An Overview of the Psychotherapy of Dissociative Identity Disorder

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Dissociative Identity Disorder (DID) is identified and studied with increasing frequency. However, the controversy that often surrounds DID can make it difficult to approach its treatment in a circumspect manner. This paper will provide an overview of DID treatment as it is practiced by those experienced and skilled in the treatment of this group of patients. The treatment of DID resembles the treatment of other traumatized populations in that it is stage-oriented, beginning with supportive and strengthening work. Various stances toward the treatment of DID are reviewed, and specific issues that arise in the psychotherapy of DID are addressed, such as pragmatic arrangements, informed consent, work with alters, and the use of specific techniques, such as hypnosis. The employment of therapeutic modalities and ancillary therapies is discussed. The heterogeneity of DID patients is reviewed, and the characteristics of three general groups of DID patients, high, intermediate, and low in both function and prognosis, are explored. Considerations in the matching of DID patients to either exploratory or supportive treatments are discussed, and observations are made about both trauma work and the supportive psychotherapy of DID.

INTRODUCTION

Dissociative Identity Disorder (DID), formerly known as Multiple Personality Disorder (MPD), has enjoyed a renaissance of recognition and study over the last three decades. Controversy has surrounded this renewed attention. Polarized and often vehemently opposed opinions about the etiology, epidemiology, and treatment of DID are voiced by many authorities; not surprisingly, mutually incompatible recommendations have been made about the conduct of its psychotherapy. Providing appropriate treatment under these circumstances can prove a daunting task. The difficulty is compounded because many aspects of relevant bodies of knowledge, such as dissociation, hypnosis, memory, cognitive psychology,

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social psychology (and others) are often complex, recondite, and fairly inaccessible to the nonspecialist.

In this article I will present an overview of the psychotherapy of DID as it is described in the mainstream dissociative disorders and psychiatric literature. I will address general principles rather than the details of "how to do it." I will not address the major controversies themselves, which are covered very well in the literature, from both the perspective of specialists in dissociative disorders (1–5), those skeptical of the legitimacy of the dissociative disorders (6–9), and those who have attempted to assemble a diversity of views (10). However, I will discuss how a therapist might address controversial areas when they may impact upon the course of an ongoing treatment.

STAGES

Within the dissociative disorders field, there is general consensus that DID is a chronic, polysymptomatic, and pleiomorphic posttraumatic dissociative psychopathology characterized by the presence of multiple identities (personality states or alters) and amnesia that requires for its definitive treatment a psychotherapy that conforms to the stage-oriented treatment of trauma, first described by Janet, and elaborated in the contemporary literature by Herman (11). (Issues specific to work with the alters will be addressed below.) Although doubt has been cast upon the posttraumatic origins of DID (12), when two series of children and adolescents with DID or DDNOS were studied recently, trauma had been documented in the histories of 95% of the young patients in each series (13,14).

Herman (11) observed that in the treatment of the traumatized, a stage in which safety is established is followed by a stage in which traumata are remembered and the effects of their impacts are grieved, and that this is followed by a stage in which reconnections are made and recovery is achieved. She calls the stages: safety, remembrance and mourning, and reconnection, respectively.

These three stages correspond well to larger numbers of stages described for the treatment of DID by Braun (15), Putam (3), and Kluft (16) in three very similar lists. In Kluft's list there are nine stages:

Establishing the psychotherapy aims for the creation of an empathic atmosphere of safety, within which the security of the treatment frame can be forged, pragmatic arrangements for the treatment can be made, the therapeutic alliance can be established, and the patient can be prepared for the therapy that will follow. This preparation involves discussion of the

proposed treatment, its anticipated benefits and risks, an indication of alternative choices and their likely outcomes, a review of techniques likely to be employed along with their proposed benefits and drawbacks, and giving the patient appropriate cautions. The informed-consent process begins. Efforts are made to address the patient's demoralization and inculcate hope.

Preliminary interventions involve efforts to strengthen the patient as a whole and across alters in order to preserve and/or enhance the patient's current level of functioning, establish the coping skills necessary to begin the difficult work that may follow, and to deal with any problems in the collaboration between the patient and the therapist. Access is gained to the more easily reached alters, agreements or contracts are established across as many alters as possible against interrupting the therapy abruptly, against suicide and self-harm, and against as many dysfunctional behaviors as the patient is ready and willing to curtail. Communication and cooperation among the alters is fostered, and increasing numbers of alters are brought into the therapeutic alliance. Further work is done with regard to the informed-consent process. Whatever symptomatic relief can be offered will be offered, and techniques for coping with some of the disruptive symptoms of DID will be taught. Punitive superego attitudes and their enactment among the alters against one another are addressed. Guilt and shame management is a focus. The patient's psychodynamics, both as a whole, and within particular alters, are studied. Not infrequently, hypnotic techniques play a valuable role in this stage, used not for uncovering, but in what are called temporizing techniques (17), designed to contain potentially disruptive material and affects, facilitate mastery and coping, and to prevent decompensation. They allow the treatment to titrate the amount of discomfort the patient must endure against his or her own resources and capacity to achieve mastery and self-efficacy. As the DID patient becomes able to use these techniques between sessions, they often allow the DID patient to feel for the first time that he or she can be effective rather than powerless in the face of the DID psychopathology and life events. For example, patients can be taught to substitute alters to stabilize the system, to create the subjective experience of sanctuary, to reduce the intensity with which they experience distressing materials, to put upset alters to sleep between sessions, to sequester overwhelming material between sessions, to break intense experiences into less overwhelming ones, and to reconfigure their alter system to effect coping that does not involve dysfunctional or

self-destructive behavior. Clearly, some of the activities of Stages 1 and 2 overlap.

History gathering and mapping investigates the alters in depth. Now with the patient strengthened, it becomes possible to proceed to history gathering and mapping, during which the therapist learns more about the personalities, their origins, their concerns, and their relationships to one another. The inner world of the DID patient, in which the alters interact governed by a unique series of rules and in relationships that often reenact family constellations or particular experiences, is explored. The therapist comes to better appreciate the unique issues and perspectives of the personalities, and to understand how the alter system responds to particular issues or stressors. With this knowledge, the therapist uses the tools established in stages 1 and 2 to address problems experienced by particular alters and in the function of the system, and presses for still more cooperation and collaboration. Many experts (16,18) feel that it is dangerous to progress into work on traumatic material without first getting "the lay of the land," and being able to anticipate how the system will react to dealing with traumata. For example, if mapping demonstrates that there are many alters with related concerns, the therapist can anticipate that active efforts to deal with the concerns of any one of these alters may mobilize the others as well, and may wish to use techniques to reduce the likelihood that this will occur (e.g., by using hypnosis to distract or put to sleep all alters with similar concerns while one is being treated). Without such advance knowledge, the therapist who believes that he or she is addressing the issues of one particular alter might suddenly be confronted with an unanticipated crisis as many alters of which he or she is unaware begin simultaneous abreactions. In the model of tactical integrationalism proposed by Fine (18,19), which will be addressed below, mapping allows the therapist to identify and work with alters who share many similarities and affiliations in a manner that minimizes the disruption of the alters who carry on daily life activities.

Metabolism of the trauma involves the interventions associated with accessing and processing the overwhelming events associated with the origins and maintenance of the DID patient's psychopathology. It is useful to remind the patient that the material to be addressed will be processed in the interests of the patient's recovery, and that neither the feelings associated with the material nor the sense of relief experienced after it has been addressed is evidence of its historical veridicality (for further discussion of this issue, see Kluft [20,21]). It is not at all unusual for the conduct of this stage to involve moratoria, and/or to involve periodic returns to the issues

of earlier stages, because an unrelenting focus on trauma work can be counterproductive for the stability and well-being of the DID patient. Many clinicians use a variety of techniques to facilitate the management of this stage. Hypnosis offers many opportunities to moderate and modulate trauma work, and Eye Movement Desensitization and Reprocessing (EMDR) (developed by Shapiro [22]) finds a role in many treatments (23,24). Both hypnosis and EMDR make it possible to fractionate the management of trauma work. In fractionation techniques, first described by Kluft (25,26), explored by Fine (18,19), and adapted in EMDR (22), a model of trauma work derived from systematic desensitization is used to replace a model of abreaction more analogous to implosion or flooding. Fractionated work (described below) is less likely to prove overwhelming to the patient, and makes this stage of therapy more gentle and manageable.

In this author's experience whatever material is represented as traumatic must be addressed in order to move toward full integration, whether or not it appears to be historically accurate (20,21). However, whenever possible, it is useful to address the more credible material first, retaining the material that gives the appearance of being most unlikely until later. In some situations the entire DID situation becomes resolved before it is addressed; in some, it is processed much more easily later, even if it is more striking and repugnant; in some, the patient, in processing the more credible material, concludes that the less credible material was a form of screen for it, and it never needs to be addressed per se; and in some instances the less credible material will require strenuous processing, but the patient will have achieved so much mastery before it is addressed that its management will be less disruptive than it otherwise would have been (21).

Moving toward integration/resolution is a stage in which efforts are made to achieve the working through of the traumatic material across all of the alters, and to encourage still more cooperation, communication, mutual empathy, and identification across the alters. As these efforts progress, and inner conflicts are increasingly reduced, it is not unusual for the alters to begin to show some blurring of their characteristics, some fading of their prominence, and some identity confusion. Often the therapist will be confronted with alters who are not sure who they are, or who experience themselves as copresent with other alters.

Integration/resolution consists of the patient's coming to a workable stance, either as a single personality or as a stable collaboration of alters, toward both self and the world. A smooth collaboration is a resolution; the alters' blending into a unity is an integration. Follow-up research suggests

that integration is a preferable outcome, but some patients resist taking this final step (27).

Learning new coping skills, of course, has gone on throughout the therapy, but now becomes a major focus as the patient needs help in negotiating circumstances in a more constructive way that once were managed in a dissociative manner. Many important life decisions and relationships, now seen without the obstructions and distortions imposed by dissociation, may require reevaluation, and both alternative problem-solving and life changes may be the outcome.

Solidification of gains and working through may prove a long process. The DID patient must learn how to live in the world using alternatives to dissociative coping, and often working through transference issues in the therapy allows a more solid mastery of the issues stemming from their traumata and past experiences. Characterologic issues that may have been hidden or camouflaged by dissociative symptoms may require attention, and often extensive coaching on the management of relationships and intercurrent traumata proves necessary.

Follow-up involves the assessment of stability and prophylaxis against relapse, which is especially important for patients who elect resolution rather than integration. Also, additional layers of alters may be encountered, and aspects of recovery that were more flight into health than substantial improvement may require attention.

This model is consistent with a treatment approach that is designed to bring about the complete resolution of DID psychopathology. However, patients are encountered (and will be discussed at length below) who are not candidates for such treatment. They fail to progress with this model, or prove unable to tolerate work with traumatic material. Such patients do better with a supportive treatment that aims to decrease their discomfort, retain or augment their level of function, and facilitate their coping with everyday life and relationship issues. The alters indeed will have to be addressed, but efforts with them will focus on their more appropriate cooperation and collaboration to deal with the patient's here-and-now concerns. Efforts will be made not to impose the additional burden of uncovering and dealing with traumatic and possibly disruptive materials. These will be addressed only if they intrude and cannot be set aside. Integration will not be a goal. Attempts to treat such patients as if they were candidates for definitive treatment are likely to cause them great distress, and make it more difficult for them to cope. The treatment of this group of DID patients is less familiar and has not been addressed in the literature

until quite recently (e.g., Boon [28]; van der Hart & Boon [29]), but it is one of the most important areas of concern in the treatment of DID. Often their entire therapy consists of efforts to achieve the goals of the first two stages of DID treatment; i.e., it remains in Herman's stage of safety.

Now, let us return to Herman's (11) three-stage model and match its components to Kluft's nine-stage DID treatment. In the definitive model described above, DID treatment stages 1 and 2 are clearly consistent with Herman's first stage, safety. DID treatment stage 4 correlates with Herman's second stage, remembrance and mourning. DID treatment stages 5–9 mirror Herman's third stage, reconnection. But what of DID treatment stage 3, history gathering and mapping? In the definitive treatment of DID, it is primarily a part of Herman's stage of safety, since it lays the groundwork for the trauma work. The mapping and the work with individual alters' issues in a preliminary way serves this purpose. However, its history-gathering component is uncovering, and uncovering may occur in the process of mapping. Therefore, if a decision is made not to progress to a definitive treatment designed to completely resolve the DID, the clinician should consider history gathering and mapping to have aspects that may or may not be appropriate in a given case. Therefore, in a supportive treatment, DID treatment stage 3 often is better understood as affiliated, along with DID treatment stage 4, with Herman's stage of remembrance and mourning (28).

The Spectrum of Stances or Approaches to the Treatment of DID

Beyond matters of theoretical orientation and the selection of techniques, the stance or approach to treatment taken by the therapist (and at times by the patient) plays a major role in what can and will transpire. Although many therapists in past years approached the treatment of DID as if it were inevitably a wild and out-of-control process, desperately applied technique after technique trying to find something that worked, or tried to force the psychotherapy of DID into a treatment paradigm with which they were already familiar, these approaches have not proven effective (30,31). In each case they treat, current practitioners knowledgeable about DID implicitly or explicitly embrace one of the following stances: strategic integrationalism, tactical integrationalism, personality-oriented treatment, adaptationalism, or minimization.

Strategic Integrationalism

Strategic integrationalism is the attempt to treat DID in a psychotherapy that is consistent with the psychoanalytic tradition of resolving pathological

defenses and structures and facilitating growth and development. From this stance the therapist generally attempts to create an atmosphere supportive of a process-oriented psychotherapy. Its goal is the integration of the personalities in the course of the recovery of the individual DID patient. Whatever additional techniques and specialized interventions may be employed in the course of the treatment are valued less for themselves than for the long-term goals to which they contribute. This approach

> focuses on rendering the dissociative defenses and structures that sustain [DID] less viable, so that the condition in essence collapses from within. Its ideal goal is the integration of the personality in the course of the overall resolution of the patient's symptoms and difficulties in living. (30, p. 2)

Tactical Integrationalism

Tactical integrationalism emphasizes the skillful orchestration and application of techniques in the service of attaining a series of discrete goals that lead to the superordinate goal of integration and recovery. This stance espouses the same ideal outcome as strategic integrationalism, the integration of the personalities,

> but the actual conduct of the therapy reveals a predominant concentration on tactics, and on discrete interventions that serve as adroit devices to accomplish a series of objectives. . . .Their planfulness and deliberateness may be conspicuous. At times these therapies take the form of a series of short-term therapies within the context of a long-term therapy. (31, p. 91)

Many interventions from many schools of therapy may be applied. Process is appreciated, but it is understood to be the context in which the therapist applies interventions which themselves are major vehicle of the treatment. Such approaches stem from the traditions of hypnosis, behavior therapy, and cognitive therapy.

Personality-Oriented Psychotherapy

Certain therapists do not regard dividedness per se as problematic. Their approaches often involve a problem-solving inner-group therapy or inner-family therapy among the alters (32,33). Smoother collaboration is encouraged to effect a more harmonious and functional arrangement among the alters. Integration may or may not be pursued.

This term has also been used to describe an approach in which the alters are understood to be genuine people who must be nurtured into health in a very tangible fashion. Although occasionally successful, many unfortunate outcomes have been noted. This latter approach is contraindicated.

Adaptationalism

This approach prioritizes the management of life activities and the maintenance and improvement of function over integration. It avoids concentration on trauma work or uncovering. It stems from the traditions of supportive psychotherapy. This is a suitable approach when a definitive treatment is contraindicated (28), but, since it has the potential to deprive a patient who is capable of engaging in a definitive treatment of the chance to make a full recovery, its use with such patients would appear to be inappropriate.

Minimization

This approach generally proceeds from the assumption that DID is not a genuine clinical phenomenon, and embraces the premise that if the manifestations of DID are not reinforced with attention, they will cease to appear. This approach is widely endorsed, mostly by those skeptical about DID, but has not demonstrated widespread clinical utility. In fact, unpublished data acquired in conjunction with a naturalistic longitudinal study of DID patients (31,34) demonstrated that every DID patient treated in this manner continued to have DID on follow-up. At the most, this approach had temporarily suppressed its manifestations.

While most therapies are dominated by one of the above stances, the circumstances and stability of DID patients in treatment may vary considerably over time, and require flexible transitions from one stance to another to address particular situations (31). For example, a mother with DID in a therapy characterized by an exploratory strategic integrationalist stance who is suddenly confronted with the serious illness of her child may profit from a transition to a personality-oriented or adaptationalist therapy while her energy must be diverted from her treatment to the care of her child.

The complete resolution of DID psychopathology can be achieved from the stances of strategic integrationalism, tactical integrationalism, and personality-oriented treatment. It cannot be achieved from the stances of adaptationalism or minimization. The supportive psychotherapy of DID is incompatible with the full application of the strategic integrationalist or tactical integrationalist stance, although these may be adapted and modified for supportive purposes. Personality-oriented treatment and adaptationalism are compatible with the supportive treatment of DID. Minimization as an overall therapeutic stance is rarely indicated. Later in this article, the matching of therapeutic stances to patient characteristics and therapeutic goals will be addressed further.

SPECIFIC ISSUES IN THE TREATMENT OF DID

Practical Arrangements

DID is a difficult condition to have, and its therapy makes substantial demands upon therapist and patient alike. It is difficult to address significant trauma from the past while addressing issues in one's contemporary circumstances. Although supportive treatments and a minority of definitive treatments (usually or relatively stable patients) can be conducted in once-weekly psychotherapy, it is typically recommended that two full sessions a week, either as two separate sessions or as a single extended session, be understood as the appropriate minimum for successful therapy. Most of the rapid results reported in earlier contributions (35,36) were achieved in patients seen 3–4 times per week. A patient usually cannot progress rapidly without the continuity, support, and security (due to greater containment and therapist availability) of a more intense treatment. Consequently, the treatment of DID must be carefully paced, bearing in mind both the patient's strength and resilience, and the actual logistics of the treatment, which may last for many years.

One of the most important aspects of the therapy of DID is ensuring that to as great an extent as possible, the patient leave the session in a relatively safe and contained frame of mind. Therefore, it is important for the therapist to master techniques that will allow the patient to be calmed at the session's end, and it is useful to respect Kluft's "rule of thirds" (16,31,37). This rule holds that if one is deliberately planning to work with painful material, one should make sure that this work begins in the first third of the session and ends by the end of the second third of the session, preserving the last third of the session for processing what has been dealt with and restabilizing the patient. This is often difficult to apply in process-oriented therapies in which material may emerge gradually throughout the session, peaking toward the end, but is quite workable in therapies in which technical interventions are used to access, initiate, and conclude the work in question.

Access to the therapist between sessions is a major concern of DID patients. Their pain is often considerable, and their vulnerability to crises can be pronounced. It is important that they have access to some sort of coverage in between appointments, and it is important to frame this in a constructive way to prevent that coverage being abused. Early in treatment, during major clashes between alters, and during particularly upsetting trauma work, are times when this need may be highest. Many factors contribute to every therapist's decisions about his or her availability. Here I can only observe that it is difficult for a patient with DID not to have access

to a clinician who is knowledgeable about DID and capable of dealing with difficulties in an informed and sensitive manner. Interim contacts with therapists unfamiliar with them and their condition may enhance rather than diminish their panic. My own practice is to respond to calls, but to confront my patients in session about occasions during which their calls do not represent true emergencies. In my experience, only a small number of DID patients will continue to abuse my availability after I clarify my stance a few times.

Informed Consent

Although informed consent from one alter can be applied to the patient as a whole, it is best to discuss issues concerning informed consent in an atmosphere that specifically encourages all alters to listen in to the discussion, especially those who see themselves as protectors of the patient (38). Litigiousness may be associated with trauma work in general, and with the treatment of DID in particular. Therefore it is important to document that the treatment is progressing under the aegis of informed consent, and, as per the recommendations of Appelbaum and Gutheil (39) to regard informed consent as a process rather than as a moment in time. Subjects that should be addressed involve alternative approaches to treatment (and their pluses and minuses), the possibility of symptomatic worsening in the course of treatment, the vicissitudes of autobiographic memory (i.e., that recalled and/or recovered memories of trauma may or may not prove accurate), the techniques that may be used (and their possible benefits and drawbacks), and that additional alters may be encountered, or even created, in the course of therapy. Some experts advise the use of a consent form, especially with regard to recovered memory, while others advise the documentation of informed consent in progress notes. The interested reader is referred to more specialized sources (39, 40). The circumspect contemporary clinician would do well to regard the informed consent process as an aspect of the therapeutic alliance in the 1990s rather than an arrogant intrusion into the therapeutic dyad. The costs to the therapist for omitting either such efforts or their documentation can be considerable.

Dealing with Alters

Many therapists are reluctant to actually elicit and/or work with the alters. They prefer to understand the alters as phenomena to be bypassed or suppressed, or they prefer to find another way of referring to the issues raised by the alters without having to address them as such. A longitudinal study of DID patients discovered that DID patients in treatments that did not address the DID directly, all had DID on follow-up (31,34). To date, I

have not been able to find a literature describing the successful definitive treatment of DID without addressing the alters. In contrast, all available reports of successful treatments, whether in the lay or the scientific literature, have involved therapies in which the alters are addressed. Therefore, the clinician who undertakes to treat DID without addressing the alters is following a path likely to prove therapeutically futile and to expose the patient to danger and excess morbidity.

This is hardly surprising. The alters are not merely curious phenomena. They express the structure, conflicts, deficits, and coping strategies of the DID patient's mind. As Coons (41) and Kluft (42) have observed, the personality of a patient with DID is to have multiple personalities. Bypassing or disregarding the alters creates a therapy in which major areas of the patient's mental life and autobiographic memory will be denied an empathic hearing. Furthermore, it is rarely sufficient simply to address the alters as they emerge. The alters are aspects of a process of defense and coping. It would be naive in the extreme to imagine that the patient will predictably present in those alters most relevant to the conduct of the therapy. Considerations of facilitating day-to-day function, shame, guilt, and apprehension dictate otherwise. Therapists who await the emergence of alters in order to work with them may prolong the treatment considerably. The need to elicit the alters in order to do the work of therapy is one of the factors that motivates the process of mapping, or understanding the structure of the system. For example, the late Cornelia Wilbur, M.D., observed that in many DID patients one personality knows the entire structure of the system, but such a personality usually stays within the inner world of the alters and does not emerge. Simply asking whether such an alter is present can lead to information that simplifies treatment considerably in those patients who answer in the affirmative. Also, many times dangerous symptoms are related to alters unknown to either the therapist or the more easily accessible alters, yet can be easily addressed if the alters associated with such symptoms are elicited and their concerns addressed. A more detailed discussion of the usefulness of talking with the alters is available (3,43). Some useful forms of therapy, such as Watkins and Watkins' (33) ego-state therapy, a productive personality-oriented approach, depend upon accessing the alters in order to move forward.

Dealing with the Surround of DID Treatment

By the surround, I mean the atmosphere of influences and information, both constructive and problematic, in which one conducts the psychotherapy of DID. This includes the flow of commentaries and data on DID

and relevant subjects, such as "recovered memory" and trauma to which the patient is subjected, and the impact of these influences upon the patient, the therapist, and concerned others in the patient's life.

It is hard enough to treat and to be treated for DID in a supportive atmosphere. In an atmosphere of polarized contention, the task becomes more complicated. In the treatment of DID in the 1990s, the therapist can expect that the patient will hear that DID does not exist, that it is an iatrogenic creation, that those who treat DID are practicing a dangerous "recovered memory therapy," which constitutes malpractice, and that all or most recovered memories of trauma are false. These opinions will be voiced on prestigious mainstream television programs by experts and professors of apparently impressive credentials. Furthermore, there are web sites on the Internet in which the above views are expressed with conviction and venom. Also, in chat rooms for dissociative disorder patients on the Internet, it is easy to find contributions that vilify prominent dissociative disorder therapists, and that advocate remaining dissociative.

In this atmosphere, it is important to appreciate that no matter how dedicated the therapist and how motivated the patient, these factors may exert an influence. An apparent straightforward agreement to avoid and/or remain uninfluenced by such pressures may inadvertently contribute to a collusion to leave doubts and negative perceptions unexplored. In my experience, it is more productive and less defensive to invite the patient to bring all experiences that reflect such impacts into the therapy, and for the therapist to acknowledge the controversies that surround the issues of concern, and to state his or her best understanding of the particular situations or issues in question (44). If this is not done, the influence of infinite third parties to the treatment may go unappreciated as they undermine the therapy. A small percentage of DID patients will use the doubts raised by external factors in the service of an ongoing resistance, but most will not. For those who do, the characterologic aspects of such a defense must be addressed. In any case, it is important not to do anything that will result in the therapist's forcing the patient to accept the therapist's point of view, or precluding the patient's exploration of his or her own misgivings.

TECHNIQUES

General

Most DID patients are treated in therapies that have a psychodynamic or cognitive-behavioral orientation, and are facilitated by additional modalities and approaches. An addition to conventional approaches is "talking

through" (45, 46), that is, talking to the personality system as a whole. In this manner the therapist keeps in mind that any and all parts of the mind may be listening, and by appealing to all parts of the mind, one encourages as many to listen as is safe and/or relevant. Also, the therapist develops a pattern of talking to both the individual alter or alters with whom the therapist is in conversation, and the person as a system and as a whole, at the same time. This both acknowledges the alters' experience of themselves as separate, and supports an appreciation that all the alters are aspects of a single human being.

In a similar manner, one often will request that if any other parts have comments to make on a particular issue, conflict, dream, etc., that they will either come forward and say what they have to say, or to speak inwardly so that their contributions will be heard as a voice within the head, and their words can be repeated aloud to the therapist. Likewise, whatever is heard inside the head should be reported unless there is some inner threat or constraint against doing so. All of the above approaches both acknowledge the patient's perception of the alters' separateness, and suggest the erosion of boundaries in a way that promotes integration (47).

Other techniques involve the use of constructive personalities as allies in the therapy and in stabilizing the system. For example, a patient who had spent years regressed in a series of child states was helped to return to function by arranging for protective personalities to attend to the child states in the world of the personalities, allowing more functional alters to come forward and resume the patient's occupational and social roles.

Mapping has been mentioned in passing, and can be done in many ways. However, one of the most straightforward was devised by Fine (18,19). The alter that is usually in control (the host) is asked to write its name on a piece of paper, sometimes at the middle of the page, and the other alters are invited to place their names, either by emerging and writing, or by instructing the alter in control what to write and where to write it. I modify the technique by asking alters that do not yet wish to declare themselves or who do not have names to make a mark to indicate their presence. One rarely gets all alters on an initial map, but the view that it gives of the alters and their relationships to one another is invaluable. This process can be repeated from time to time to see what alters and groups of alters not previously available are now declared. If one wishes to work in a tactical integrationalism manner, as described by Fine (18,19), mapping is essential, because in this approach the therapist tries to avoid allowing painful material to intrude into the alters that attend to day-to-day activities

until late in the treatment, lest the patient's function be inadvertently impaired.

Not infrequently, it is useful to suggest that the patient keep a journal for 20–30 minutes per day in a free-associative manner. This often allows additional ventilation, communication among the alters, revelation of additional alters, and sharing by alters as yet unable, unwilling, or unprepared to enter treatment. Valuable material is often first revealed in this medium.

Hypnosis

Hypnosis long has played a valuable role in the treatment of DID, and remains the most commonly employed family of specific techniques (48). Recent concerns about the possibility of retrieving confabulated and concretized pseudo-memories with hypnosis have been allowed to obscure the fact that hypnosis can offer anxiety relief, the opportunity to create sanctuary for the beleaguered personalities in "safe place," and allied techniques, as well as unsurpassed opportunities to explore and influence the alter system, containment of affect, control of the abreactive process, facilitation of integration, and a variety of temporizing techniques used to quiet and protect unsettled personality systems. For more detailed information on the use of hypnosis in the treatment of DID, consult Braun (46), Frederick and Phillips (49), Hammond (50), Kluft (17,25,45,51,52), and Putnam (3).

EMDR

In recent years, EMDR has been used extensively with trauma victims, and increasingly for processing the traumas of DID patients, but, unless cautiously introduced, EMDR may prove an overwhelming experience for the DID patients (22). In workshop settings Fine, who is perhaps the most experienced clinician in the use of EMDR with dissociative disorders, advises that (with few exceptions) it be withheld until the therapy is well underway and the therapeutic alliance is strong. She rarely employs it in the first year of therapy. Paulson (23) and Lazrove and Fine (24) have described approaches to the use of EMDR with DID. In the author's experience EMDR is most helpful in a highly structured therapy, but can be used with caution in a more process-oriented treatment. EMDR used precipitously in the context of a process-oriented therapy can mobilize many types of traumatic material and traumatized alters at once, and prove disruptive.

Psychopharmacology

Medication does not address the core symptomatology of DID, but can be very effective in addressing particular target symptoms and in alleviating

comorbid drug-responsive conditions. Since DID patients commonly have additional diagnoses as well (3,4,16,53), most DID patients receive medication. The art of medicating DID patients has been addressed elsewhere (54–59).

Group Therapy

DID patients often have difficulty participating in traditional therapy groups because they often are experienced as disruptive to such groups and in turn are vulnerable to being disrupted by them. In recent years groups for DID patients have been conducted by a number of clinicians and have proven useful (60,61). In such settings the DID patient is neither abnormal nor an outcast. These groups function most effectively when they focus on psychoeducational objectives, here-and-now coping, and problem-solving rather than the traumatic past.

Support groups for DID patients that are leaderless or facilitated by non-professionals have a very poor track record, suffering from contagion, the disruption of of the members by one another, and by becoming such preoccupations to their members that their individual psychotherapies are derailed by dealing with the repercussions of their relationships with the group and group members.

Groups for family, friends, and the concerned others of DID patients can be a valuable support for these individuals and to the treatment of the DID patient (62–64).

Family Therapy

Family treatment with the DID patient's family of origin is an enterprise fraught with peril if family members are alleged to have been abusive. Confrontations about abuse in this context may be disruptive to the family and patient alike, and may lead to the therapist's being held to be responsible for the consequences of the confrontation to family members. Often the patient is repudiated, and families are alienated. The cost-benefit ratio of these meetings often is prohibitive (65).

Conversely, family work with the DID patient and concerned others and children of the DID patient can help these persons to cope with the DID patient and with their reactions to the DID patient and his/her condition (66–68).

Creative Arts Therapies; Functional Therapies

It is difficult to overstate how useful art, movement, music, poetry, and occupational therapy can be with DID patients. Often stymied in their verbal expression, these modalities may provide a forum for the expression of what cannot be said and acknowledged in words. Since many DID

patients are very creative, they often are able to use these modalities with great ease. A discussion of the roles of these modalities is available in Estelle Kluft's text, *Expressive and Functional Therapies in the Treatment of Multiple Personality Disorder* (69).

THE HETEROGENEITY OF DID PATIENTS AND ITS IMPLICATIONS FOR TREATMENT

The Discovery of Heterogeneity

One of the most intriguing aspects of the modern treatment of DID, more evident in the setting of workshops than in the literature, is that an initial tremendous optimism, fueled by the reported accomplishments of some of the early pioneers, was replaced by a wave of pessimism as others found themselves unable to duplicate these successes. Clinicians wondered whether the pioneers' reports were accurate, whether the pioneer clinicians had special gifts, or whether DID was simply too complex to be treated by the average clinician. As DID patients were encountered who reported extremely involved patterns of abuse and extremely complex alter systems, many clinicians began to declare a substantial proportion of DID patients untreatable (31).

However, as this phenomenon was studied, it became clear that DID was an extremely heterogeneous condition, and that three subgroups of DID patients could be characterized (35,70–76).

The first was characterized by primarily dissociative and posttraumatic psychopathology and by relatively high functioning; whatever comorbid disorders were present, such as major depression, responded well to treatment. These patients had considerable ego strength and many psychological assets. They required hospital care infrequently if at all. They usually integrated, and generally completed treatment in 2–7 years. They generally did well with neophytes and experienced DID therapists alike, though they integrated more rapidly with more experienced clinicians.

The second group had fewer psychological resources and more borderline features; their comorbidity was considerable, and might include affective disorders, eating disorders, and histories of substance abuse. Their function and interpersonal circumstances were more problematic, and dependency and attachment issues were more marked. While many ultimately integrated or reached stable resolutions (more harmonious functioning of their system of personalities), their treatment courses were more likely to be more tumultuous and marked by crises, and/or their progress was slower and more irregular. Many had long periods of instability, and required a number of hospitalizations; some required ongoing

supportive help and could not engage in definitive treatments. This second group did distinctly better with therapists with extensive experience with DID, who were better prepared to deal with their problematic behavior and crises by intervening actively within the alter system.

The third group showed more extreme problems of the nature encountered in the second (e.g., their comorbid conditions were more severe), were more likely to be enmeshed in exploitive relationships, self-destructive, and identified with a dissociative life style (i.e., unwilling to consider working to integration), and might demonstrate features associated with psychotic disorders or refractory affective disorders (either from time to time or on an ongoing basis). Supportive treatment was required for protracted periods of time, and many therapies never progressed beyond supportive measures. A minority made its way to integration or to stable resolution, but many simply slowly became more modulated and less chaotic over time, became less disrupted, and, in some cases, were ultimately amenable to a definitive treatment.

Viewed retrospectively, the largely private-practice caseloads of many pioneers included very high percentages of the first (more high-functioning DID) group and relatively few of the third (most compromised) contingent, while groups drawn from a clinic, state hospital system, or social agency referral base had a higher percentage of the second and third groups of DID patients. This discrepancy led, for example, to Kluft's (45) stating 22.8% of his private practice DID patients had strong borderline features while Horevitz and Braun (76), working largely with a social agency referral base, found diagnosable borderline personality disorder in 70% of their subjects. Furthermore, Kluft followed 123 DID patients, 120 in therapy with himself and 3 in treatment with Cornelia B. Wilbur, in an open-ended follow-up project. Summarizing several studies (31,35,36,43), ultimately 109 (89%) achieved integration. The remainder were either deceased, left treatment, terminated with an incomplete result, or remain in active treatment. While other follow-up studies are not readily comparable for many reasons, Coons' (77) 39-month average follow-up of state hospital clinic DID patients in treatment with (mostly) neophyte therapists found that 25% had integrated and 67% were considerably improved; and Ellason and Ross (78) found that 23% of patients hospitalized for DID were reported integrated by their therapists two years later.

Therefore, the crests of optimism and the troughs of despair about the prognosis of DID patients, in general, appear, in retrospect, to have reflected (among other factors) overgeneralizations drawn from experiences with rather different populations of DID patients. It is interesting to

speculate whether some of the discordant treatment advices to be found in the literature stem from similar sampling problems. For example, if a clinician observed several DID patients from the third group decompensate when they were treated in an exploratory therapy of the sort appropriate for the first group, it would be natural for that clinician to conclude that one should not do uncovering work with DID patients, and that treatment should remain supportive and stress symptom containment. However, if a clinician observed several DID patients from the first group who had not prospered in treatments that did not address their DID rapidly move into productive therapy and progress toward integration in the course of an exploratory therapy, it would be natural for that clinician to conclude that uncovering therapies are appropriate to use in DID, and that treatments that remain supportive and stress symptom containment are counterproductive.

Heterogeneity and Clinical Practice

The contemporary clinician must approach the treatment of DID with an appreciation that treatment strategies must be devised to approach the individual DID patient, that a "one size fits all" approach will not be effective. There are several approaches to determining how to assess the circumstances of a DID patient. Those most current are: 1) establishing an initial prognostic profile, 2) measuring the patient's response to treatment with a rating instrument, and 3) using a trial of psychotherapy. The latter two might be regarded as hazardous by someone afraid of decompensating the DID patient with interventions that later may prove to have been inappropriate. However, as has been noted above, all treatments should have rather comparable initial phases.

Initial Prognostic Profile

Many of the findings about the profiles of DID patients with different prognoses have been reviewed above; here the more specific factors discussed by Boon (28) and Caul (72) will be reviewed. Caul (72) described sixteen issues in the patient's history and early therapy behavior to consider for prognosis. In each case, if a factor is present, a longer course of treatment and/or a less favorable prognosis should be anticipated; furthermore, the presence of increasing numbers of poor prognostic features augurs for increasingly difficult and/or prolonged treatments: 1) the patient does not accept the diagnosis; 2) the patient, for no external reason, has left or failed to improve with a capable therapist; 3) after diagnosis, the patient has focused on uncovering rather than improvement; 4) the diagnosis has been known for a period of time in the therapy, and there have been many

therapists; 5) great complexity of the alter system and tenacity in maintaining it; 6) extreme specialization in the alter system; 7) great investment in the separateness of the alters; 8) preoccupation with the use of alters as the exclusive means of problem-solving; 9) patient tries to control the nature and course of the therapy; 10) patient tries to control the therapist; 11) it is difficult to make contracts with the patient; 12) confabulation appears extensive, persistent, and inconsistent with known facts; 13) violence or a violent attitude; 14) despite verbal statements of motivation, an equivocal emotional commitment to change; 15) the patient pushes more toward uncovering than dealing with what has been uncovered and attempting to resolve problems; 16) the patient makes a prolonged effort to protect and preserve groups of alters that attempt to dominate others or keep others out of the therapy. Caul acknowledged that some degree of most of these factors is "par for the course" with DID, but when they are pervasive and persistent, they are problematic.

Boon's (28) profiling efforts were designed to indicate whether a patient is a candidate for stabilization only, or for a more encompassing therapy. She advised evaluating five areas: 1) the patient's current personal and professional functioning; 2) the presence of an Axis II disorder; 3) the patient's life cycle phase and/or external life crises; 4) substance abuse; and 5) ongoing abuse. Boon noted that unless functioning is adequate, or improves in the first stages of therapy, it is not feasible to contemplate a definitive therapy. She cautioned against mistaking posttraumatic chaos for borderline personality disorder, and against mistaking the features of some alters for a true character disorder. She also warned that when a true firmly established borderline character disorder is manifested in all the alters, unless the problems likely to be associated with it can be resolved (such as difficulties in attachment to the therapist, pathological self-soothing behaviors, poor judgment in interpersonal relationships, the reenactment of prior traumatic attachments, and testing behaviors) it is unwise to proceed beyond supportive work to a definitive therapy. Certainly, a patient's life circumstances may make it unwise to move beyond supportive work. If patients are using substances to self-treat their pain, and/or are reluctant to give up the substances, and/or have not developed alternative strategies, it is likely that attempts to do definitive treatments will cause them to increase or resume substance abuse. Finally, if the patient is involved in ongoing abuse, it is unlikely that treatment can proceed into definitive DID therapy until this is addressed.

Taken together, the diagnosis and life-circumstance factors considered by Boon and the historical data and in-session behaviors reported by Caul

are useful tools with which to determine whether a given DID patient should be considered a candidate for supportive work alone, or for therapy designed to resolve the entire DID condition.

Rating Instruments

Two attempts have been made to describe the DID patient's response to treatment, Kluft's (70,71) Dimensions of Therapeutic Movement Instrument (DTMI) and Boon's (28) Checklist for the Evaluation of Treatment Process of DID. The former involves the scoring of 12 basic (and one elective) dimensions of patient behavior and experience at selected intervals, the latter involves the description of the patient's functioning and cooperation with therapy in 13 areas at baseline and at subsequent times. There are considerable overlaps between the two, but, as Boon notes, her instrument is designed for the patient in supportive treatment, while Kluft's is more appropriate for use in a definitive therapy. Consequently, the Checklist focuses more on adaptation, coping, and functioning, while the DTMI emphasizes containment and progress toward integration.

Using the DTMI (70), which remains an empirical rather than a validated instrument, and scoring the patient at least quarterly for a year, it will be possible to classify a patient as being on a high, intermediate, or low trajectory in therapy. These trajectory categories overlap considerably with the three categories described earlier, but there is a significant difference. The DTMI allows the identification not only of how patients use their evident assets in treatment, but also how some patients who at first glance appear quite impaired are able to use their treatment to make rapid gains of which they would not have appeared capable. Such patients are not uncommon because the chaos of DID may obscure considerable strength and potential, and may create the appearance of problematic comorbidity that proves to be simply an epiphenomenon of the DID rather than an independent co-occurring disorder.

Trial of Therapy

If the therapist applies the three-stage model of trauma treatment described by Herman (11) or the eight- to thirteen-stage models of DID treatment proposed by Braun (15), Kluft (16), and Putnam (3), the treatment process itself helps to define the course and nature of the therapy. All start with attempts to stabilize and strengthen the patient prior to approaching trauma work or considering integration. The implicit assumption is that the trauma work may be a major stressor, and the patient should be safe, protected, and provided with new and more effective ways of dealing with traumatic scenarios and disruptive symptoms before being

asked to undertake it. Therefore, a therapist who appreciates that his or her patient has not mastered the tasks of the stages preliminary to trauma work will, with rare exceptions (79), defer the trauma work which is an integral part of a definitive therapy for DID. Furthermore, if a patient appears to have mastered what must be accomplished in order to proceed to trauma work, yet proves unable to manage trauma work, it will be essential to both assess what has gone wrong, and to redirect the treatment back to the concerns of earlier stages in order to further strengthen the patient. Until it is understood why problems have been encountered, and those problems have been addressed, it will rarely be appropriate to go forward. A patient who repeatedly either cannot master the tasks of the early stages of therapy or who repeatedly cannot apply what has been learned to make trauma work safe will be a candidate for ongoing supportive therapy.

The exception noted above occurs when the clinician, after due consideration, determines that a particular piece of trauma work must be undertaken in order to make the patient able to move forward with the earlier stages of therapy (79). For example, a woman with a history suggestive of high function and good ego strength presented for treatment overwhelmed by flashbacks of a particular incident that could not be contained with medication or supportive measures, and were proving too disruptive to allow the patient to focus on the issues that are usually addressed in the first and second phases of DID therapy. Hypnosis was used to help her abreact and contain the incident associated with the flashback. This completed, therapy returned to the concerns of the first stages of treatment. No further deliberate trauma work was done for over a year.

MATCHING PATIENTS WITH THERAPEUTIC STANCES, MODALITIES, AND INTERVENTIONS

The psychotherapy of DID, with rare exceptions noted above, should begin with a period of treatment in which safety and strengthening are the objectives, and in which direct efforts to elicit and process traumatic material with affect are avoided. During this period the therapist learns from both observation and from discussions with the patient that surround the formation of the therapeutic alliance, the making of contracts, the modalities of treatment, and the informed consent process what sort of treatment process will 1) best fit the patient's needs, and 2) best respect the patient's wishes and concerns. In further dialog, options are discussed and tentative decisions made, always subject to revision. If it proves impossible to come to an understanding that the therapist thinks is likely to be helpful

to the patient and which is acceptable to the patient, it is important not to proceed. Consultation may be warranted.

As noted above, a DID patient who appears capable of undertaking a definitive treatment and is motivated to do so should be offered such treatment, and that treatment should be conducted from a stance that is consistent with such a goal (i.e., strategic integrationalist, tactical integrationalist, or personality oriented). The choice of stance and selection of techniques often will be made in connection with a study of the patient's ego strength, track record, character style, and an appreciation of what tasks often accomplished by techniques can be accomplished deliberately by the alter system. For example, a very strong DID patient with good accessibility to alters upon request and good capacities for coconsciousness might be treated from a strategic integrationalist stance in a psychodynamic psychotherapy with only a few modifications. A similar patient with less certain accessibility to alters upon request and with poor capacities for coconsciousness might be treated from the same stance and with the same basic modality, but it would be anticipated that another modality, such as hypnosis, would be a useful adjunct in addressing the less certain accessibility and the problematic coconsciousness.

Conversely, a DID patient who does not appear to be a candidate for a definitive therapy should be treated in a manner that is more able to contain the treatment process, such as from an adaptationalist or personality-oriented stance, or from a modified strategic or tactical integrationalist stance. If such a patient were switching actively and the personality system were out of control, techniques would be necessary to access and address the elements of the personality system and to facilitate containment (e.g., hypnosis with temporizing techniques). If such a patient were "shut down," and the personalities were not very much in evidence, techniques designed for accessing and working with the personality system would not be necessary.

It is very important to appreciate that the therapist should review the treatment plan on a regular basis, and whenever either a crisis or an unexpected development in treatment suggests that the patient's situation should be reassessed. I do this regularly in my own practice, and have found it an invaluable exercise. A checklist for this process is available (80). DID patients are very complex, and often much is going on below the surface. In one recent case, an apparently chaotic and hopeless patient who appeared to require supportive treatment pulled out a list of complaints about my work with her. Chief among them was that I had not appreciated that major changes had occurred in her system (about which I had not been

told) that made her able to commit herself to work in a definitive treatment. After completing a rigorous reassessment, it became clear that she had many strong alters that had not made themselves evident or available when I evaluated the patient, but had now decided to participate in the therapy. We are now moving along well in the processing of her traumatic material.

ADDITIONAL NOTES ON DEFINITIVE TREATMENT FOR DID: TRAUMA WORK AND THE PURSUIT OF INTEGRATION/RESOLUTION

The decision to proceed with trauma work should be made with care. A specific set of criteria was proposed by Kluft (79).

First, it is essential to have the patient's voluntary cooperation. Under no circumstances should the therapist push this work on the patient. Such efforts can become intrusive sadomasochistic enterprises and/or reenactments of abuse which the patient may fight, submit to, or alternate between accepting and opposing.

Second, the patient should have reasonable motivation. For example, either a rush to "get all the trauma out" or to please the therapist may be strongly felt as a motivator, but is not rational. Reasonable motivation usually reflects both an appreciation that the work may be difficult, and an understanding that the trauma work is useful in freeing the present from the burdens of the perceived past, not an end in and of itself.

Third, it is important to assess whether the patient's life circumstances are consistent with trauma work. Stressors must be assessed and alleviated when possible, crises must be addressed, and supports or the lack of supports taken into account. It is best to avoid beginning trauma work in the face of major stressors or crises. While it is optimal to have a support system, many DID patients do not, and the therapist must ascertain whether the patient is capable of doing trauma work in the absence of an optimal support system.

Fourth, it is crucial to address comorbid conditions, psychiatric and medical, and to treat them to as full an extent as possible prior to initiating the additional stress of trauma work. For example, I declined to move into trauma work with a DID patient whose fear of medications compelled her to refuse to allow me to treat her comorbid major depression. I feared the combined pain of the depression and trauma work would place the patient at risk for decompensation, and that it would be difficult for her to process the meaning of the trauma in the face of the cognitive distortions that attend a major depression.

Fifth, it is useful to put aside the patient's DID diagnosis, and ask

whether the ego functions of the "total human being" are capable of handling the anticipated additional stress of trauma work.

Sixth, the therapist must consider whether the patient has truly mastered the goals of the first three stages of DID therapy. This does not mean reflecting only upon whether the work has been accomplished in session—it includes appreciating whether the patient has proven capable of using what he or she has learned in his or her daily life. Unless this has been achieved, one cannot be confident that the patient is actually capable of using the tools that have been provided to master the symptoms that may emerge in the trauma work.

Seventh, if the DTMI has been used, its scoring should confirm that the patient has a strong therapeutic alliance and is on a high or improving trajectory.

Eighth, it is important for the therapist to be prepared, both with the skills and resilience necessary for doing this kind of work.

Finally, ninth, it is important that the logistics of the treatment are capable of supporting trauma work. Sessions must be frequent enough and long enough in duration to contain the trauma work. For some patients, this will mean additional and/or prolonged sessions. Access to the therapist or a suitable substitute between sessions is advisable in order to address any incidents or difficulties before they escalate into major crises.

Once trauma work is contemplated it is useful to consider the details of how it will be done (20). The therapist-patient dyad that does not plan to use any additional techniques must cautiously await what Briere (81) has called "windows of opportunity" in which traumatic material can be addressed and processed without threatening the stability of the patient. Traditional approaches to abreaction, which tend to promote the expression of affect to the point of exhausting the patient's response to a traumatic incident or stimulus, often can be overwhelming to many DID patients. Therapists who plan to utilize the techniques of hypnosis have considerable latitude in initiating and controlling the flow of the abreactive process. Therapists considering the use of EMDR must be able to work with the alter system in such a manner as to avoid overstimulating the DID patient into cascades of abreaction.

Fractionation, noted above, often holds the potential to make the processing and/or abreacting of traumatic material less stressful (79). It focuses on bringing the patient to a position of mastery about his or her traumatic experiences. By exposing the patient to the trauma in a piecemeal and controlled manner, a desensitization is undertaken while the patient is protected from confronting overwhelming memories and affects at a

potentially disorganizing level of intensity. Temporizing techniques (17) and many hypnotic approaches (50), several of which can be used without inducing formal hypnosis, are used to titrate the amount of material and pain to which the patient is exposed (18).

The therapist and patient collaboratively determine how much information and pain will be dealt with in a given session. Active planning toward mastery replaces the patient's previous experience with the trauma, which usually involved relative passivity and helplessness. Traumatic incidents are broken down into small steps. The patient is taught techniques by which pain and affect can be experienced as percentages of the original pain and affect, and then is helped to face increasing percentages of the dysphoria associated with the trauma. The BASK dimensions (behavior, affect, sensation, knowledge) (82) can be further broken down in a therapeutic use of dissociation, such that, for example, the sensations from physical pain and the affect of emotional pain can be experienced separately. Also, if more than one alter is associated with the trauma, all but one can be segregated from the experience, and alters not associated with the experience can be blocked from participation. Furthermore, often an alter that is perceived as weak or vulnerable can process its trauma in the company of or temporarily combined or blended with a stronger alter (18,19). Using some or all of the above techniques to fractionate the abreactive experience, an overwhelming experience can be addressed gradually without threatening the stability of the patient (18,19, 25,26,79).

When trauma work is underway, the patient should once more be cautioned about the risks attendant upon taking the materials under consideration as literal historical truth. Instead, the patient should be helped to appreciate that the processing of traumatic material is in the service of the patient's recovery, and its actual veridicality remains uncertain.

Integration often occurs spontaneously as alters work on the issues, such as the traumatic experiences in autobiographic memory, that are associated with their origins. Also, as alters share more and more, there is a tendency for the barriers between them to blur, or break, and for them to become more alike and fuse, or for some to feel reduced in importance, size, power, and clarity, and fade from separateness. At times alters arrange their own strategies for coming together. When neither spontaneous integration nor patient-initiated strategies occur, it is often useful to facilitate integration with imagery and suggestion (27).

ADDITIONAL NOTES ON THE SUPPORTIVE THERAPY FOR DID

Boon and van der Hart (28,83,84) have described eight treatment strategies as useful in the early stages of DID treatment. These eight strategies are continued as major efforts in ongoing supportive work. First, the therapist uses the general supportive interventions that are useful with most groups of patients. Second, the therapist engages in psychoeducational efforts to help the patient better understand dissociation, DID, and posttraumatic stress, which may heighten the patient's sense of control, and reduce shame and anxiety. Also, the patient is educated about attachment issues and traumatic bonding. Third, the patient is taught enhanced coping skills. Also, the patient is taught to use dissociative abilities constructively in techniques for the containment of traumatic memories and flashbacks associated with them. Fourth, the alters are taught to interact more cooperatively, especially those who function in daily life, and are often largely unaware of the traumatic past (69). Fifth, efforts are made to develop positive contact between the therapist and those alters that are aggressive against the self and/or others. This constructive relationship is used as the foundation to develop better relationships between these alters and other alters. Sixth, cognitive therapy interventions are made to correct the faulty cognitions and basic assumptions of the various entities (85–87). Seventh, marital and/or family therapy is used with the patient, the patient's partner, and the patient's current family (66,67). Eighth, an individualized protocol is developed for crisis intervention, including plans for short-term inpatient treatment.

These interventions, when applied over time, gradually help the DID patient to learn and internalize more productive ways of coping and functioning both within the alter system and in the "outside world." In this manner, they usually are able to reduce the chaos and difficulty in their daily living, and to gradually become able to function in a more productive manner.

CONCLUSION

Psychotherapy remains the cornerstone of the treatment of dissociative identity disorder. DID does not improve in nonspecific treatments that fail to address its core psychopathology. However, when efforts are made to provide a specific DID treatment that is stage-oriented, carefully paced, and matched to the patient's needs and capacities, most DID patients can, over time, make complete recoveries or achieve significant improvements.

REFERENCES

1. Kluft, RP (1995). The confirmation and disconfirmation of memories of abuse in dissociative identity patients: A naturalistic clinical study. *Dissociation, 8*, 253–258.
2. Kluft, RP (1998). Reflections on the traumatic memories of dissociative identity disorder patients. In S.J. Lynn & K. McConkey (Eds.), *Truth in memory* (pp. 304-322). New York: Guilford.
3. Putnam, FW (1989). *Diagnosis and treatment of multiple personality disorder.* New York: Guilford.
4. Ross CA (1997). *Dissociative identity disorder: Diagnosis, clinical features, and treatment of multiple personality.* New York: Wiley.
5. Boon S, & Draijer N (1993). *Multiple personality disorder in the Netherlands: A study on reliability and validity of diagnosis.* Amsterdam: Swets & Zeitlinger.
6. Fahy TA (1988). The diagnosis of multiple personality disorder: A critical review. *British Journal of Psychiatry, 153*, 597–606.
7. Merskey H (1992). The manufacture of personalities: The production of multiple personality disorders. *British Journal of Psychiatry, 160*, 327–340.
8. Piper A (1997). *Hoax and reality: The bizarre world of multiple personality disorder.* Northvale, NJ: Aronson.
9. Brenneis CB (1997). *Recovered memories of trauma: Transferring the present to the past.* Madison, CT: International Universities Press.
10. Cohen LM, Berzoff JN, & Elin MR (1995). *Dissociative identity disorder: Theoretical and treatment controversies.* Northvale, NJ: Aronson.
11. Herman JL (1992). *Trauma and recovery.* New York: Basic Books.
12. Frankel F (1993). Adult reconstruction of childhood events in the multiple personality literature. *American Journal of Psychiatry, 150*, 954–958.
13. Coons P (1994). Confirmation of childhood abuse in child and adolescent cases of multiple personality disorder and dissociative disorder not otherwise specified. *Journal of Nervous and Mental Diseases, 182*, 461–464.
14. Hornstein N, & Putnam FW (1992). Clinical phenomenology of child and adolescent multiple personality disorder. *Journal of the Academy of Child and Adolescent Psychiatry, 31*, 1055–1077.
15. Braun BG (1986). Issues in the Psychotherapy of Multiple Personality Disorder. In B.G. Braun (Ed.) *Treatment of Multiple Personality Disorder* (pp. 1–28). Washington, DC: American Psychiatric Press.
16. Kluft RP (1991). Multiple personality disorder. In A. Tasman & S. Goldfinger (Eds.), *Annual review of psychiatry*, vol. 10 (pp. 161–188). Washington, DC: American Psychiatric Press.
17. Kluft RP (1989). Playing for time: Temporizing techniques in the treatment of multiple personality disorder. *American Journal of Clinical Hypnosis, 32*, 90–98.
18. Fine CG (1991). Treatment stabilization and crisis prevention: Pacing the therapy of the multiple personality disorder patient. *Psychiatric Clinics of North America, 14*, 661–675.
19. Fine CG (1993). A tactical integrationalist perspective on the treatment of multiple personality disorder. In R.P. Kluft& C.G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 135–153). Washington, DC: American Psychiatric Press.
20. Kluft RP (1996). Treating the traumatic memories of patients with dissociative identity disorder. *American Journal of Psychiatry* (Festschrift Supplement), *153*, 103–110.
21. Kluft RP (1997). Overview of the treatment of patients alleging that they have suffered ritualized or sadistic abuse. In G.A. Fraser (Ed.), *The dilemma of ritual abuse: cautions and guides for therapists* (pp. 31–64). Washington, DC: American Psychiatric Press.
22. Shapiro F (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures.* New York: Guilford.
23. Paulsen S (1995). Eye movement desensitization and reprocessing: Its cautious use in the dissociative disorders. *Dissociation, 8*, 32–44.
24. Lazrove S, & Fine CG (1996). The use of EMDR in patients with dissociative identity disorder. *Dissociation, 9*, 289–299.
25. Kluft RP (1988). On treating the older patient with multiple personality disorder: Race against time or make haste slowly? *American Journal of Clinical Hypnosis, 30*, 257–266.
26. Kluft RP (1990). The fractionated abreaction technique. In D.C. Hammond (Ed.), *Handbook of hypnotic suggestions and metaphors* (pp. 527–528). New York: Norton.

27. Kluft RP (1993). 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.
28. Boon S (1997). The treatment of traumatic memories in DID: Indications and contra-indications. *Dissociation, 10*, 65–80.
29. van der Hart O, & Boon S (1997). Treatment strategies for complex dissociative disorders: Two Dutch case examples. *Dissociation, 10*, 157- 165.
30. Kluft RP (1988). Today's therapeutic pluralism. *Dissociation , 1*, 1–2.
31. Kluft RP (1993). Treatment of dissociative disorder patients: An overview of discoveries, successes, and failures. *Dissociation, 6*, 87–101.
32. Caul D (1984). Group and videotape techniques for multiple personality disorder. *Psychiatric Annals, 14*, 46–50.
33. Watkins J, & Watkins H (1997). *Ego states: theory and therapy*. New York: Norton.
34. Kluft RP (1995). The natural history of multiple personality disorder. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 197–238). Washington, DC: American Psychiatric Press.
35. Kluft RP (1984). Treatment of multiple personality disorder. *Psychiatric Clinics of North America, 7*, 9–29.
36. Kluft RP (1986). Personality unification in multiple personality disorder: A follow-up study. In B.G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 29–60). Washington, DC: American Psychiatric Press.
37. Kluft RP (1993). Basic principles in conducting the psychotherapy of multiple personality disorder. In R.P. Kluft & C.G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 19–50). Washington, DC: American Psychiatric Press.
38. Putnam FW (1984). The study of multiple personality disorder: General principles and practical considerations. *Psychiatric Annals, 14*, 58–61.
39. Appelbaum PS, & Gutheil TG (1991). *Clinical psychiatry and the law,* 2nd ed. Baltimore: Williams & Wilkins.
40. Brown D, Scheflin A, & Hammond CD (1997). *Memory, trauma treatment, and the law*. New York: Norton.
41. Coons PM (1984). The differential diagnosis of multiple personality. *Psychiatric Clinics of North America, 7*, 51–68.
42. Kluft RP (1987). An update on multiple personality disorder. *Hospital & Community Psychiatry, 38*, 363–373.
43. Kluft RP (in press). The psychoanalytic psychotherapy of dissociative identity disorder in the context of trauma therapy. *Psychoanalytic Inquiry.*
44. Kluft RP (1995). Current controversies surrounding dissociative identity disorder. In L. Cohen , J. Berzoff, & M. Elin (Eds.), *Dissociative identity disorder: Theoretical and treatment controversies* (pp. 347–377). Northvale, NJ: Aronson.
45. Kluft RP (1982). Varieties of hypnotic interventions in the treatment of multiple personality. *American Journal of Clinical Hypnosis, 24*, 230–240.
46. Braun BG (1984). Uses of hypnosis with multiple personality. *Psychiatric Annals, 14*, 34–40.
47. Kluft RP (1995). Psychodynamic psychotherapy of multiple personality disorder and allied forms of dissociative disorder not otherwise specified. In J.P. Barber & P. Crits-Cristoph (Eds.), *Dynamic therapies for psychiatric disorders (axis I)* (pp. 332–385). New York: Basic Books.
48. Putnam FW, & Loewenstein RJ (1993). Treatment of multiple personality disorder: A survey of current practices. *American Journal of Psychiatry, 150*, 1048–1052.
49. Phillips M, & Frederick C (1995). *Healing the divided self: Clinical and Ericksonian hypnotherapy for post-traumatic and dissociative conditions*. New York: Norton.
50. Hammond DC (Ed.). (1990). *Handbook of hypnotic suggestions and metaphors*. New York: Norton.
51. Kluft RP (1983). Hypnotherapeutic crisis intervention with multiple personality. *American Journal of Clinical Hypnosis, 26*, 73–83.
52. Kluft RP (1994). Applications of hypnotic interventions. *Hypnos, 21*, 205–283.
53. Putnam FW, Guroff JJ, Silberman EK, et al. (1986). The clinical phenomenology of multiple personality disorder: A review of 100 recent cases. *Journal of Clinical Psychiatry, 47*, 285–293.
54. Kluft RP (1984). Aspects of the treatment of multiple personality disorder. *Psychiatric Annals, 14*, 51–55.

55. Barkin R, Braun B., & Kluft RP (1986). The dilemma of drug therapy for multiple personality disorder. In B.G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 107–142). Washington, DC: American Psychiatric Press.
56. Loewenstein RJ, Hornstein N, & Farber B (1988). Open trial of clonazepam in the treatment of posttraumatic stress symptoms in multiple personality disorder. *Dissociation, 1*(3), 3–12.
57. Braun BG (1990). Unusual medication regimens in the treatment of dissociative disorder patients. Part I. Noradrenergic agents. *Dissociation, 3,* 144–150.
58. Loewenstein RJ (1991). Rational psychopharmacology in the treatment of multiple personality disorder. *Psychiatric Clinics of North America, 14,* 721–740.
59. Torem MS (1996). Psychopharmacology. In L.K. Michelson & W.J. Ray (Eds.), *Handbook of dissociation: Theoretical, empirical, and clinical perspectives*(pp. 545–566). New York: Plenum Press.
60. Coons PM, & Bradley K (1985). Group psychotherapy with multiple personality patients. *Journal of Nervous and Mental Disease, 173,* 515–521.
61. Benjamin LR, & Benjamin R (1994). A group for partners and parents of MPD clients. Part I: Process and format. *Dissociation, 7,* 35–43.
62. Fine CG, & Madden NE (in press). The role of group psychotherapy in the treatment of dissociative identity disorder and allied dissociative disorders. In R. Klein & V.L. Schermer (Eds.), *The healing circle: Group psychotherapy for psychological trauma.* New York: Guilford.
63. Benjamin LR, & Benjamin R (1994). A group for partners and parents of MPD clients. Part II: Themes and responses. *Dissociation, 7,* 104–111.
64. Benjamin LR, & Benjamin R (1994). A group for partners and parents of MPD clients. Part III: Marital types and dynamics. *Dissociation, 7,* 191–196.
65. Kluft RP, Braun BG, & Sachs R (1985). Multiple personality, intrafamilial abuse, and family psychiatry. *International Journal of Family Psychiatry, 5,* 283- 301.
66. Panos PT, Panos A, & Allred GH (1990). The need for marriage therapy in the treatment of multiple personality disorder. *Dissociation, 3,* 10–14.
67. Sachs RG, Frischholz EJ, & Wood JD (1988). Marital and family therapy in the treatment of multiple personality disorder. *Journal of Marital and Family Therapy, 14,* 249–259.
68. Williams MB (1991). Clinical work with families of multiple personality disorder patients: Assessment and issues for practice. *Dissociation, 4,* 92–98.
69. Chiappa F (1994). Effective management of family and individual interventions in the treatment of dissociative disorders. *Dissociation, 7,* 185- 190.
70. Kluft E (1993). *Expressive and functional therapies in the treatment of multiple personality disorder.* New York: Charles C. Thomas.
71. Kluft RP (1994). Treatment trajectories in multiple personality disorder. *Dissociation, 7,* 63–76.
72. Kluft RP (1994). Clinical observations on the use of the CSDS Dimensions of Therapeutic Movement Instrument (DTMI). *Dissociation, 7,* 272–283.
73. Caul D (1988). Determining the prognosis in the treatment of multiple personality disorder. *Dissociation ,* 1(2), 24–26.
74. Horevitz RP, & Loewenstein RJ (1994). The rational treatment of multiple personality disorder. In S.J. Lynn & J. Rhue (Eds.), *Dissociation: Clinical and theoretical perspectives.* New York: Guilford.
75. Ross C, & Dua V (1993). Psychiatric health care costs of multiple personality disorder. *American Journal of Psychotherapy , 47,* 103–106.
76. Fraser GA, & Raine D (1992). Cost analysis of the treatment of MPD. In B.G. Braun (Ed.), *Proceedings of the Ninth International Conference on Multiple Personality/Dissociative States* (p.10). Chicago, IL: Rush.
77. Horevitz RP, & Braun BG (1984). Are multiple personalities borderline? *Psychiatric Clinics of North American, 7,* 69–88.
78. Coons PM (1986). Treatment progress in 20 patients with multiple personality disorder. *Journal of Nervous and Mental Disease, 174,* 715–721.
79. Ellason J, & Ross C (1998). Two-year follow-up of inpatients with dissociative identity disorder. *American Journal of Psychiatry, 154,* 832–839.
80. Kluft RP (1997). On the treatment of the traumatic memories of DID patients: Always? Never? Sometimes? Now? Later? *Dissociation ,10,* 80–90.

81. Kluft RP (in press). The difficult to treat dissociative disordered patient. In M. Dewan & R. Pies (Eds.), *The difficult to treat psychiatric patient.* Washington, DC: American Psychiatric Press.
82. Briere, J (1991). *Treating victims of child sexual abuse.* San Francisco: Jossey-Bass.
83. Braun, BG (1988). The BASK (behavior, affect, sensation, knowledge) model of dissociation. Dissociation, 1(1), 4–23.
84. Boon, S, & van der Hart, O (1994). Supportive psychotherapy for MPD patients. In B.G. Braun & K.L. Robins (Eds.), *Proceedings of the 11th International Congress on Dissociative States.* Chicago: Rush.
85. Boon, S, & van der Hart, O (1995). De behandleing 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.
86. Fine, CG (1988). Thoughts on the cognitive perceptual substrates of multiple personality disorder. *Dissociation,* 1(4), 5–11.
87. 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.
88. Ross, C.A. (1990). Twelve cognitive errors about multiple personality disorder. *American Journal of Psychotherapy, 44,* 348–356.