

TREATMENT STRATEGIES FOR COMPLEX DISSOCIATIVE DISORDERS: TWO DUTCH CASE EXAMPLES

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ABSTRACT

In the Netherlands, the diagnosis of dissociative identity disorder (DID) is widely accepted, although skeptics also have made their opinions known. Dutch clinicians treating DID patients generally follow the common three-phase model for treatment of post-traumatic stress. Given the fact that they usually deal with complicated cases and enmeshed patients (cf. Horevitz & Loewenstein, 1994), most often treatment is restricted to Phase 1: stabilization and symptom reduction. Treatment of higher functioning patients, on the other hand, usually aims at processing of traumatic memories and complete personality integration as well. In this article, two Dutch cases are described in detail, with a special emphasis on the clinical deliberations which, in the first case, led to the decision to proceed to trauma treatment, and which led in the second case to the decision to refrain from it.

The current standard of care with regard to the treatment of trauma-induced disorders, including post-traumatic stress disorder and many dissociative disorders, entails, among other things, the application of a phase-oriented treatment model (e.g., Brown, 1995; Brown, Schefflin, & Hammond, 1998; Courtois, 1996; Herman, 1992; Kluft, 1993a; Horevitz & Loewenstein, 1994). Phase-oriented trauma treatment has its origins in the pioneering work of Pierre Janet (1898, 1919/25), who described three phases in the overall treatment: 1) stabilization and symptom reduction; 2) treatment of traumatic memories; and 3) personality reintegration and rehabilitation (van der Hart, Brown, & van der Kolk, 1989). In the Netherlands, clinicians usually follow

Janet's terminology, while mentioning the following treatment goals for each separate phase: 1) overcoming the phobia of dissociative identities; 2) overcoming the phobia of traumatic memories; and 3) overcoming the phobia of normal life and attachment (Nijenhuis, 1994; Nijenhuis & van der Hart, in press; van der Hart & Boon, 1998). In actual clinical practice the model is not applied in a strict linear model, but rather takes the form of a spiral in which attention to tasks belonging to the various phases alternates (Courtois, 1996).

In the treatment of complex dissociative disorders (i.e., dissociative identity disorder [DID] and dissociative disorder not otherwise specified [DDNOS]) it is often unclear if the patient will be capable of integrating the traumatic past). Kluft (1993a, 1994) emphasized that DID clients constitute a very heterogeneous group with widely different treatment prognoses. Horevitz and Loewenstein (1994) divided them into three subgroups that reflect important differences in treatment complexity and prognosis: 1) high-functioning DID clients; 2) complicated cases with comorbid conditions, e.g., borderline personality disorder (BPD); and 3) enmeshed patients, who are the most recalcitrant to treatment and who tend to remain enmeshed in abusive relationships, have a "dissociative" lifestyle, and actively participate in self-destructive and/or antisocial behaviors and habits. For the latter, treatment geared at stabilization and symptom reduction will be, as a rule, the only feasible option.

In this paper two case examples are presented from the authors' clinical practice in the Netherlands, with the emphasis on relevant diagnostic and treatment issues, including phase-oriented treatment and clinical considerations with regard to the transition from Phase 1, stabilization and symptom reduction, to Phase 2, treatment of traumatic memories. In the 1980s, pioneering clinicians in the dissociative disorder field in the Netherlands were more optimistic that unification of the personality was a feasible goal for most DID patients. However, most of these clinicians worked in psychiatric settings where complicated cases and enmeshed patients, in Horevitz and Loewenstein's (1994) terminology, were admitted. In due time, they experienced disappointments with regard to the feasibility of attaining this goal. The several hundreds of dissociative patients we have diagnosed, consulted upon, or treated during the past ten years

mainly belonged to the second and third of Horevitz and Loewenstein's (1994) categories (Boon & Draijer, 1993; Groenendijk & van der Hart, 1995). We believe that this factor has been of major importance in the development of the strong sensitivity which the dissociation field in the Netherlands manifests with regard to possible contra-indications for Phase 2 treatment (Boon, 1995; Boon & van der Hart, 1996). If there is a bias in this respect, it is more towards conservatism. However, although the category of "high-functioning" DID patients, as defined by Horevitz and Loewenstein (1994), is not widely encountered in the Netherlands, in these cases treatment usually includes successful processing of traumatic memories and work towards personality unification.

The two cases presented here show, among other things, some of the considerations Dutch clinicians use when dealing with the question of whether or not trauma treatment is indicated.

PATIENT HISTORIES

Case Example One

Bettie (a pseudonym), divorced and age 32, is the mother of a three-year-old son (Jan) whom she cares for herself and a five-year-old son (Daan) who stays with his father. She was referred by her former therapist, who suspected the diagnosis DID. Bettie had come into treatment with the previous therapist for marital problems. During this therapy, Bettie had reported incestuous abuse by her father and she had shown signs of a dissociative disorder. Especially at night she changes into very anxious, aggressive, or self-destructive personality states, for which she is amnesic afterwards. The problems associated with these states caused much tension in the relationship with her husband, and eventually led to a divorce. Bettie subsequently stayed in individual psychotherapy, in which she became more and more aware of details of the sexual abuse perpetrated by her father. Various personality states could be identified, among them a six-year-old child identity, Lientje, and an aggressive boy identity, Albert. Under Albert's influence, Bettie sometimes mutilated herself using knives or glass fragments, or attempted to strangle herself. In order to protect herself against such dangerous behaviors, Bettie started, earlier than had been their plan, to live together with her current partner, Peter. Because they had recently moved to another city, the therapist referred her to another institute. A diagnostic interview with the SCID-D confirmed the diagnosis DID. Subsequently, Bettie came into therapy with a psychologist with specialized expertise in DID.

Case Example Two

Ms. Jansen (a pseudonym), age 55, has been divorced for several years. She has two children, ages 22 and 25, who live elsewhere. She was admitted to a general hospital for subcutaneous bruises which supposedly had appeared spontaneously. Since no somatic explanation could be found, the

hypothesis was entertained that self-mutilation might be the cause of these symptoms. Ms. Jansen has been previously admitted to a neurological ward for blackouts, for which no neurological cause was found. The attending physician decided to refer her for outpatient psychiatric treatment. There she explained that apart from some sessions with a social worker, she has never had psychiatric or psychological treatment. With this social worker she had started to talk about her incest history and physical abuse by her ex-husband. She felt she got worse from talking about these problems, so she had discontinued this treatment. Her main complaint pertained to the blackouts. During these *absences* she breaks things. She is suicidal at times, and on a number of occasions she has tried to kill herself.

Diagnosis

An important development in the area of diagnosis of dissociative disorders has been the construction of questionnaires measuring dissociative phenomena, such as the Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986) and the Dissociation Questionnaire (DIS-Q) (Vanderlinden, 1993), and the construction of structured clinical interviews for the diagnosis of dissociative disorders. Of the latter, the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) (Steinberg, 1993) has been validated and is widely used in the Netherlands (Boon & Draijer, 1993).

In clinical practice, it is important to recognize the existence of a complex dissociative disorder at an early stage. Patients with such disorders can thus be protected from prolonged involvements with the mental health system in which potentially ineffective treatment approaches are used. One approach to effective early detection is the standard use of the DES or DIS-Q, with patients who attain or surpass a cut-off score (e.g., 25 on the DES and 2.5 on the DIS-Q), to do a SCID-D interview. In the Netherlands in recent years the development and validation of the Somatoform Dissociation Questionnaire (SDQ-5) has been a welcome addition to our screening instruments (Nijenhuis, Spinhoven, Van Dyck, van der Hart & Vanderlinden, 1997).

Case Example One – Continued

In Bettie's case the psychiatrist doing the diagnostic assessment identified clusters of severe dissociative symptoms using the SCID-D, i.e., her recurrent amnesic episodes, chronic feelings of de-personalization and derealization. Also, Bettie feels very confused about her identity, especially because she has heard from her partner that at times she acts very differently and that she uses different names at those times. He has told her about the two identities, Lientje and Albert, who usually manifest themselves at night. She often hears voices in her head, and, when alone she can hear herself talking aloud without willing herself to speak.

Based on both the SCID-D interview and the information provided by the previous therapist and by Peter, the psychiatrist makes the tentative diagnosis of DID.

Case Example Two

In the case of Ms. Jansen, the diagnosis DDNOS is made using the SCID-D. Apart from the serious episodes of amnesia, she suffers from chronic depersonalization and derealization. In the course of therapy, the therapist suspects the diagnosis of DID, and she observes different identities: a personality state unable to read and repeatedly refers to this inability; an anxious girl identity; a writer identity who is busy writing and drawing her life history; an adult female identity, fearful and phobic; a verbally aggressive lady-like identity; and a very suicidal identity always preoccupied with how to kill herself.

In Ms. Jansen's case, the therapist chooses not to explore the possible alter personalities, but opts instead for a "here-and-now" approach. The reasons for this choice will be discussed below.

TREATMENT INDICATION

When the diagnosis of DID has been made and shared with the patient, treatment as a rule is aimed at stabilization and symptom reduction (including containment of traumatic memories). For some patients, the whole therapy does not proceed beyond this stage. Factors that may influence a decision towards a focus on stabilization only are the following: 1) patient's current functioning; 2) nature and severity of comorbid psychiatric conditions, in particular Axis II diagnoses; 3) patient's ego-strength and capacity to utilize attachment figures for self-soothing; 4) patient's life cycle phase; 5) ongoing enmeshment with perpetrators; 6) substance abuse; 7) and external life crises (Boon & van der Hart, 1996).

The essence of what can be reached with therapy geared toward stabilization and symptom reduction is living which is oriented more or less toward the present, thanks to a "covered" traumatic past. In Appelfeld's (1993) terms, it concerns "life lived on the surface" (p. 18). This implies an unstable balance which is easily disturbed by new stressful experiences; something to which fully integrated DID clients are much less vulnerable (Kluft, 1993b). However, ill-advised trauma treatment may lead to chronic decompensation or worse. When therapist and client, after a thorough assessment and frank discussion, eventually agree on this matter, (e.g., after a half year or a couple of years) the stabilization phase can be followed by the treatment of traumatic memories, as well personality reintegration and rehabilitation.

Case Example One – Continued

In the therapist's first sessions has with Bettie, who was sometimes accompanied by her partner, Peter, attention was paid to the diagnosis (DID), her life history, her current problems and general functioning, and the degree of support she could find in her surroundings. During the nights there still have been serious crises during which Bettie re-experiences

sadistic sexual abuses, in response to which she mutilates herself or attempts to commit suicide. This would awaken Peter, who then would need to restrain her. He was deeply worried. The therapist proposed a supportive therapy for him with a colleague, as well as regular sessions with Bettie and Peter together. For the following reasons, the therapist believes that Bettie's treatment will soon enter the phase of trauma resolution: 1) the existence of a number of strong identities who learn to cooperate rather quickly and who appear to be strongly motivated for trauma treatment; 2) the lack of indications of a personality disorder; 3) the existence of a strong supportive network; 4) the ability to make and keep clear agreements, (e.g., an anti-suicide contract); and 5) the ability to learn containment techniques.

Case Example Two – Continued

In the case of Ms. Jansen, the therapist thinks from the start that treatment of traumatic memories will not be indicated. Ms. Jansen is a single, mature woman, living in complete isolation, without a supportive social network. She had prevented collapse by continuous hard work, both in her family and outside. At the time of her referral, she was hardly able to function anymore. In recent years her parents have died, which perhaps triggered recovery of the memories of abuse. Then she divorced and the children left home. Because of back problems, she became unable to work. Finally, she was terrified and very defensive about treatment because talking with the social worker about her traumatic experiences had made things worse. Taking all these factors into account, the therapist offered her a supportive therapy in which the main goals would be: learning how to cope with her dissociative symptoms, learning to contain traumatic memories, and improvement of her current life situation.

TREATMENT*Treatment Frame and Therapeutic Alliance*

A basic condition for reaching a good therapeutic outcome is the therapeutic alliance. Building some trust is an essential part of the first phase of therapy. It is of importance that the therapist is honest, clear, and predictable. The boundaries of the relationship need to be spelled out: frequency of contact; crises calls, vacations, phone calls, etc. (Kluft, 1993a). The goals of the treatment and the treatment process need to be discussed. Finally, flexibility of the therapist is of great importance, (e.g., with respect to distance regulation in the therapeutic relationship and moving back and forth between treatment phases).

Phase 1: Stabilization and Symptom Reduction: Overcoming the Phobia of Dissociative Identities

Treatment is geared in the first place to regaining some stability in daily life, to symptom reduction, and to the establishment of personal safety and self-care (Herman, 1992).

Dutch therapists have learned to pay careful attention to this phase, which in their experience, easily can take a year (or even much longer). The better this groundwork, the more successful the next phase – treatment of traumatic memories – can be (Kluft, 1993c). For some patients like Ms. Jansen, treatment will consist only of stabilization. During this phase, Dutch therapists usually apply the following treatment strategies (Boon & van der Hart, 1995):

- a. General applicable supportive interventions, useful in the care of many other clients in crisis as well;
- b. Psycho-education with regard to dissociation, DID, and PTSD, which may heighten a sense of control and which lower feelings of anxiety and shame. Psycho-education 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, 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.

In our clinical experience, during the first treatment phase the therapist preferably directly contacts only identities which actively participate in daily life. Furthermore, contacting in an early stage the so-called “perpetrator-introjects” can be extremely helpful in reducing instability, inner unrest, and self-destructiveness. These identities, which

developed from identification with the perpetrators from the past, are ranked high in the inner hierarchy of identities (because of which we prefer to call them the “inner leaders”) and they usually contain much anger. The therapist should emphasize their contribution to survival of the patient and invite their help to prevent unnecessary reactivation of this anger and other trauma-induced emotions (van der Hart, Steele, Boon, & Brown, 1993). All this work of gradual exposure of dissociative identities to one another, and of fostering cooperation instead of inner fights and avoidance, aims at overcoming the phobia of dissociative identities.

Case Example One – Continued

The therapist focused on a number of parallel goals. First, he made agreements with Bettie and Peter about details of possible crisis intervention. Then he discussed with them how more stability can be reached. For this purpose he needed a detailed overview of Betty’s symptoms and subpersonalities, in particularly those participating in daily life, which can learn to cooperate better with each other and reduce crises. In his approach of gradually contacting identities, it is not his aim to make complete map of all existing identities, although several authorities maintain that doing this may help to anticipate and interdict future trouble spots (Kluft, personal communication, May, 1995). Peter is already acquainted with the following identities: Bertha, the mother identity who usually takes care of her son; Paul, a quiet male identity who is doing household chores; Sandra (age 19), who is mostly involved with sex; Lientje (age six), who has been repeatedly sexual abused by her father; Albert, a rather angry boy identity; Irene (age 14) who is currently re-experiencing a former boyfriend’s sadistic abuse. Lientje sometimes wakes up Peter, reporting that Irene is strangling herself.

The therapist feels that the successful fostering of collaboration between identities will be a good prognostic sign. In Bettie’s case there seems to be a willingness on the part of various identities to cooperate with the therapist. Initially, he regularly makes a behavior contract against suicide with the whole system of identities (“all parts of Bettie”). Bettie feels that making such a contract at the end of each session is supportive.

Although Bettie believes that there are no “perpetrator introjects,” the therapist assumes their existence. There are, in any case, aggressive identities such as Albert. The therapist discusses with Bettie their survival value at the time of traumatization and its wake, for instance by containing the anger evoked by the abuse. By repeating this message often, the therapist later also develops some understanding with these identities, who have begun to feel understood and accepted by him. It is remarkable that traumatized child identities such as Lientje have already their own imaginary “safe place,” something which the therapist therefore does not

need to teach them. However, Lientje experienced herself being verbally abused and molested by aggressive male identities when she leaves her "safe place." These identities became less aggressive toward her when they achieved a better understanding with the therapist. He also discusses more constructive ways of dealing with their anger and aggressive energy (e.g., by running and playing tennis) until the traumatic memories which evoke these emotions become integrated. Although the therapist was able to help the patient techniques for the containment of traumatic memories, Irene's current traumatic re-experiences at night were not much affected by these efforts. Therefore, earlier than the therapist was accustomed to do with other DID patients, he agreed to temporarily focus on these reactivated traumatic memories. If he can help the patient to process these memories successfully (see below), the focus will be on return to further stabilization and symptom reduction.

Case Example Two – Continued

With Ms. Jansen, the therapist started the supportive therapy aimed at stabilization with providing psycho-education about her dissociative symptoms, in particular her blackouts, hallucinations, and flashbacks. Ms. Jansen was afraid she was crazy, because she destroys her belongings during these blackouts and because she "sees" things, especially at night, like the turning of a door handle or a man in her bedroom. At times she sat the whole night frozen in her bed. Sleep medication and tranquilizers, which she had received from her general practitioner, had not helped. The therapist explains that blackouts and "seeing things" are often the result of having had bad childhood experiences, such as sexual and physical abuse. The increase of her symptoms is most probably a result of everything she has had to go through in recent years. Ms. Jansen experiences the explanations as reassuring, and she began to feel free to mention other complaints hoping to hear that they were not crazy either: finding things which she must have made or bought, for instance. Without speaking in terms of identities, the therapist explained that people with these problems may have various "moods," often related to different feelings about the past, in which they do certain things which they subsequently do not remember doing. The therapist used the metaphor of a dresser with many drawers to illustrate the fact that such memories and feelings are kept at different places in the mind.

Then the therapist wanted to chart the situations which might be aggravating the symptoms and triggering the destructive blackouts. Some of them were contacts with relatives and television programs on incest. The therapist guided Ms. Jansen to avoid these "triggers" as much as possible. By listening to an audio-cassette on which the therapist emphasized the safe present, using auditory, visual, and tactile anchors, she became more able to stay in the present, or return to it more quickly. By using her own dissociative skills, Ms. Jansen also learned to create an imaginary safe

place for herself, as well as imaginary places for the storage of traumatic memories. During almost each session the therapist assured her that having such extreme feelings is not unusual. Gradually the therapists taught her different ways of coping with anger.

With the aid of specialized home help, the therapist tried to help Ms. Jansen change her social isolation. Apart from infrequent contact with her children and a neighbor, she was always alone. Attempts to motivate her for psychiatric daycare failed, because she was afraid that she would blackout and destroy things there. For the same reason she once refused admission to a crisis center.

In the course of a four year long supportive therapy, Ms. Jansen's situation has slightly improved. She has found a more stable balance. But there are still episodes during which she is acutely suicidal or, during a blackout, destroys her things. She has developed a good working relationship with the therapist and with the nurses of the local crisis intervention team. When crises occur, they can usually be resolved in an outpatient setting; then she is temporarily seen more often by these nurses.

Phase 2: Treatment of Traumatic Memories: Overcoming the Phobia of Traumatic Memories

The purpose of the phase of treatment of traumatic memories, not indicated for each and every DID client, is the transformation of dissociative traumatic memories into autobiographical-narrative memories of the traumas. In order to bring this transformation about, the therapist guides the client during short but intensive episodes during which dissociative aspects of a traumatic memory are evoked, re-experienced and "brought together." Although some authors describe this process in terms of abreaction (e.g., Kluff, 1996; Ross, 1989), we believe that the concept of *synthesis* is more appropriate (van der Hart & Brown, 1992; van der Hart et al., 1993). Nijenhuis (1994) describes synthesis as controlled exposure to the feared traumatic memory (which was avoided by continued dissociation of the memory) under conditions of response prevention.

The result of successful synthesis is that the dissociation is lifted, that the traumatic memory as an active experiential state (with its related manifestations) eventually ceases to exist, and that the client gradually becomes able to relate the narrative of the trauma, thereby realizing what has been done to her or him and by whom. Synthesis sessions usually need to be alternated with sessions aimed at stabilization. The long-term task of trauma-work is to integrate the narrative-autobiographical memory in the whole of the personality.

In the example, below, of Bettie a synthesis technique (described in detail by van der Hart et al., 1993) is used with which a traumatic memory or a series of traumatic memories can be processed in a short amount of time. It should be emphasized that Dutch clinicians recognize that such an

"all-in" approach may be too demanding for many DID patients, who would therefore benefit more from controlled fractionated/gradual exposure such as those developed by Kluff (1990, 1996).

Case Example One – Continued

As no contra-indications for the treatment of the currently reactivated traumatic memories (pertaining to the sadistic abuse by her former boyfriend André) were encountered, the therapist made an agreement with Bettie and Peter to prepare for the synthesis of the memories. First, he discussed the dissociative nature of traumatic memories, the essence of trauma treatment, and the successive steps of the synthesis technique. Then he contacted Bettina, an alter personality who knows all about this trauma and who has an overview of the internal system of identities. After having assured that identities (including Bettie) who now should not be informed about the trauma are withdrawn behind a "dissociative wall" (as suggested by the therapist), she related in general terms the rapes and torture committed by a former boyfriend, André, for nine months. The identity Irene (age 14) had endured all pain, fear, and related emotions, while Sandra (age 19) had experienced sexual arousal and pleasure. The therapists then asked whether there is an identity that holds the anger about this abuse. As Bettina did not acknowledge the existence of such an identity, the therapist asked if their system as a whole agrees to this step. He then discussed again, in more detail, the purpose and procedure of the synthesis. He explained that, in order for the traumatic memory to become past tense, Irene and Sandra need to share their experiences of the trauma. Other identities may participate in this sharing, provided that they are strong enough to stand it. However, identities which are not yet up to participate should be protected from it. Bettina informs the therapist that, apart from Irene and Sandra, she herself will be present as well as several other identities. Bettie, the host, will be among the ones who need to withdraw from the experience.

The therapist then explained that when he has received an account of the traumatization, he will divide this account into approximately ten pieces. During the actual synthesis he will count and together with each count a certain section of the overall experience will be shared, while he will encourage them to make one whole of the fragments. One function of this counting is to do the trauma work in a fractionated manner, another to give them some sense of what has been accomplished and how much still needs to be done. He emphasized the need to share in particular the most threatening aspects of the trauma, which he calls the *pathogenic kernels* (van der Hart & Op den Velde, 1991). When not shared, these kernels will continue to exert their malignant influence. Bettina agreed to cooperate, and delivered a written account of the trauma in the form of a summary of the pattern of sadistic abuse the former boyfriend Andre

committed.

During the next session, the procedure was once more rehearsed. The therapist had divided Bettina's written account into nine segments. Bettina reports the existence of yet another identity, Gerda, which underwent parts of the abuse and who keeps in particular the anger about it. Gerda is also willing to participate in the synthesis. The therapists checked which identities will be present and he suggested that all others withdraw to their respective safe places. Then he asked all attending identities mentally to go back to the events with André, while at the same time keeping contact with him, Peter, and an attending female colleague. He suggested that they re-experience the abuse no more intensely than is needed for sharing their respective experiences with each other. Then he read the text about the abuse, count after count, each time adding the suggestion that they share with each other what has been seen, felt, heard, smelled, tasted, thought, and done. When they had thus gone through the whole account, the therapist inquired what percentage of the whole experience has now been shared. Bettina reports 95%, and she was certain that they can do the remainder on their own. The therapist suggested then letting go of the experience, adding suggestions for comfort and relaxation. A sense of relief prevailed. The other identities were invited to join those present, and finally the therapists asks Betty to come forward.

During the session one week later Bettie reported that the re-experiencing of the trauma has stopped. Irene feels rather quiet. In the following months it seems clear that this series of traumas has become a thing of the past. However, other traumas experienced by other identities were reactivated and subsequently successfully dealt with using the synthesis technique. Hypnotic suggestions were given for containment of unprocessed traumatic memories, and the therapist used more fractionation, (e.g., by making the pauses between counts longer and adding more suggestions for quiet breathing and relaxation in between). In the end, Bettie, the host, participated successfully in these syntheses. Throughout, synthesis sessions were alternated with sessions aimed at stabilization.

Phase 3: Personality Reintegration and Rehabilitation: Overcoming the Phobia of Normal Life and Attachment

During the third treatment phase, at times alternating with elements of phase 1 and phase 2, the goals were: guiding the patient with further integration and unification of the personality and with becoming self-supportive in daily life. Fusions between identities are important moments along this way. Guided imaginary fusions rituals may be helpful at appropriate times (Kluff, 1993b), but in Bettie's case these fusions usually occurred spontaneously, after the respective identities had shared so much with each other that staying apart had lost its function.

An often mistaken belief pertains to the final fusion:

more often than not the first fusion defined as such is not the last one. Kluft (1993b) mentions six criteria for complete unification of the personality. When these criteria have been fulfilled for 27 months, Kluft states that one can use the term "stable fusion."

There are patients who opt, even after successful trauma treatment, to keep going with a number of identities. Although impressive reasons may be given for this decision, in our clinical experience there is an inherent avoidance of the confrontation with still unresolved trauma or other crucial issues. Kluft's (1988, 1993b) observation that not completely integrated patients remain more vulnerable for dissociative fragmentation when new stresses occur, has been confirmed in our practice.

Completely integrated patients do seem to need guidance in developing new coping strategies instead of relying on dissociative identities to solve problems. In fact, often "normal" psychotherapy is indicated for the more complete resolution of the traumatic past, attachment problems, sexual issues, and so on.

Case Example One – Continued

Based on an improved cooperation and increased exchange among identities as well as further processing of traumatic memories, several of Bettie's identities spontaneously opted for fusion in the course of therapy. The first fusion gradually occurred between Bettie, the host, and Bertha, the mother-identity. Subsequent fusions took place among several identities containing anger and aggression, and child identities, always among identities which had something in common. Coupled with this increasing integration, Bettie functioned better in all respects. She has become more assertive, less dependent on Peter and on friends, and she found a job. She suffered less from traumatic re-experiences and slept better. She ended her relationship with Peter, with whom she felt she repeated abusive patterns from the past, and she started a new relationship. Eventually a stage was reached during which Bettie believed she had become fully integrated. However, the recurrence of some amnesic episodes and flashbacks of the incestuous abuse by her father not previously processed convinced her that there was still integrative work to do, in particular with child sexual abuse. This work took place over several months, after which Bettie stopped therapy.

A follow-up talk two years later indicated that Bettie was leading a satisfactory life with her new partner, to whom she is now married, and with good friends. She has been aware that she still has one other identity, Lientje, which occasionally manifests itself, usually with Bettie's consent, but on rare occasions by emerging spontaneously. Recently, traumatic memories of child sexual abuse were reactivated in Lientje, which makes Bettie uncertain about her situation. As of this writing she is considering whether or not she should return for further therapy.

DISCUSSION

In the Netherlands, as well as in the Dutch-speaking part of Flanders in Belgium, much research has been done with respect to screening and diagnosing dissociative pathology (e.g., Boon & Draijer, 1993; Nijenhuis, Spinhoven, Van Dyck, van der Hart, & Vanderlinden, 1996, 1997, 1998; Vanderlinden, 1993; Vanderlinden, van der Hart, & Varga, 1996). This has had a considerable influence in heightening awareness of dissociative symptoms and disorders in these areas, as compared to the situation in many other European countries. Diagnostic instruments have been translated and validated, and many teaching seminars are being held to instruct clinicians all over the country in their use. However, there are still instances encountered of false-negative diagnoses, and, unfortunately, an increase in false positives, since the media have been paying more attention to DID (Boon & Draijer, 1995).

Although the same development is taking place with regard to treatment (van der Hart, 1993), clinical experience develops only gradually, and controlled outcome studies are virtually non-existent. One such study is currently underway in the Netherlands. Nevertheless, as has been presented above, there is a general agreement in the field that the standard of care includes adherence to a phase-oriented model, not only in the treatment of complex dissociative disorders but also with regard to other forms of post-traumatic stress. The emphasis in many Dutch cases is heavily on stabilization/symptom reduction phase (phase 1), in which the patient's dissociative capacities are constructively used (for the construction of imaginary safe places and for containment of traumatic memories; controlled, very gradual inter-identity exposure takes place; and cooperation among identities is fostered).

Given the known abundance of complicated cases and enmeshed patients in the Netherlands, major strategic issues pertain to the length of phase 1 and to the question whether treatment of traumatic memories will be feasible; frequency of sessions; medication; and prevention of false beliefs of abuse. The two cases described above reflect these issues. The first case was a rather high-functioning patient, and the decision to treat traumatic memories could easily be made. In fact, most of the high-functioning patients we have treated or whom we know through case consultation and supervision follow this pathway, eventually reaching unification or proceeding in this direction. However, complicated cases such as presented in the second example seem to be much more commonly encountered.

In these cases, (i.e., categories 2 and 3 in Horevitz and Loewenstein's [1994] classification), it often takes several years of limit-setting, structuring, and building a sufficiently safe therapeutic relationship before phase 2 treatment can even be considered to be an option. A recurrent theme with

these patients is the recognition that maintaining a clear treatment frame and clear boundaries are essential for successful treatment. Too often, therapists have gotten over-involved in the therapeutic relationship while being unable to disengage, with burnout and secondary traumatization among the results. Dutch therapists recognize that building good professional support systems and consultation possibilities must receive more attention.

In several regions in the Netherlands, "special care" programs – with an emphasis on continuity of care – are currently being developed for the treatment of dissociative disorder patients. Changes in the organization of the Dutch mental health system, in which regional outpatient, day-treatment, and inpatient facilities are in the process of merging, seem to foster cooperation between these facilities; hopefully, these changes will also contribute to the improvement of the treatment conditions for these patients.

In the Netherlands, the recovered memory/false memory debate has also been raging. The media regularly contains information about attempts to deny the validity of both delayed recall and the diagnosis of DID – often illustrated by cases of parents correctly or incorrectly stating that they have been falsely accused. However, this country is not characterized by a litigation culture such as in the United States. Some parents claiming to be falsely accused by their children try to follow the lead of their North American counterparts with regard to filing suits against therapists, but the level of legal aggression shown in the United States is still inconceivable here. In some of the Dutch cases, a major issue has sometimes been made about the accusation that the patient was wrongly diagnosed as DID. Apart from the false-negatives which are probably still in the majority, the problem of false-positive DID diagnoses certainly exists in the Netherlands (Boon & Draijer, 1995; Draijer, van der Hart & Boon, 1996), and some false memory advocates indeed use this as a weapon to discredit the validity of the diagnosis entirely. However, the emphasis on increasing diagnostic skills – as sketched above – is, among other things, directed to keep this clinical problem controlled. ■

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