of multiple personality disorder. *DISSOCIATION, 1*(2), 24-26.

Comstock, C., & Vickery, D. (1992). The therapist as victim: A preliminary study. *DISSOCIATION, 5*(3), 155-158.

Coons, P. (1986). The treatment progress in 20 patients with multiple personality disorder. *Journal of Nervous and Mental Disease, 174,* 12, 715-721.

Fine, C.G. (1988). Thoughts on the cognitive perceptual substrates of multiple personality disorder. *DISSOCIATION, 1*(4), 5-11.

Fine, C.G. (1991). Treatment stabilization and crisis prevention: Pacing the therapy of the MPD patient. *Psychiatric Clinics of North America, 14,* 661-675.

Fine, C.G. (1992). The cognitive therapy of multiple personality disorder. In A. Freeman & F.M. D'Attilio (Eds.), *Comprehensive textbook of cognitive-behavior therapy* (pp. 347-360). New York: Plenum.

Fine, C.G. (1993). A tactical integrationalist perspective. In R.P. Kluft & C.G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 135-153). Washington, DC: American Psychiatric Press.

Groenendijk , I., & Van der Hart, O. (1995). Treatment of DID and DDNOS patients in a regional institute for ambulatory mental health care in the Netherlands: A survey. *DISSOCIATION, 8,* 73-83.

Herman, J.L. (1992). *Trauma and recovery.* New York: Basic Books.

Horevitz, R., & Loewenstein, R.J. (1994). The rational treatment of multiple personality disorder. In S.J. Lynn & J.W. Rhue (Eds.), *Dissociation* (pp. 289-316). New York: Guilford.

International Society for the Study of Dissociation (1994, 1997). *Treatment guidelines for Dissociative Identity Disorder.* Northbrook, IL: Author.

Kluft, R.P. (1984). Treatment of multiple personality disorder: A study of 33 cases. *Psychiatric Clinics of North America, 7,* 9-29.

Kluft R.P. (1985) The natural history of multiple personality disorder. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality disorder* (pp. 197-238). Washington, DC: American Psychiatric Press.

Kluft, R.P. (1986a). Personality unification in multiple personality disorder: A follow-up study. In B.G. Braun (Ed.), *The treatment of multiple personality disorder* (pp. 29-60).Washington, DC: American Psychiatric Press.

Kluft, R.P. (1986b). High-functioning multiple personality patients: Three cases. *Journal of Nervous and Mental Disease, 174,* 722-726.

Kluft, R.P. (1988a). The post-unification treatment of multiple personality disorder: First findings. *American Journal of Psychotherapy,* 42, 212-228.

Kluft, R.P. (1988b). The phenomenology and the treatment of extremely complex multiple personality disorder. *DISSOCIATION, 1*(4), 47-58.

Kluft, R.P. (1988c). On treating 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. (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. (1993a). The initial stages of psyho-therapy in the treatment of multiple personality disorder. *DISSOCIATION, 6,* 145-161.

Kluft, R.P. (1993b). Clinical approaches to the integration of personalities. In R.P. Kluft & C.G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 101-133). Washington, DC: American Psychiatric Press.

Kluft, R.P. (1993c). 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 use of the CSDS Dimensions of the Therapeutic Movement Instrument (DTMI) *DISSOCIATION, 7*(4), 273-28.

Kluft, R.P. (1996). Treating the traumatic memories of patients with dissociative identity disorder. *American Journal of Psychiatry, 153* (Festschrift Supplement), 103-110.

Panos, P.T., Panos, A., & Alfred, G.H. (1990). The need for marriage therapy in the treatment of multiple personality disorder. *DISSOCIATION, 3,* 10-14.

Putnam, F.W., & Loewenstein, R.J. (1993). Treatment of multiple personality disorder: A survey of current practices. *American Journal of Psychiatry, 150,* 1048-1052.

Sachs, R.R., Frischholz, E.J., & Wood, J. (1988). Marital and family therapy in the treatment of multiple personality disorder. *Journal of Marital and Family Therapy, 14,* 249-259.

Ross, C., & Ross, C.A. (1989). *Multiple personality disorder: Diagnosis, clinical features, and treatment.* New York: Wiley.

van der Hart, O., Brown, P., & van der Kolk, B.A. (1989). Pierre Janet's treatment of post-traumatic stress. *Journal of Traumatic Stress Studies, 2,* 379-395.

van der Hart, O., Boon, S., & van Everdingen, G.B. (1990). Writing assignments and hypnosis in the treatment of traumatic memories. In M.L. Fast & D.P. Brown (Eds.), *Creative mastery in hypnosis and hypnoanalysis: A Festschrift for Erika Fromm* (pp. 231-253). Hillsdale, NJ: L. Erlbaum Associates.

van der Hart, O., & Boon, S. (1990). Contemporary interest in multiple personality disorder and child abuse in the Netherlands. *DISSOCIATION, 8*(1), 34-38.

van der Hart, O, van der Kolk, B., & Boon, S. (1997). Treatment of dissociative disorders. In J. Bremner & C. Marmer (Eds.) *Trauma, memory and Dissociation.* Washington, DC: American Psychiatric Press.

APPENDIX I
Checklist for the Evaluation of Treatment Process of DID

I. BIOGRAPHICAL DATA
Age
Sex
Marital status
Children
Education
Employment status

II. *DSM-IV* DIAGNOSES	Baseline	After (Fill in time)
AXIS I		
AXIS II		
AXIS III		
SCID-D symptom profile		
DES score		

III. PSYCHIATRIC HISTORY	Baseline	After . . .
Prior treatment		
Inpatient treatment		
Suicide attempts		

Scoring: 1 = absent, 2 = present, 3 = seldom, 4 = recurrent, 5 = frequent, 8 = unclear

APPENDIX I
Checklist for the Evaluation of Treatment Process of DID, Continued

IV. MEDICAL HISTORY	Baseline	After (Fill in time)
Somatic complaints		
Neurological complaints		
Neurological examination		
Other		

VI. TRAUMA HISTORY	Baseline	After . . .
Memories of abuse		
Abuse reported above age 12		
Sexual abuse		
Physical abuse		
Other abuse/trauma		
Between ages 6-12		
Sexual abuse		
Physical abuse		
Other abuse/trauma		
Under age 6		
Sexual abuse		
Physical abuse		
Other abuse/trauma		
No memories of abuse		
No memories of other traumatic events		

Scoring: 1 = absent, 2 = present, 3 = seldom, 4 = recurrent, 5 = frequent, 8 = unclear

APPENDIX I
Checklist for the Evaluation of Treatment Process of DID, Continued

VI. ONGOING/CURRENT ABUSE	Baseline	After (Fill in time)
Enmeshment with original perpetrators		
Ongoing abuse reported		
Enmeshment with new perpetrators		
Abuse reported		
Reenactment of the trauma		
Prostitution		
Destructive relationships with significant others		

VII. CURRENT FUNCTIONING	Baseline	After . . .
1. **Daily activities** work/study/school		
volunteer job		
taking care of children, household		
hobbies/sports		
2. **Support system** contact with partner		
contact with children		
contact with friends		
contact with colleagues		
other significant relationships		
3. **Self-care** care for the body		
food		
sleep		

Scoring: 1 = absent, 2 = present, 3 = seldom, 4 = recurrent, 5 = frequent, 8 = unclear

APPENDIX I
Checklist for the Evaluation of Treatment Process of DID, Continued

VIII. LIFE-CYCLE PHASE/INTERACTION WITH CURRENT FUNCTIONING	Baseline	After (Fill in time)

IX. OTHER PROBLEMS INFLUENCING CURRENT FUNCTIONING	Baseline	After . . .
Financial problems		
Health problems		
Housing problems		
Substance Abuse		
Alcohol		
Drugs		
Medication		

X. SPECIFIC PROBLEMS	Baseline	After . . .
Self-destructive behavior		
Compulsive behaviors		
Eating problems		
Antisocial behavior		
Contact with the law		
Other problems		

XI. ACCEPTANCE OF DID DIAGNOSIS	Baseline	After . . .

Scoring: 1 = absent, 2 = present, 3 = seldom, 4 = recurrent, 5 = frequent, 8 = unclear

APPENDIX I
Checklist for the Evaluation of Treatment Process of DID, Continued

XI. **ACCEPTANCE OF TREATMENT FRAME AND BOUNDARIES**	Baseline	After (Fill in time)

XII. **EXTENT OF COOPERATION WITH THERAPIST**	Baseline	After . . .
Willingness to allow contact with alters		
Willingness to allow contact with perpetrator parts/"inner leaders"		
Willingness to learn (or increase) internal communication/ cooperation among alters		
Willingness to be taught (hypnotic) techniques for:		
1. Building ego-strength		
2. Coping with reactivated traumatic memories/ containment techniques		
3. Self-soothing		
4. Coping with and regulating intense feelings		
5. Willingness to do homework assignments		

Scoring: 1 = absent, 2 = present, 3 = seldom, 4 = recurrent, 5 = frequent, 8 = unclear

APPENDIX I
Checklist for the Evaluation of Treatment Process of DID, Continued

XIII. **SPECIFIC PROBLEMS IN THERAPEUTIC RELATIONSHIP**	Baseline	After (Fill in time)
Severe attachment problems		
Unable to engage in an intense therapeutic relationship		
Constant "testing"		
(Very) controlling		
(Very) manipulating		
(Very) demanding		
Continuous suicidal threats		
Regressive dependency (strong wishes for nurture)		
Attention-seeking between sessions		
Aggressive behavior towards therapist		
Unable to take responsibility "to get well" (others have to do the work)		

XIV. CRISIS DURING TREATMENT	Baseline	After . . .
Phone calls with therapist		
Admitted in psychiatric hospital		
Suicide attempts		
Severe self-mutilation		
Severe (life-threatening) loss of weight		
Other crises		

Scoring: 1 = absent, 2 = present, 3 = seldom, 4 = recurrent, 5 = frequent, 8 = unclear