

Richard P. Kluft

Clinical Professor of Psychiatry at Temple University School of Medicine, Philadelphia, PA, USA

Рихард П. Клюфт

Current Issues in Dissociative Identity Disorder

Текущие аспекты

в диссоциативных нарушениях личности

Summary. Dissociative Identity Disorder (DID), formerly Multiple Personality Disorder (MPD), remains among the most challenging of mental disorders. It is difficult to understand, to diagnose, to treat, to discuss objectively in the face of the many controversies that swirl around it. It remains a condition that requires intensive individual psychotherapy for its satisfactory resolution.

The controversies that have surrounded DID have often obscured the progress that has been made. DID is emerging as a not uncommon consequence of overwhelming childhood events.

The major challenges facing the treatment of DID are disentangling this condition and its therapy from the controversies that swirl about them, encouraging the more widespread use of specific diagnostic approaches, educating managed care organizations to accept standards of care for DID that are based upon those treatment approaches that are effective, making specific treatments for DID more available, and continuing to develop more successful approaches for the more difficult-to-treat DID subgroups of DID patients.

Резюме. Диссоциативные нарушения личности (ДНЛ), в прошлом - расстройство множественной личности, остаются в числе наиболее вызывающих психических заболеваний. Их тяжело понять, диагностировать, лечить, объективно обсуждать, учитывая спорные и противоположные их характеристики. Это остаётся условием, при котором необходима интенсивная индивидуальная психотерапия для успешного решения данных проблем. Разногласия, окружающие ДНЛ, иногда затухивают достигнутый прогресс в лечении. ДНЛ возникает как частое последствие давящих ключевых событий детства. Основной принцип лечения ДНЛ - это обнаруживание условий, вызывающих данное состояние, излечение от невозможности совместить противоположности, поддержка наиболее распространенных способов специфического диагностирования, обучение организаций помощи больным принятию стандартов ухода за ДНЛ-пациентами, базированных на эффективных достижениях терапии и большей доступности специфических методов лечения ДНЛ. На сегодняшний день продолжается поиск и развитие более успешных принципов оказываемой помощи наиболее тяжелым подгруппам пациентов с ДНЛ.

Introduction

Dissociative Identity Disorder (DID), formerly Multiple Personality Disorder (MPD), remains among the most challenging of mental disorders. It is difficult to understand, difficult to diagnose, difficult to treat, and difficult to discuss objectively in the face of the many controversies that swirl around it. Furthermore, in an era increasingly dominated by psychopharmacology and

short-term approaches to treatment, it remains a condition that requires intensive individual psychotherapy for its satisfactory resolution.

Defining Dissociative Identity Disorder

DSM-IV Criteria

DSM IV (1) (Criteria in Table I) indicate that the

Table 1

DSM-IV Criteria for Dissociative Identity Disorder (Multiple Personality Disorder)
A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
B. At least two of these identities or personality states recurrently take control of the person's behavior.
C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
D. Not due to direct effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., partial complex seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

essential feature of DID is "the presence of two or more distinct identities or personality states (Criterion A) that recurrently take control of behavior (Criterion B)" (p. 484) along with amnesia (Criterion C). These are not due to the direct effects of a substance or general medical condition (Criterion D).

The core phenomena of DID may include lesions or problems of identity, memory, thinking, containment (the intrusion of information, affects, etc., from one dissociated aspect of the mind into another), cohesive conation (the ability of the volition of any one identity to actually control what occurs), and difficulties with the switch process (the transition from one identity, personality state or alter to another). Each category is briefly explained below.

The lesions of identity may include both the presence of the alter personalities, states of depersonalization, and/or absence or confusion about identity, as well as the impingement of one alter on another or the combined presence (copresence) of two or more identities.

Memory problems may include amnesia for past events, blocks of lost contemporary time, uncertainty about whether certain events have or have not occurred, fragmentary recall of traumata, and the experience of events as dream-like or derealized, and of uncertain reality. There may also be amnesic barriers across the alters, which may be aware of one another, unaware of one another, or have directional amnesia (e.g., alter A knows about B and is aware of its thoughts and activities, while alter B knows little or nothing about A, is unaware of A's thoughts, and is amnesic when A has executive control).

Containment issues include the intrusion of one alter into another and the leakage of the memories, feelings, and sensations of one alter into the awareness and experience of another.

Lesions of cohesive conation refer to the distribution of executive control across alters. The alters' sense of

control of themselves and their actions is often compromised, and with it the sense of ownership, responsibility, voluntary control, and locus of control over choices and actions.

Finally, in some cases the process by which the alters switch is not smooth, which can lead to jarring or incomplete transitions, or occurs with such frequency that the person cannot achieve continuity in what he or she attempts to accomplish.

DSM-IV made several changes from DSM-III-R. (2) The name change to DID from MPD was made ostensibly to distance the study of this condition from the controversies of the past, to create a uniformity of nomenclature throughout the dissociative disorders, and to emphasize that the nature of the condition is the lack of an integrated identity. (3) Identity was chosen to replace personality, in the belief that personality was both too reified and implied a greater degree objective existence and organization than did the term identity. An amnesia criterion (absent from DSM-III and DSM-III-R) was also added, and the impact of intrusion phenomena was acknowledged by indicating that alters may assume a control that is not complete.

It is questionable whether the changes in name and terminology have achieved their stated goals. The amnesia criterion did not have a significant impact, since most clinicians in the field had already been using that criterion informally -- only a small percentage of MPD diagnoses were made in patients who did not have amnesia for events long past or for contemporary periods of time. Instances in which one observes the presence of alters without amnesia are classified as a subgroup of Dissociative Disorder Not Otherwise Specified (DDNOS).

Identities, Personalities, and Personality States

The alters, identities, personalities, or personality states that occur in DID are often are puzzling

phenomena. Elsewhere (Kluft, 1988, p. 51), (4) I have described a personality as:

... the mental address of a relatively stable and enduring particular pattern of selective mobilization of mental contents and functions, which may be behaviorally enacted with noteworthy role-taking and role-playing dimensions and sensitive to intrapsychic, interpersonal, and environmental stimuli. It is organized in and associated with a relatively stable (but order effect dependent) pattern of neuropsychophysiological activation, and has crucial psychodynamic contents. It functions both as a recipient, processor, and storage center for perceptions, experiences, and the processing of such in connection with past events and thoughts, and/or present and anticipated ones as well. It has a sense of its own identity and ideation, and a capacity for initiating thought processes and actions.

The personalities are not unconscious in the traditional psychoanalytic sense. They constitute a parallel set of processes consistent with Hilgard's neodissociation theory (5) and laboratory studies, which I have called the "elsewhere thought known." (6) They arise as desperate coping strategies in an overwhelmed child, and initially have an adaptational and defensive

design. However, as they achieve a secondary autonomy, and persist beyond the stressors to which they are responses, they can become increasingly problematic and disruptive. In order for a personality to be created, there must be a disidentification from a sense of self and a self-representation that is intolerable. Empathic connectedness with what is intolerable is repudiated, and a boundary is formed between the newly formed sense of self and self-representation and the one that has become intolerable. The patient forms and autohypnotically envisions an illusory embodiment of an identity that could manage the adaptation that is believed to be required. What is envisioned with a great sense of reality is believed to be real, and the mind undergoes a cognitive restructuring that accepts and interprets what is believed to be real as real, and makes it possible to act as if it were real. This type of process makes it possible for not only the alter personalities, but also modified versions of autobiographic memory, to be experienced and endorsed as real. (7, see pp. 315-316) For example, let us imagine the circumstances of Lois, a five-year old girl molested by her previously warm and loving and deeply loved Uncle Ben. Table 2 indicates some of the coping strategies that might be enlisted under these circumstances and indicates how they may contribute to alter formation.

Table 2.

Coping Strategies and Alter Formation	
<u>Coping Strategy</u>	<u>Alter Created</u>
This did not happen I must deserve it	A Lois who knows, and a Lois who does not Bad Lois, whose behavior would explain trauma as punishment
I must have wanted it	A sexual alter, Sherrie
I can control it better if I take charge	An aggressively sexual alter, Vickie
I would be safe if I were a boy	Louis, Lois's male "twin"
I wish I were a big man who could prevent this	Big Jack, based on some person of power
I wish I were the one who could hurt someone, and not be hurt	Uncle Ben, or a more disguised identification with the aggressor
I wish I could feel nothing	Jessie, who endures all yet feels nothing
I wish someone could replace me	"The Girls" who encapsulate specific experiences of trauma unknown to Lois
I wish someone would comfort me	Angel, with whom Lois imagines herself to be while the body is being exploited and "The Girls" are experiencing the trauma

Reprinted with permission from Kluft (1998, p. 315 [7])

The purpose for which each alter is created may dictate the transformation and/or distortion of both identity and autobiographical memory. For example, Bad Lois must disconnect herself from information that

would indicate that she was an innocent victim; Louis must disregard femininity and all experiences that would force him to acknowledge that he is in fact a female.

Not only do DID patients form alters. They often

create a complex inner world in which the alters are experienced as relating to one another. This inner world may be experienced as if it were as real or even more real than external reality. If one understands historical reality to be a “first reality,” and the sense of personal reality and autobiographical narrative truth that has been influenced and distorted from congruence with historical reality due to misperceptions, fantasies, transferences, cognitive distortions, and external pressures and suggestions as a “second reality,” then the events in this inner world, which may at times be confused with external reality, may be understood to constitute a “third reality.” (7)

The clinician who is unprepared to work with a circumspect acknowledgement of these levels of reality is in danger of becoming either overwhelmed by the complexity of the phenomena that he or she encounters or drawn to oversimplified conceptualizations (e.g., all accounts are accurate, all accounts are confabulated, it is unproductive to work with the alters, etc.) that make the successful treatment of DID unlikely.

Common Areas of Controversy Re: Dissociative Identity Disorder

The study of DID has been characterized by controversies. In the following section, I briefly discuss concerns that have been raised about the epidemiology and etiology of DID, allegations of abuse by DID patients, assessing DID, and whether to deal with the alters and the trauma history in treatment.

Epidemiology

Despite the controversy that surrounds the frequency with which DID and other dissociative disorders can be found in psychiatric populations, studies in several countries that have examined groups of psychiatric patients with standardized, reliable, and valid screening instruments and structured diagnostic instruments demonstrate that these conditions are not uncommon (Table 3).

Table 3

The Prevalence of DID and All Dissociative Disorders Among Patient Populations		
<u>Study</u>	<u>Percent DID</u>	<u>Percent Any Dissociative Disorder</u>
<u>Inpatients</u>		
Canada		
Ross et al. (8)	55.4	20.7
Horen et al. (9)	6.0	17.0
United States		
Saxe et al. (10)	4.0	15.0
Latz et al. (11)	12.0	46.0
The Netherlands		
Boon & Draijer (12)	5.0	-----
Norway		
Knudsen et al. (13)	4.7	8.2
<u>University Clinic Inpatients and Outpatients</u>		
Turkey		
Tutkun et al. (14)	5.0	
<u>Chemical Dependency Populations</u>		
United States		
Ross et al. (15)	14.0	39.0
Leeper et al. (16)	5.1	15.4
Ellason et al. (17)	18.6	56.9
Dunn et al. (18)	7.0	15.0

In inpatient psychiatric populations, mixed inpatient and outpatient groups, and chemical dependency treatment settings, previously undiagnosed DID is found in between 4% and 18.6% of the patients. Taken together, these studies suggest that DID is not

uncommon, occurs in many different countries at approximately the same rate in the psychiatric inpatient population, and usually goes undiagnosed. Even among diagnosed DID patients, Putnam and his coworkers found that the average patient had been in the mental

health care delivery system for 6.8 years before being accurately diagnosed. (19)

Etiology

There is dispute over whether DID is a condition that occurs naturalistically or whether it is iatrogenic. Eminent clinicians (e.g., Merskey [20]), and laboratory scientists (e.g., Spanos [21]) as well as advocates for extreme and polarized positions (e.g., Piper [22]) have argued that DID is an artifact of the expectations and suggestive interventions of enthusiastic clinicians and that it never occurs prior to such expectations and interventions. Some experienced investigators in the dissociative disorders field have argued that one pathway to the etiology is iatrogenesis (e.g., Ross [23]), but that iatrogenic DID occurs only when there has been a very extensive amount of effort over a long period of time (i.e., the threshold for such an occurrence is very high indeed). The majority of knowledgeable clinicians remain unconvinced that the full DID condition can be created as an iatrogenic artifact, but do believe that iatrogenic factors can further complicate and/or worsen the condition.

What are the data concerning the etiology of DID? It has long been clear that many of the symptoms of DID can be created by simple suggestion or experimental manipulation, and that with minimal suggestion, subjects can be induced to enact several DID behaviors. This data has been summarized by many authors. (21, 23-26). However, the enactment of behaviors associated with a mental disorder is not proof that one has the mental disorder -- anymore than a stage hypnotist's subject's clucking like a chicken is a justification for cooking him or her for dinner. Cultural influence and expectations may exert a significant impact upon the phenomenology of DID, but this does not make the condition invalid. For example, Turkish DID patients' personalities reflect the culture and traditions of Islamic Turkey, especially in cases from rural areas, but the patients have the same type of problems as DID patients from the United States. Likewise, it is clear that clinicians' expectations can influence aspects of DID's phenomenology, but this fails to invalidate the condition itself. For example, clinicians who believe that certain personality types are universally encountered in DID deliberately or inadvertently exert pressures upon their patients to manifest these personality types, which will therefore occur more frequently in the caseloads of these clinicians than in those who do not share this belief. (25) Despite this, their patients resemble those of other clinicians in other ways.

Although it is clear that DID's phenomenology may at times respond to social pressures and suggestions, many observations that demonstrate DID can occur in the absence of suggestive influences. There are numerous instances of DID emerging spontaneously in front of a clinician who had not suspected the condition

or inquired about its presence in any way.

Epidemiological studies in Turkey (14) and Norway (13), nations in which DID was not part of the popular culture, and in which the patients were not exposed to antecedent suggestive influences, found similar percentages of DID and dissociative disorders as in North America and the Netherlands, where such influences are much stronger. Somer and Weiner (27) studied the adolescent diaries of a small group of subjects and found evidences of early dissociation long before their subjects sought treatment, and from years before discussions of DID became popular in the media.

It was formerly thought that exposure to hypnosis might create DID; however, Ross and Norton (28) found that exposure to hypnosis did not materially affect the symptoms of DID patients. It has been argued that DID is induced by "enthusiasts" who conduct themselves in such a way as to create the condition, yet Ross et al. (29) found that the features of DID patients diagnosed by so-called "enthusiasts" did not differ substantially from those reported by clinicians describing their first cases.

In recent years, the development of a new form of treatment inadvertently demonstrated the naturalistic occurrence of DID. As increasing numbers of clinicians learned Fran cine Shapiro's eye movement desensitization and reprocessing (EMDR) technique (30) as a treatment for the traumatized, their use of this technique occasionally caused a patient with previously undiagnosed DID to dissociate and switch openly. While EMDR may be useful in treating DID, this use of EMDR must be applied cautiously, and not early in the psychotherapy. Shapiro formed a task force to study this problem. It recognized that DID patients were being inadvertently found and unsettled by exposure to EMDR in this precipitous manner, and it generated a report recommending that all patients be screened for dissociative disorders prior to receiving EMDR. (30)

Also of interest is the fact that the incidence of DID in psychiatric inpatients in different countries is so similar. If one were to argue that DID patients who appear to have naturalistic cases must have been exposed to media and cultural representations of DID that suggested the DID to them, one would expect that surveys would find more DID cases in comparable populations in countries in which the media had brought to DID to the public awareness over a period of time. Instead, the percentage of DID found in surveys of psychiatric inpatients in Canada, the United States, and the Netherlands, where the media have publicized DID, is comparable to the percentages in Norway and Turkey, where the subject of DID had not been promoted in the media. The available information strongly indicates that DID occurs naturalistically, but that the condition, once begun, is sometimes somewhat responsive to suggestive influences. If it were completely responsive to suggestion, it would be easy to treat.

Some DID patients may respond to the impact of

their therapist, the media, and others in their lives by modifying or creating additional alters and/or by modifying or experiencing difficulties with autobiographic memory (e.g., coming to believe that an event that *has* occurred has not occurred, or coming to believe that an event that *has not* occurred as occurred). There is considerable controversy over whether the condition can be created *de novo* from iatrogenic pressures. My review of the literature, and my experience with many situations in which this is alleged to have occurred, suggest that if this does occur, it is infrequent and happens only after prolonged and intense interventions. Therefore, if the manifestations of DID are noted after relatively brief clinical contact, or in the context of efforts that do not involve prolonged and intense indoctrination, iatrogenesis is not a likely etiology.

Allegations of Abuse

Doubt has been cast on the allegations of abuse made by DID patients (e.g., Frankel [31]), largely in the context of current controversies about whether repressed memory exists and whether recollections of abuse long absent from memory can be accurate. This larger issue has been addressed at length in a number of publications (e.g., Brown [32]; Kluft [7, 33]; Hammond et al. [34]; Brown, Schefflin, & Hammond [35]; Appelbaum et al. [36]). Although some authorities continue to hold polarized opinions, it seems well established that some interventions *can* instigate inaccurate memories in some people, but that accurate recollection of once-unavailable traumatic material can also occur.

A priori protests against the accuracy of DID patients' allegations of mistreatment often appear to stem from society's aversion to acknowledging the prevalence of child abuse, and extreme extension of the "false memory" perspective, and an extension of skepticism about many extreme claims, such as satanic ritual abuse, to all claims of mistreatment. Very few authorities continue to endorse the extreme "false memory" perspective that it is impossible for memories of abuse to be forgotten and then recovered.

A review of the DID literature demonstrates numerous instances of documented abuse. Two studies of younger dissociative patients (37, 38) found documentation of abuse for 95% of their young subjects. The documentation of recovered memories of childhood abuse in DID populations has been documented. (7, 39) However, I have also documented that DID patients may represent confabulated recollections of abuse as if they had occurred and that both accurate recovered memories of abuse and confabulated memories of abuse may occur in the same DID patient. (39) The literature, then, suggests that DID patients usually have a background of overwhelming childhood circumstances, usually involving child abuse, but that pseudomemories can be

encountered in this patient population. Therefore, the presentation or recovery of traumatic material should not be greeted with either endorsement or skepticism. Furthermore, material that immediately creates concern about its accuracy should be studied in terms of its dynamic meaning rather than discarded or dismissed. The only test for the accuracy of an allegation, whether it has always been recalled or is newly recovered, is external confirmation. Therefore, traumatic material that emerges in therapy, however crucial it may be for the patient's recovery or the progress of the therapy, should be retained in the therapy and absent external confirmation, should not form the basis for legal actions.

Assessing for DID

It has been argued that efforts should not be made to assess for DID lest the disorder be created in the process of making the inquiry. It is clear from the arguments above that there is insufficient evidence to sustain this stance; however, there is reason to be circumspect and cautious about leading or pressuring patients when such inquiries are being made. (25)

Dealing with Alters and Trauma History in Treatment

Similar concerns have caused some authorities to advise against working with and/eliciting the alter personalities. (40) This recommendation is based on the assumption that the alters are artifacts rather than an intrinsic aspect of the patient's condition and that it is therefore unnecessary to deal with them and that dealing with them may actually reinforce them. Still others (e.g., Barach and Comstock [41]) maintain that a psychoanalytic approach can obviate much, if not all, of the need to work directly with alters, or to elicit them. Unfortunately for this line of argument, virtually all successful treatments for DID that have been published to date have found it useful, if not essential, to work with the alters. As long ago as 1985, my data showed that only 2-3% of DID patients could achieve integration without specific treatments that dealt with the alters. (42, 64) Therefore, unless there are specific contraindications, it is appropriate to work with and to elicit alter personalities. I have discussed this issue in more detail from a psychoanalytic perspective elsewhere. (43)

A closely connected concern is whether to address and explore traumata that are disclosed by the DID patient, either spontaneously or in response to exploration. Many authors attempt to simplify this complex issue by maintaining that there is no reason to doubt traumata that have *always* been available in conscious recollection, but that all so-called recovered memories should be regarded with skepticism (e.g.,

Brenneis [40]). However, in the only study that has attempted to gauge the reliability of always present and recovered memories, Dahlenberg discovered that 74% of both types could be confirmed. (45) A study on the confirmation and disconfirmation of traumatic memories in DID patients demonstrated that, while many recovered memories of trauma could be confirmed and some recovered and some always present memories of abuse could be disproved, the majority of allegations could neither be confirmed nor disproved. (7, 39)

My clinical experience, the experience of dozens of colleagues who are knowledgeable about the treatment of DID, and my review of the literature demonstrate that most DID patients do not do well with attempts to dismiss their memories of traumata -- but that many are also unable to tolerate working with them. There is no published study in which the phenomenology of DID has been definitively resolved to the point of integration and has remained resolved on follow-up by a treatment that was dismissive of patients' memories of trauma. However, a number of reports document that some DID patients cannot tolerate dealing with their traumatic memories, and that these patients should be treated supportively, with attention to their comfort and function rather than the integration of their DID. (46, 47) Therefore, the decision of whether to work with traumatic material should be based on clinical considerations rather than on abstract hypothetical models and assumptions. Any efforts to deal with traumata should be undertaken with a profound respect for the meaningfulness of the material to the patient and conducted with tact and sensitivity. In a given patient, one may encounter both amazingly accurate and completely inaccurate memories of abuse, and all degrees and admixtures between these two extremes. (7, 39, 46-49)

The Diagnosis of DID

Diagnostic issues associated with DID are often said to be complex and difficult. While this is occasionally the case, it would be more accurate to state that clinicians' lack of familiarity with relevant information and issues, problematic stances and attitudes, confusions in the face of apparent comorbidity, and responses to political and economic pressures and incentives complicate what can be a reasonably straight-forward process.

Dissociation, hypnotic phenomena, the trauma response spectrum, the dissociative disorders, and the phenomenology and natural history of DID are not as familiar to the average clinician as are considerations that bear on the diagnosis of depression, bipolar disorders, anxiety disorders, and schizophrenia. For example, many clinicians who would be sensitive to the implications of the report of a single spell of manic

behavior, however long ago, because they are familiar with the natural history of bipolar disorders, will dismiss a report of disremembered out-of-character behavior without ever considering whether it may be an indicator of a dissociative disorder, expecting instead to encounter a florid "flying circus" of dissociative phenomena in order to take the possibility of DID seriously. However, the natural history of DID (42) is such that 94% of patients with DID do not display floridly DID on an ongoing basis. Rather, most patients with DID spend most of their lives manifesting phenomena that would yield the diagnosis of DDNOS or perhaps of no dissociative disorder at all, unless interviewed in a manner that would elicit their longitudinal experience of dissociative phenomenology (as elicited in the SCID-D-R of Steinberg [49]).

Diagnostic Approaches

DID is a pleiomorphic, polysymptomatic, chronic dissociative disorder that occurs in the context of overwhelming experiences in childhood, most often reported in connection with abuse. Its manifestations are often subtle and intermittent. Its most dramatic findings are often covert and can easily be dissimulated during a typical diagnostic interview. A given personality may also not have access to or be willing to share the data necessary for the diagnosis to be suspected or made. Many DID patients will not open up until they feel relatively secure with the interviewer. Denial and retraction of previous communications bearing on dissociative phenomena are commonplace.

Consequently, if there is a history suggestive of dissociative phenomena, it is not good practice to conclude that the DID could not be present on the basis of a negative standard clinical interview. (42, 50) Again, the analogy with bipolar disorders is useful you would not conclude that a person is not bipolar if he or she manifested only depressed or euthymic features during a diagnostic interview.

Clinical Interview and Mental Status Examination

The basic psychiatric interview and mental status examination are very limited instruments for the diagnosis of DID. They simply were not designed to explore dissociative phenomena in depth and include very few inquiries that bear directly upon dissociative disorders. In the early days of the modern era of work with DID, clinicians would attempt to discern whether patients had signs suggestive of DID, and then follow up the suggestive signs with further inquiry. These signs remain useful to alert the clinician, especially if an initial presentation has not otherwise suggested DID. However, while pursuing suggestive signs remains useful, many clinicians now augment this approach with the screening measures and structured interviews discussed below. The suggestive signs (51) are:

1. Prior treatment failure
2. Three or more prior diagnoses
3. Concurrent psychiatric and somatic symptoms
4. Fluctuating symptoms and levels of function
5. Severe headaches and other pain syndromes
6. Time distortion, time lapses, or frank amnesia
7. Being told of disremembered behaviors
8. Others noting observable changes
9. The discovery of objects, productions, or handwriting in one's possession that one cannot account for or recognize
10. Hearing voices (80% or more experienced as within the head) that are experienced as separate, often urging the patient toward some activity
11. The patient's use of "we" in a collective sense and/or making self-referential statements in the third person.
12. The eliciting of other entities through hypnosis or a drug-facilitated interview
13. A history of child abuse
14. An inability to recall childhood events from the years 6 to 11

Most of these suggestive signs are self-evident, but items 12 and 14 require further commentary. If other identities are elicited in the course of an intrusive inquiry, these identities may represent the mobilization of ego states in a person whose experience of self is rather modular. Ego states are defined as "organized systems of behavior and experience that are bound together by some common principle, and which are separated from other such states by a boundary that is more or less permeable" (p. 25 [52]). What are actually normative ego states or Hilgard's hidden observer phenomenon may be misunderstood as true alter personalities. Some patients may understand the inquiries as instructions to enact behavior that they believe has been requested. Also, some people have rather literal understandings of the processes of introjection and identification. Furthermore, it is not uncommon to find ego states based on recently deceased love objects in grieving individuals. For these and other reasons, mobilizing an apparent alter is only suggestive of DID.

With regard to 14, we tend to regard amnesia for the first few years of life as normative. Although there certainly are persons without DID who have little memory of the years 6-11, it is very common for DID individuals to demonstrate some tangible lack of information about these years.

Because of the complex and confusing presentation of DID, Loewenstein developed a special mental status examination to elicit signs of dissociation and related phenomena. (53) This examination taps six areas:

- 1) indications of the DID process at work (e.g., differences in behavior, linguistic indications, switching)

- 2) signs of the patient's high hypnotic potential (e.g., enthrallment, trance logic, out of body experiences)
- 3) amnesia
- 4) somatoform symptoms
- 5) PTSD symptoms
- 6) affective symptoms

The patient who has signs and symptoms in all of these areas during the first interview is a good candidate for the diagnosis of DID.

When a clinician suspects the presence of DID but is unable to elicit its phenomena in a standard interview, it can be helpful to ask the patient to keep a journal for 20-30 minutes a day, since other alters will often make entries. Since research has demonstrated that DID patients tend to switch much more frequently than is clinically evident in brief encounters and in their self-report (54), it is often useful to do an extended interview in order to enhance the chance that the patient will switch spontaneously before the clinician. Such prolonged interviews should not be staring contests or pressured -- rather, they work from the assumption, based on clinical experience and research, that most DID patients, even if dissimulating, will begin to experience a pressure to switch and will actually switch or show signs suggestive of switching after 2.5 to 3 hours. This can be very useful in forensic circumstances, when it is important to avoid any contaminants in the interviewing process. It should be noted that this is not an unusual technique. Many forensic evaluations are conducted on an extended basis, usually due to considerations of convenience (such as the evaluator's having to travel in order to do the assessment).

Although the use of psychological testing for the diagnosis of DID has been proposed, and one elaborate battery (55, 56) has much merit, articles promoting one particular test or another have been followed by articles that challenge their use for DID. Psychological testing cannot be considered a powerful diagnostic tool for DID at this time.

In the presence of suggestive signs of DID and the absence of the spontaneous emergence of an alter, many clinicians will consider asking to meet an alter directly. (57) This is usually done in connection with a puzzling or out of character event which is known to have occurred, but for which the patient has no memory. This often works. However, at times, denial, resistance, and apprehension are insurmountable. On these occasions, it is not uncommon for there to be signs of visible discomfort to appear; if they are pursued, may yield further suggestive data and possibly lead to the emergence of an alter later in the session or in a different session. Hypnosis and drug-facilitated interviews may be used diagnostically, bearing in mind the caveats noted above. (Note that these observations are related to the use of hypnosis and drug-facilitated interviews in the diagnosis of DID. Should these techniques be used for

memory retrieval, additional constraints and cautions apply. The interested reader is referred to a specialized text. [34])

Screening and Diagnostic Instruments

Several instruments have been developed for the purpose of screening people for dissociation. Of these, the most widely used, researched, and respected is the Dissociative Experiences Scale (DES) of Bernstein and Putnam. (58) This self-administered test consists of 28 questions. The patient is asked to indicate the percentage of the time that he or she experiences the symptom asked about in the question. The DES is a screening instrument which relies on the patient's honesty and is vulnerable to both simulation and dissimulation. In clinical situations in which one is interested in detecting dissociative disorders of clinical significance, a score of 20 or more should warrant further exploration. However, when considering overt DID, it appears that using a cut-off of 30, one of seven who score 30 or more will have DID, while only 1% of those who score under 30 will have this condition. However, in my experience, if there is any reason to suspect the possibility of DID or a closely related form of DDNOS, a low DES score should not discourage further exploration.

Two structured interviews have been developed for the diagnosis of DID, the Dissociative Disorders Interview Schedule (DDIS) of Ross (59) and the Structured Clinical Interview for the Diagnosis of DSM-IV Dissociative Disorders - Revised (SCID-D-R) of Steinberg. (49) Both have excellent psychometric properties in psychiatric patient populations. The DDIS, although much easier to administer, does make intrusive inquiries about abuse, which may be problematic in some settings, and recently has been suspected of generating a small number of false positives in non-clinical populations. (23) The SCID-D-R, while more difficult and time-consuming to administer, does not ask about abuse and, as yet, is not associated with false positives in normal populations. It also gives a rich portrait of the patient's subjective experience of dissociative phenomena that is profoundly useful for psychotherapy. The SCID-D-R generates a score (from 5-20) that is derived from the prevalence, pervasiveness and disruptiveness of phenomena in the five areas of amnesia, depersonalization, derealization, identity confusion, and identity alteration, each of which is scored 1-4. Patients with clinical dissociative disorders generally score 15 or above; mixed psychiatric patients average 8-12; and normal subjects score 7 or less. DID patients who are not being defensive often score 17-20. Sections of the SCID-D-R that are not included in the score allow the clinician to record observations that contribute to making a definitive diagnosis (e.g., observations that the patient has switched, demonstrated different patterns of behavior, or has had a brief episode of amnesia while with the clinician).

A clinician who is not experienced with dissociative

disorders would be wise to do both a DES and SCID-D-R when attempting to resolve a differential diagnosis involving DID. Using the SCID-D-R is an excellent way for clinicians to learn which questions they might wish to incorporate into their routine clinical evaluations. There is also much to be said for using a structured clinical interview in forensic circumstances.

Differential Diagnosis

Studies of comorbidity (23, 60) have demonstrated that patients with DID also meet the diagnostic criteria for many other conditions. However, it remains uncertain to what extent these diagnostic criteria are being satisfied by phenomena that are part of the DID itself and to what extent they represent other independent diagnoses that are difficult to make without longitudinal observation. (60) Clinical experience has repeatedly demonstrated that both types of situation are commonplace and, can occur at the same time in a given DID patient. For example, a DID patient with apparent recurrent major depression and borderline personality disorder may prove to have an independent affective disorder, but no more than the appearance of a character disorder, the manifestations of which clearly stem from the chaotic switching and hostile interactions among the alters.

The differential diagnosis for DID includes other dissociative disorders, psychoses, affective disorders, borderline personality disorder, partial complex seizures, factitious disorders, and malingering. Table 4 presents considerations that may assist the clinician in making diagnostic distinctions between DID and other disorders. However, if the criteria for DID are met and there is no definitive proof of malingering or factitious disorder, the disorder should be regarded as present. It is useful to bear in mind that malingering and factitious augmentations may accompany legitimate DID.

It must also be remembered that a clinician's perception is not immaculate it is colored by his or her attitudes and experiences. In approaching the differential diagnosis of a possible dissociative disorder, many clinicians are predisposed to discount the possibility of making the diagnosis or are inclined to be very skeptical about indicators of a DID process, while being more enthusiastic about other diagnostic possibilities. In the presence of diagnostic confusion or apparent comorbidity, motivated skepticism and/or confirmatory bias against DID may lead clinicians to misattribute dissociative symptoms to other disorders. On the other hand, clinicians predisposed in favor of a DID diagnosis may misattribute dissociative phenomena that fall short of DID to a DID process they assume must be present.

Finally, we must acknowledge that both political and economic pressures and incentives may impede the accurate recognition of a controversial disorder, especially one that generally requires expensive and intensive treatment. The making of a DID diagnosis is

Table 4

Considerations in the Differential Diagnosis of DID
<p>DID vs. Other Dissociative Disorders</p> <ol style="list-style-type: none"> 1. Other dissociative disorders usually do not have the associated polysymptomatic findings of DID (Exception: Forms of DDNOS that resemble DID) 2. Other dissociative disorders (besides some dissociative fugues and some DDNOS) do not score high on the Identity Alteration scale of the SCID-D-R. 3. Other dissociative disorders with amnesia usually occur as one or a small number of discrete events. 4. Distinguishing many cases of DDNOS from DID can become a matter of clinical judgment.
<p>DID vs. Psychotic Disorders</p> <ol style="list-style-type: none"> 1. Remember first rank symptoms are more common in DID and are not a useful indicator of psychosis in this differential. 2. Incoherence and true loosening of associations and true negative symptoms are not associated with DID. 3. Deteriorated behavior is uncommon in DID unless there has been prolonged hospitalization. 4. Auditory hallucinations in DID usually refer to a traumatic scenario, an inner conversation among alters, or alters' attempts to influence the identity in apparent executive control. They are usually coherent. When fragmentary, it is usually because they have not been heard completely. 5. Auditory hallucinations of DID patients are heard as emanating from inside the head in over 80% of cases. For schizophrenics, over 80% are heard as emanating from outside of the head. 6. Hypnotizability scales are useful, especially the brief HIP (Hypnotic Induction Profile [Spiegel, 1978]). The HIP is usually high in DID and low in schizophrenia. 7. Suggestive techniques often can modify "psychotic" symptoms in DID quite readily.
<p>DID vs. Affective Disorders</p> <ol style="list-style-type: none"> 1. Posttraumatic and other misery may cause confusion. 2. Comorbidity is common. 3. The presence of identities and amnesia in DID is crucial. 4. Look for the presence of affective symptoms in all alters or in an increasing number of alters to avoid mistaking a "depressed personality" for an affective disorder. 5. Mood shifts in DID tend to be mercurial rather than rapid, and often are associated with switches. 6. Affective symptoms without comorbid affective disorders usually respond at least transiently to suggestive measures.
<p>DID vs. Borderline Personality Disorder</p> <ol style="list-style-type: none"> 1. The disorders are not mutually exclusive and often occur as sequelae of trauma. 2. Dissociative phenomena in pure borderline personality disorder are relatively unstructured. 3. More DID patients appear phenomenologically borderline that prove to be borderline by structure or behavior in therapy (for specific therapies). 4. A crude but useful rule: Withhold or consider tentative the borderline diagnosis unless its manifestations are present within several personalities rather than as a phenomenon of their interaction.
<p>DID vs. Partial Complex Seizures</p> <ol style="list-style-type: none"> 1. Partial complex seizures are usually brief (30 seconds to 5 minutes), and are rarely chronic or more prolonged. 2. Dissociative phenomena associated with seizures are usually depersonalization variants. 3. Attempts to elicit alters associated with the symptoms in question may be helpful. 4. Hypnosis may be used to modify the symptoms as they occur, or to recreate the symptoms. 5. Consider drug-facilitated interviews. 6. Combined EEGs and observation in specialized monitoring facilities may resolve matters.
<p>DID vs. Factitious Disorders</p> <ol style="list-style-type: none"> 1. Ascertain whether seeking the patient role is reasonable given the patient's distress; i.e., is it legitimate help-seeking behavior? 2. Recent studies have demonstrated the cooccurrence of signs suggestive of DID in Munchausen's syndrome. 3. Use of objective measures of dissociation and dissociative phenomenology and hypnosis. 4. Use all available sources of data. 5. Classic core symptoms without ancillary and/or lesser known findings suggest a simulation based on lay sources. 6. Dissimulation rather than simulation is characteristic of DID patients.
<p>DID vs. Malingering</p> <ol style="list-style-type: none"> 1. Many DID and Malingering behaviors overlap: The utility of many usual indicators of malingering may be compromised. 2. Malingerers usually enact polarized good-bad differences across apparent alters. 3. Most malingered cases involve fewer alters that contemporary DID cases show. 4. Most malingered cases are less consistent and competent in demonstrating DID signs and symptoms in areas remote from their forensic concerns. 5. Classic core symptoms without ancillary and less well-known suggests a simulation based on lay sources. 6. Dissimulation rather than simulation is characteristic of DID patients. Suspect the patient eager to demonstrate psychopathology (unless treatment has been withheld -- some DID patients will become quite florid to demonstrate that they need therapy). 7. Use forensic guidelines for any hypnotic or drug-facilitated interviews.

strongly discouraged in some settings, and is therefore unlikely to be made. In other settings, it is possible that overdiagnosis may occur. However, it is wise to bear in mind that the underdiagnosis of DID is a well-documented phenomenon, as demonstrated by the surveys tabulated in Table 3, while overdiagnosis, which certainly can occur, is of unknown incidence.

Treatment of DID

Stances toward the treatment of DID

Many approaches to the treatment of DID have been advocated, often quite vociferously. No controlled studies comparing different models have been published; however, the vast majority of published reports of successful treatments have involved practitioners who augment a basic therapeutic stance, usually psychodynamic or cognitive, with a wide range of techniques, usually including hypnosis. DID patients constitute a very heterogeneous group; each patient's psychotherapy should be carefully individualized. Therapists' stances toward the treatment of DID can be classified into several groups; (64, 65) however, the treatment of the average DID patient usually requires switching in and out of several models in order to offer a flexible response to clinical realities. (64)

Among the approaches, those that emphasize the flow of the therapeutic process over the use of a wide range of techniques with the goal of integrating the personalities are called **strategical integrationalist**. They stem from the psychoanalytic tradition of DID treatment pioneered by the late Cornelia B. Wilbur, M.D. Therapies that emphasize the adroit use of techniques and specific interventions to attain a series of goals and objectives ultimately proceeding toward integration are called **tactical integrationalist**. In essence, these treatments are a series of short-term psychotherapies imbricated within the flow of a single long-term therapeutic process. **Personality-oriented** treatments are designed to improve the functioning of the alter system until the patient becomes asymptomatic. They aim for a good resolution and only incidentally might proceed to integration. **Adaptationalist** approaches prioritize here and now functioning. The goals of integration or resolution are secondary, and might not even be addressed. **Minimization** attempts to eliminate the DID by not reinforcing the alters. I studied over 50 patients treated in this manner while following a large group of DID patients in a study reported elsewhere. (42, 64) Every patient treated in this manner still had clinical DID on follow-up. There is no published report of a large series of DID patients treated successfully in this manner. Consequently, although such an approach has a common-sense appeal to many clinicians, it appears to be an ineffective clinical strategy. However, it is useful to appreciate that for some patients at some stages in

therapy, any work with alters runs the risk of proving disruptive.

In a given therapy, all of the above approaches might be useful or necessary from time to time. However, in general, the overall tenor of any treatment is likely to be dominated by one of these stances. To remain fully within a strategic integrationalist model is difficult with all but a few very highly functioning DID patients; for others, it offers inadequate resources to respond to crises, and may provide insufficient support. Tactical integrationalism is the most flexible model and is applicable to almost all DID patients. It offers a gentle, structured step-wise approach for working with the alters and their memories, most clearly demonstrated in the work of Fine. (66, 67) Personality-oriented approaches have great flexibility, but require access to the alter system, which often is withheld for periods of time. These approaches work best with high-functioning and cooperative patients who display relatively little acting out, but can be used effectively with more compromised patients. Adaptationalism is often elected more because of therapist and resource limitations than because it is effective in attaining the long-term resolution of DID. Although often promoted by managed care organizations through a backhanded injunction against therapies that these organizations label as regressive, it has yet to be proven capable of actually curing DID. Minimization is a strategy advocated by those who maintain that DID is a social-psychological or iatrogenic artifact. Although frequently advocated, there is no evidence that it is effective in curing DID rather than reducing the frequency with which its manifestations are reported to the treater, and it cannot be regarded as a legitimate therapeutic strategy.

Stages of Treatment

The treatment of DID follows the same general three stage pattern as was outlined by Herman (68) for the treatment of the traumatized. A phase of **safety** in which the patient is given sanctuary and support and strengthened is followed by a phase of **remembrance and mourning** in which the mind's representation of its traumatic experiences is explored, processed, and mastered, and the consequences of the traumatization are grieved. Finally, in a phase of **reconnection**, the mind is reintegrated, the impact of the trauma and its mastery have been taken into one's identity and sense of self, and disrupted development, roles, and functions are resumed.

Stages in the treatment of DID have been described by many authors; their formulations, compared in a recent review (64), are remarkably similar. I have proposed a nine stages formulation in which stages 1-3 correspond to Herman's stage of safety, stage 4 corresponds to remembrance and mourning, and stages 5-9 correspond to reconnection. When it is clear from the first that therapy must be supportive (see below),

Herman's stage of safety corresponds to Kluff's stages 1. and 2. This modification is useful because extensive mapping and history-taking from the alters may precipitate the patient prematurely into traumatic material, and this type of treatment will not move to address traumatic material unless it is forced to do so. The nine stages are described below (based on Kluff, 1991 [60], pp.178-179).

1. **Establishing the psychotherapy** involves creating an atmosphere of safety in which evaluation can be completed, the security of the treatment frame can be assured, the therapeutic alliance begins. The patient comes to understand the treatment and accepts it in an atmosphere of informed consent, and his or her patient's demoralization is addressed.

2. **Preliminary interventions** involve gaining access to more readily available alters, making contracts for safety and cooperation, fostering cooperation and communication among the alters, offering symptomatic relief, and teaching techniques for strategies such as grounding, self-soothing, and containment. Coping skills are also addressed.

3. **History gathering and mapping** refers to learning more about the alters (and their histories), the alter system (and its rules of interaction), the world of the personalities (the "third reality", and how it interacts with external reality), and the particular problems functions, and concerns of various alters. As one learns more, one works with the alters' individual and interactional difficulties and presses for still more cooperation and collaboration.

4. **Metabolism of the trauma** refers to the efforts involved in accessing and processing the overwhelming experiences reported as autobiographical memory. Although currently controversial, abreactive work has been very successful in negotiating this stage of treatment. This stage must be conducted with a sense of timing and tact so that the patient does not become overwhelmed, and with an appreciation that what is reported and experienced as autobiographic memory may have an uncertain connection to historical reality. It is important to keep this work contained in the therapy whenever possible so that the patient's relationships with significant others will not be compromised prematurely. The patient's sense of the reality of his or her autobiographic memories may vacillate back and forth many times. The historical veracity of most material will neither be confirmed nor disconfirmed, so tact and discretion are advisable.

5. **Moving toward integration/resolution** involves working through material across alters and facilitating increasing cooperation, communication, and mutual awareness with enhanced mutual identification and empathy. In this process, many internal conflicts become muted or resolved, and the alters begin to demonstrate some blurring of their once more discrete characteristics; some experience identity confusion.

6. **Integration-resolution** consists of the patient's coming to a new and more solid stance toward his or her self and the world. A smooth collaboration of the alters is a resolution; the blending of the alters into a smooth unity is an integration.

7. **Learning new coping skills** is crucial. Now integrated and stable, or with a functional resolution, the DID patient may appreciate important problem areas and issues for the first time, and will require assistance in working out alternatives to dissociative functioning. Many important life decisions and relationship issues, postponed or left unaddressed during the course of the patient's illness, may require attention.

8. **Solidification of gains and working through** involves the DID patient continuing to process what has been learned while mastering how to live in the world without the use of pathological dissociative defenses and structures. Often work in the transference is instrumental, and previously inaccessible character issues may require attention. It often is necessary to provide considerable supportive coaching on the management of relationships and intercurrent stressors and traumata.

9. **Follow-up** is preferable to termination for a number of reasons. The stability of the outcome should be monitored, especially for those who have reached a resolution rather than an integration. Additional layers of alters may be encountered. Many patients with DID also have such painful attachment and loss issues that aiming for a formal termination will unduly complicate the therapy. Generally, treatment is tapered as tolerated until follow-up sessions are held every several months; this degree of follow-up remains in place indefinitely. In the era of managed care, such an approach might be challenged. However, these few sessions are an excellent means of preventing relapses or rapidly responding to relapses to minimize regression and morbidity. Responding to a full-fledged relapse is a far more costly alternative.

Pragmatic aspects of treatment

The core symptoms of DID do not respond to psychopharmacology or to simple redirection. Many groups of DID patients respond very well to an intense individual psychotherapy facilitated when necessary with an eclectic array of techniques and modalities. These treatments can be arduous for patient and therapist alike. Although some highly functioning DID patients, some with minimal symptoms, or some seen supportively (often with an adaptationalist stance) may do well in one session per week, the majority of experienced clinicians have found that two or more sessions, or at least a single session of 90 minutes duration, are preferable. (57, 60, 69) More sessions offer more structure and support, and more opportunity to move beyond here and now concerns to address underlying difficulties. Unfortunately, many patients seen once weekly or less never experience treatment as

providing enough safety or sufficient intensity and structure to move forward with the work of treatment, and therapy deteriorates into an endless chain of supportive crisis intervention.

Because DID patients are vulnerable to crises and the treatment can be demanding and occasionally destabilizing, it is desirable that the therapist be accessible to the patient between sessions, but that the therapist insist that this accessibility be treated with respect. Most crises of most DID patients can be resolved in short order over the telephone, thus preventing decompensations and hospitalizations.

Patient Subgroups

A number of investigators (70-74) have described DID subgroups with different characteristics and prognoses. Three general types of DID patients have been described. The first are relatively high-functioning individuals with many assets and psychological strengths. While they may be very symptomatic and uncomfortable, their symptoms are by and large all epiphenomena of DID and trauma spectrum disorders. If they have independent comorbid conditions, they are straight-forward and respond to treatment with clarity. In general, they do well in therapy, are infrequently hospitalized after the earliest stages of treatment, if they are hospitalized at all. They usually integrate and complete treatment in 2-7 years.

A second group has fewer resources, more borderline features and considerable comorbidity, especially with affective and eating disorders and substance abuse. Their interpersonal circumstances are often difficult and marked dependency issues are often present. Their treatment course is rockier, with more crises, and follows a slower and/or more tumultuous course. Many ultimately integrate many reach good resolutions; however, many remain unstable for long periods of time. Some neither integrate nor find a stable resolution and require ongoing supportive help. This group does distinctly better with more experienced DID therapists, who often can convert them into higher functioning individuals.

The third group, referred to as "enmeshed" by Horevitz and Loewenstein (72), "poor prognosis" by Caul (71), and as "low-functioning" or "chronic" in workshop settings, shows more extreme versions of the difficulties of the second group, may be much more enmeshed in abusive relationships, more actively self-destructive and identified with a dissociative lifestyle, and may show intermittent or ongoing features of more out-of-control affective disorders or of other psychotic conditions. This group must be treated in a supportive manner for long periods of time, and often slowly becomes more modulated. A minority ultimately progress to integrations or satisfactory resolutions. Often they are chaotic for years, and gradually burn out and become more treatable.

Although some authorities (e.g., Boon [47]) believe that a patient's history will allow his or her assignment to a group with a better or worse prognosis at the time of assessment, I have found that this type of decision should be deferred for 6 months to a year, to give the therapist time to assess the patient's response to specific DID-oriented treatment. Very often DID patients who have had extensive prior treatment that did not address their DID adequately make a very deteriorated initial presentation, but rapidly demonstrate their capacity to respond to appropriate therapy. The Dimensions of Therapeutic Movement Instrument (DTMI) (70) was developed to measure initial responsiveness to DID treatment to allow proper classification. As an example, a woman who appeared very disturbed and quite psychotic in addition to her DID had spent 13 years in state hospitals. Appropriately diagnosed, she responded rapidly to treatment, ultimately integrated, obtained her doctorate in psychology, and now is both widely published in her fields of interest and fully employed as a psychologist.

Monitoring the Flow of Treatment (adapted from Kluff, 2001[75])

If the patient is motivated for treatment, the psychotherapy begins with an attempt to establish the therapy and make the preliminary interventions. If these are successful, the therapist attempts to learn about the personalities and their stories without getting into abreaction or strong affect in the stage of history-gathering and mapping. If the patient can tolerate this preliminary exploration, the therapist and patient can discuss moving on to process the traumatic material. However, if this early exploration proves unduly upsetting, it is essential to return to the issues addressed earlier, and to work to strengthen the patient further. If this proves possible, trauma work can be approached once again. If this proves impossible, therapy should remain focused on supporting and strengthening the patient.

Once trauma work has begun, the therapist must be exquisitely sensitive to the patient's capacity to tolerate this type of work. Trauma should not be the focus of session after session after session. Instead, as material is retrieved, it is more important to process that material in a manner that allows the patient to remain stable than it is to move on to find and/or deal with more material. Slower turns out to be faster, because when there are fewer crises and the treatment remains a relatively safe place for the patient, the overall length of the treatment is reduced.

If there are difficulties at any point, the therapist should undertake a comprehensive re-evaluation of the treatment process, bearing in mind patient, therapist, situational, logistical, and process-related factors. A list of considerations is available elsewhere. (75) If, at any point, the therapist feels that the trauma work is either

overwhelming or on the verge of becoming overwhelming, efforts to deliberately seek and process traumatic material should cease, and a supportive focus should be adopted in which the interactions and difficulties of the personalities are addressed, but traumatic material is worked with only to the extent that it intrudes or must be dealt with in order to ease the pain of an alter. If and when deliberate trauma work is resumed, this should be done with extreme caution, and no more than every several sessions. The therapist and patient must be prepared at any time to abandon this focused DID work to address matters related to the patient's daily life, crucial relationships, and ability to function.

Although the integration of the personalities is an ideal outcome, patients will often decline to work toward this, preferring instead a more facile collaboration of the alter personalities. The therapist should be prepared to work toward this latter objective if necessary—it often proves a preliminary to an integration. The successful therapist will be flexible, always ready to reconsider how to adapt the therapy and its goals to best serve the patient and to remain within the realm of the safe and the possible. Although some DID patients may be unable to respond to the therapist's best efforts to conduct a planful and circumspect therapy, and there will be moments of apparent failure and disappointment even in therapies that ultimately prove successful, the majority of DID patients will, over time, be able to form a reasonable therapeutic alliance and move forward.

Special Issues and topics

In the following section, I briefly discuss certain topics that can cause clinicians special concern in treating patients with DID. Many of these subjects have been addressed earlier in this article; however, I address some additional aspects of these issues here.

Working with the Alters (Identities, Personalities)

Many clinicians continue to have difficulty with the concept of the alters and struggle with whether to address, access, accept, and worked with them. It is crucial to appreciate that, in order to deal with the many realities in which the DID patient lives, the clinician must at once understand the alters as having compelling senses of separateness that must be addressed, and at the same time understand them to be parts of a single individual. The clinician must steer a course between the Scylla of perceiving the alters as actual independent persons and the Charybdis of perceiving them as no more than annoying extraneous phenomena that can be dispensed with or neglected. The weight of clinical experience is that it is productive and often essential to work with the alters. Virtually every published series of DID patients who have made progress or achieved integration has involved treatment by therapists who

worked with alters; the most successful therapists in the field work vigorously with alters. Furthermore, some approaches to treatment that are widely acknowledged to be successful, such as Fine's version of tactical integrationalism (66, 67) and the ego state therapy of Jack and Helen Watkins (52) require active efforts to engage the alters.

Trauma and Abreaction

Notwithstanding the vicissitudes of autobiographic memory and the encoding of memories of traumata, it is clear that DID patients as a group have had overwhelming childhood experiences. Two recent studies (37, 38) attempted to document trauma in the histories of children and adolescents with dissociative disorders. Each study found that trauma could be documented in 95% of the cases studied. Furthermore, notwithstanding the contemporary "Memory Wars," it is quite clear that accurate memories of trauma endured by DID patients may be driven from awareness and recovered in therapy. (39, 48) For a comprehensive review of issues regarding memory, see the recent text by Brown, Schefflin, and Hammond (35). Having stated this, it remains quite clear that inaccurate memories may be reported with conviction by this patient group, among others. (39, 48) Relatively few DID patients can put traumatic material, whether accurate, inaccurate, an admixture, or of uncertain veracity, aside without processing it. (33, 76) In my clinical experience it is often after such material has been successfully processed that the patient becomes calm enough to reflect on its veracity and to become philosophical about matters of uncertainty. It is important that traumatic material be handled gently, with great tact and careful timing, so that work with it does not overwhelm the patient unnecessarily. The patient should be fully informed, from a stance of compassion rather than one of dismissive skepticism, that memories of trauma, both those that have always been in awareness and those that emerge after not having been in awareness, should be regarded as tentative rather than receiving the therapist's stamp of "accurate" or "false." The only test of the veracity of a memory is external confirmation, and most persons who could give such confirmation are not eager to indict themselves. Therapy is better at healing memories of trauma than ascertaining their veracity. (77)

Memories of trauma must be processed in a way that palliates their impact on the ongoing life and functioning of the patient and reverses the negative and distorted cognitions and self-concepts that have emerged in their wake. Although conversation alone may be sufficient and spontaneous abreaction sometimes clears matters up, more often than not deliberate efforts to initiate and contain abreactions take place in DID therapies. Hypnosis has long been a major tool for effecting such abreactions, and remains valuable. More recently, Eye Movement Desensitization and Reprocessing (EMDR) has been employed. (78, 79) Approaches based on

Janet's technique of "realization" have been described by van der Hart et al. (80). I developed the technique of fractionated abreaction in order to make this process more contained and controlled (81, 82) (see also Fine (66, 67). In this approach, traumas are processed bit by bit and abreactions rarely prove overwhelming.

Hypnosis

When tested systematically, patients with DID prove to be a highly hypnotizable group. (83) The high hypnotic potential of these patients predisposes them to spontaneous trance and autohypnotic phenomena. Indeed, Bliss felt that the unwitting use of autohypnosis was the basis for DID. (84) Therefore, even if no formal hypnosis is used in a treatment, the patient's hypnotic potential, use of autohypnosis, and proclivity for spontaneous trance phenomena injects hypnosis into every DID treatment. Although the use of hypnosis for memory recovery with DID should be approached with appropriate caution, numerous hypnotic techniques have been derived for facilitating the psychotherapy of DID. (24, 85-90) These interventions include accessing the alters, reducing anxiety, reconfiguring the alter system to enhance functioning, containing disruptive affects and memories, controlling abreactions, teaching control of spontaneous dissociation and abreaction.

Hypnosis has been used by most clinicians treating DID. (88) Clinicians who are concerned about the impact of hypnosis on memory distortion can omit the use of hypnosis in memory exploration while still providing their patients the many benefits of hypnotic interventions. To illustrate, a physician who had long been disabled by DID was enabled to return to practice because of hypnotic interventions that taught the patient to "put to sleep" alters whose presence would be problematic in professional settings while the physician was at work.

Hypnosis is also an extremely powerful tool to use for reducing amnesic barriers, controlling apparent "psychotic" symptoms, and for facilitating integration. (24, 85)

Medication

As stated previously, although the core symptoms of DID do not respond to medications, the average DID patient has many anxiety and affective symptoms that are legitimate targets for psychopharmacology; some have symptoms of irritability, impulsivity, or psychosis that may respond to medication. The drug treatment of DID patients has been discussed in several publications, (89, 91-93) but the accumulated clinical wisdom in the field continues to be based on anecdotal experiences. Hence, Colin Ross' 1989 remark that every medication treatment of a DID patient constitutes an uncontrolled clinical trial. (59)

Loewenstein offered three rules for the pharmacotherapy of DID. (92) First, he insisted that the use of medications for DID had to be understood in the context of the total treatment, and that it be difficult to

assess what is a clear psychopharmacologic response. Apparent responses often prove to be placebo responses or related to changes in the alters system. Second, he noted that most problems in the treatment of DID are not solvable with medication. Third, one must restrict one's prescribing to efforts to address valid psychopharmacologic targets; insofar as possible, one should try to target symptoms that are present across the whole human being instead of being localized in particular alters. It is very common to find that symptoms presented for medication treatment represent the issues of one or a group of alters, or emerge from the conflicts within the alter system. As a general rule of thumb, if a symptom is present in only one or a small group of alters, it is unlikely to be a valid target; nevertheless one may decide to prescribe because one feels one must respond to the patient's (or the non-medical therapist's) distress. If, however, a target symptom is generally present, or present in an increasing number of alters, it may be a legitimate target. In such situations, the absence of a target symptom in alters designed to be anesthetic or unfeeling should not be considered a contraindication (it may be role-related denial); but, conversely, when such alters begin to experience a potential target symptom, it will be wise to prescribe. The deterioration of this group of alters may be a major crisis for the patient with DID and should be taken seriously.

Concluding Remarks

It is a curious irony that recent major advances in the diagnosis and treatment of DID occurred in close proximity to both the rise of managed care and a backlash against the psychotherapy of victims of trauma. The controversies that have surrounded DID in these contexts have often obscured the progress that has been made. DID is emerging as a not uncommon consequence of overwhelming childhood events. It has been identified as occurring in many nations and is often very responsive to treatment.

The major challenges facing the treatment of DID are disentangling this condition and its therapy from the controversies that swirl about them, encouraging the more widespread use of specific diagnostic approaches, educating managed care organizations to accept standards of care for DID that are based upon those treatment approaches that are effective, making specific treatments for DID more available, and continuing to develop more successful approaches for the more difficult-to-treat DID subgroups of DID patients.

References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders - 4th ed. Washington, DC, American

- Psychiatric Association; 1994.
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders - 3rd ed. - revised. Washington, DC, American Psychiatric Association; 1987.
 3. Cardena E, Lewis-Fernandez R, Bear D, Pakianathan I, Spiegel D. Dissociative disorders. In: Widiger TA, Frances AJ, Pincus HJ, Ross R, First MB, Davis WW. DSM-IV sourcebook, Vol. 2. Washington, DC: American Psychiatric Press; 1996: 973-1005
 4. Kluff RP. The phenomenology and treatment of extremely complex multiple personality disorder. *Dissociation* 1988; 1 (4): 47-58.
 5. Hilgard ER. Divided consciousness: multiple controls in human thought and action (expanded edition). New York: Wiley-Interscience; 1986.
 6. Kluff RP. Psychodynamic psychotherapy of multiple personality disorder and allied forms of dissociative disorder not otherwise specified. In: Barber JP, Crits-Cristoph P, eds. *Dynamic therapies for psychiatric disorders (axis I)*. New York: Basic Books; 1995: 332-385.
 7. Kluff R: Reflections on the traumatic memories of dissociative identity disorder patients. In: Lynn S, McConkey K, eds. *Truth in memory*. New York: Guilford; 1998:304-322.
 8. Ross CA, Anderson G, Fleisher WP, Norton R. The frequency of multiple personality disorder among psychiatric inpatients. *American Journal of Psychiatry* 1991; 148: 1717-1720.
 9. Horen S, Leichner P, Lawson J. Prevalence of dissociative symptoms and disorders in an adult psychiatric inpatient population in Canada. *Canadian Journal of Psychiatry* 1995; 40: 185-191.
 10. Saxe G, van der Kolk B, Berkowitz R, Chinman G, Hall K, Lieberg G, Schwartz J. Dissociative disorders in psychiatric inpatients. *American Journal of Psychiatry* 1993; 150: 1037-1042.
 11. Latz T, Kramer S, Hughes D. Multiple personality disorder among female inpatients in a state hospital. *American Journal of Psychiatry* 1995; 152: 1343-1348.
 12. Boon S, Draijer N. Multiple Personality Disorder in the Netherlands: A study on reliability and validity of the diagnosis. Amsterdam, Swets & Zeitlinger, 1993.
 13. Knudsen H, Draijer N, Haslerud J, Boe T, Boon S. Dissociative disorders in Norwegian psychiatric inpatients. Paper presented at the Spring Meeting of the International Society for the Study of Dissociation, Amsterdam, The Netherlands, 1995.
 14. Tutkun H, Sar V, Yargiuc I, Ozpulat T, Yanik M, Kiziltan E. Frequency of dissociative disorders among psychiatric inpatients in a Turkish university clinic. *American Journal of Psychiatry* 1998; 155: 800-805.
 15. Ross C, Kronson J, Koensgen S, Barkman K, Clark P, Rockman, G. Dissociative comorbidity in 100 chemically dependent patients. *Hospital and Community Psychiatry* 1992; 43: 840-842.
 16. Leeper D, Page B, Hendricks D. The prevalence of dissociative disorders in a drug and alcohol abusing population of a residential treatment facility in a military medical center. Unpublished manuscript, 1992.
 17. Ellason JW, Ross CA, Sainon K, Mayran LW. Axis I and II comorbidity and childhood trauma history in chemical dependency. *Bulletin of the Menninger Clinic* 1996; 60: 39-51.
 18. Dunn G, Paolo A, Ryan J: Dissociative symptoms in a substance abuse population. *American Journal of Psychiatry* 1993; 150: 1043-1047.
 19. Putnam FW, Guroff JJ, Silberman EK, Baran L, Post RM. The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. *J Clin Psychiatry* 1986; 47: 285-293
 20. Merskey H. The manufacture of personalities: The production of multiple personality disorders. *British Journal of Psychiatry* 1992; 160: 327-340.
 21. Spanos N. Multiple identities & false memories: a sociocognitive perspective. Washington, DC: American Psychological Association; 1996.
 22. Piper A. Hoax and reality: the bizarre world of multiple personality disorder. Northvale, NJ: Aronson; 1997.
 23. Ross C. Dissociative identity disorder: diagnosis, clinical features, and treatment of multiple personality. New York: Wiley; 1997.
 24. Kluff R. Varieties of hypnotic interventions in the treatment of multiple personality. *American Journal of Clinical Hypnosis* 1982; 24, 230-240.
 25. Kluff RP. Current controversies surrounding dissociative identity disorder. In: Cohen L, Berzoff J, Elin M, eds. *Dissociative identity disorder: theoretical and treatment controversies*. Northvale, NJ: Aronson; 1995.
 26. Braun BG. Hypnosis creates multiple personality: myth or reality? *International Journal of Clinical and Experimental Hypnosis* 1984; 32: 191-197.
 27. Somer E, Weiner A. Dissociative symptomatology in adolescent diaries of incest victims. *Dissociation* 1996; 9: 197-209.
 28. Ross CA, Norton GR. Effects of hypnosis on the features of multiple personality disorder. *American Journal of Clinical Hypnosis* 1989; 32: 99-106.
 29. Ross CA, Norton GR, Fraser GA. Evidence against the iatrogenesis of multiple personality disorder. *Dissociation* 1989; 2: 61-65.
 30. Shapiro F. Eye movement desensitization and reprocessing: basic principles, protocols, and procedures. New York: Guilford; 1995.
 31. Frankel F. Adult reconstruction of childhood events in the multiple personality literature. *American Journal of Psychiatry* 1993; 150: 954-958.
 32. Brown D. Pseudomemories, the standard of science, and the standard of care in trauma treatment. *American Journal of Hypnosis* 1995; 31: 1-24.
 33. Kluff RP. The argument for the reality of delayed recall of memory. In: Appelbaum PS, Ueyehara LA, Elin M, eds. *Trauma and memory: Clinical and legal consequences*. New York: Oxford; 1997: 25-57.
 34. Hammond DC, Garver RB, Mutter CB, Crasilenck HB, Frischholz EJ, Gravitz MA, Hilber NS, Olson J, Schefflin AW, Spiegel H, Wester W. *Clinical hypnosis and memory: Guidelines for clinicians and for forensic hypnosis*. Des Plaines, IL: American Society of Clinical Hypnosis Press; 1995.
 35. Brown D, Schefflin A, Hammond D. *Memory, trauma treatment, and the law*. New York: Norton; 1997.
 36. Appelbaum PS, Ueyehara LA, Elin M. (eds.). *Trauma and memory: Clinical and legal consequences*. New York: Oxford; 1997.
 37. Coons P. Confirmation of childhood abuse in child and adolescent cases of multiple personality disorder and dissociative disorder not otherwise specified. *Journal of Nervous and Mental Disease* 1994; 182: 461-464.
 38. Hornstein, Putnam F. Clinical phenomenology of child and adolescent multiple personality disorder. *Journal of the Academy of Child and Adolescent Psychiatry* 1992; 31: 1055-1077.
 39. Kluff R. The confirmation and disconfirmation of memories of abuse in dissociative identity patients: a naturalistic clinical study. *Dissociation* 1995; 8: 253-258.
 40. Orne MT, Dinges DF. Hypnosis. In: *Comprehensive textbook of psychiatry*, V. Baltimore: Williams & Wilkins; 1989: 1501-1516
 41. Barach P, Comstock C: Psychodynamic psychotherapy of dissociative identity disorder. In: Michelson LK, Ray WJ, eds., *Handbook of dissociation: theoretical, empirical, and clinical perspectives*. New York: Plenum; 1996.
 42. Kluff RP. The natural history of multiple personality disorder. In: Kluff RP, ed., *Childhood antecedents of multiple personality*. Washington, DC: American Psychiatric Press; 1985: 197-238.
 43. Kluff RP. The psychoanalytic psychotherapy of dissociative identity disorder in the context of trauma therapy. *Psychoanalytic Inquiry*; in press.
 44. Brenneis CB. *Recovered memories of trauma: transferring the present to the past*. Madison, CT: International Universities Press; 1997.
 45. Dahlenberg C. Accuracy, timing and circumstances of disclosure in therapy of recovered and continuous memories of abuse. *Journal of Psychiatry and Law* 1996; 24: 229-275.
 46. Kluff RP. On the treatment of the traumatic memories of DID patients: always? never? sometimes? now? later? *Dissociation* 1997; 10: 80-90.
 47. Boon S. The treatment of traumatic memories in DID:

indications and contra-indications. *Dissociation* 1997; 10: 65-80.

48. Kluft RP. Treatment of multiple personality disorder. *Psychiatric Clinics of North America* 1984; 7: 9-29.

49. Steinberg M. Structured Clinical Interview for DSM-IV Dissociative Disorders - Revised. Washington, DC: American Psychiatric Press; 1994.

50. Kluft RP. Clinical presentations of multiple personality disorder. *Psychiatric Clinics of North America* 1991; 14: 605-629.

51. Kluft RP. An update on multiple personality disorder. *Hospital & Community Psychiatry* 1987; 38: 363-373.

52. Watkins J, Watkins H. Ego states: Theory and therapy. New York: Norton; 199 dissociative symptoms and multiple personality disorder. *Psychiatric Clinics of North America* 1991; 14: 567-604.

53. Loewenstein RJ. An office mental status examination for complex chronic dissociative symptoms and multiple personality disorder. *Psychiatr Clin North Am* 1991; 14: 567-604

54. Loewenstein RJ, Hamilton J, Alagna S, Reid N, Devries M. Experimental sampling in the study of multiple personality disorder. *American Journal of Psychiatry* 1987; 144: 19-21.

55. Armstrong JG, Loewenstein RJ. Characteristics of patients with multiple personality and dissociative disorders on psychological testing. *Journal of Nervous and Mental Disease* 1990; 178: 448-454.

56. Armstrong JG. The psychological organization of multiple personality disordered patients as revealed in psychological testing. *Psychiatric Clinics of North America* 1991; 14: 533-546.

57. Putnam FW. Diagnosis and treatment of multiple personality disorder. New York: Guilford; 1989.

58. Bernstein E, Putnam F. Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease* 1986; 174: 727-735.

59. Ross C. Multiple Personality Disorder: diagnosis, clinical features, and treatment. New York: Wiley; 1989.

60. Kluft RP. Multiple personality disorder. In: Tasman A, Goldfinger S, eds. Annual review of psychiatry, Volume 10. Washington, DC: American Psychiatric Press; 1991: 161-188.

61. Spiegel H, Spiegel D. Trance and treatment: Clinical uses of hypnosis. New York: Basic Books; 1978.

62. Goodwin J. Munchausen's syndrome as a dissociative disorder. *Dissociation* 1988; 1: 54-60.

63. Kluft RP. The simulation and dissimulation of multiple personality disorder. *American Journal of Clinical Hypnosis* 1987; 30: 104-118

64. Kluft R. Treatment of dissociative disorder patients: An overview of discoveries, successes, and failures. *Dissociation* 1993; 6: 87-101.

65. Kluft RP. Today's therapeutic pluralism. *Dissociation* 1988; 1: 1-2.

66. Fine C. Treatment stabilization and crisis prevention: Pacing the therapy of the multiple personality disorder patient. *Psychiatric Clinics of North America* 1991; 14: 661-675.

67. Fine C. A tactical integrationalist perspective on the treatment of multiple personality disorder. In: Kluft RP, Fine CG, eds., Clinical perspectives on multiple personality disorder. Washington, DC: American Psychiatric Press; 1993: 135-153.

68. Herman J. Trauma and recovery. New York: Basic Books; 1992.

69. International Society for the Study of Dissociation: guidelines for treating Dissociative Identity Disorder (Multiple Personality Disorder) in adults (1997). Glenview, IL: International Society for the Study of Dissociation; 1997.

70. Kluft R. Treatment trajectories in multiple personality disorder. *Dissociation* 1994; 7: 63-76.

71. Caul D. Determining the prognosis in the treatment of multiple personality disorder. *Dissociation* 1988; 1(2): 24-26.

72. Horevitz R, Loewenstein R. The rational treatment of multiple personality disorder. In: Lynn S, Rhue J, eds., Dissociation: clinical and theoretical perspectives. New York: Guilford; 1994: 289-316.

73. Ross C, Dua V. Psychiatric health care costs of multiple personality disorder. *American Journal of Psychotherapy* 1993; 47: 103-106.

74. van der Hart O, Boon S. Treatment strategies for complex dissociative disorders: Two Dutch case examples. *Dissociation* 1997;

10:157-165.

75. Kluft RP. The difficult to treat dissociative disordered patient. In: Dewan M, Pies R, eds., The difficult to treat psychiatric patient. Washington, DC: American Psychiatric Press; 2002: 209-242.

76. Kluft RP. Overview of the treatment of patients alleging that they have suffered ritualized or sadistic abuse. In: Fraser GA, ed., The dilemma of ritual abuse: cautions and guides for therapists. Washington, DC: American Psychiatric Press, 1997: 31-64.

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

78. Paulsen S. Eye movement desensitization and reprocessing: Its cautious use in the dissociative disorders. *Dissociation* 1995; 8: 32-44.

79. Lazrove S, Fine CG. The use of EMDR in patients with dissociative identity disorder. 1996; 9: 289-299.

80. van der Hart O, Boon S, Steele K, Brown P. The treatment of traumatic memories: synthesis, realization and integration. *Dissociation* 1993; 6: 182-180.

81. Kluft R. On treating the older patient with multiple personality disorder: Race against time or make haste slowly? *American Journal of Clinical Hypnosis* 1988; 30: 257-266.

82. Kluft R. The fractionated abreaction technique. In: Hammond DC, ed., Handbook of hypnotic suggestions and metaphors. New York: Norton, 1990: 527-528.

83. Frischholz EJ, Lipman LS, Braun BG, Sachs RG. Psychopathology, hypnotizability, and dissociation. *American Journal of Clinical Hypnosis* 1992; 149: 1521-1525.

84. Bliss EL. Multiple personality, allied disorders and hypnosis. New York: Oxford University Press; 1986.

85. Kluft RP. Hypnotherapeutic crisis intervention with multiple personality. *American Journal of Clinical Hypnosis* 1983; 26: 73-83.

86. Kluft RP. Playing for time: Temporizing techniques in the treatment of multiple personality disorder. *American Journal of Clinical Hypnosis* 1989; 32: 90-98.

87. Kluft RP. Applications of hypnotic interventions. *Hypnos* 1994; 21: 205-83

88. Putnam F, Loewenstein R. Treatment of multiple personality disorder: A survey of current approaches. *Am J Psychiatry* 1993; 150: 1048-1052

89. Kluft RP. Aspects of the treatment of multiple personality disorder. *Psychiatric Annals* 1984; 14: 51-55

90. Phillips M, Frederick C. Healing the divided self: Clinical and Ericksonian hypnotherapy for post-traumatic and dissociative conditions. New York: Norton; 1995

91. Barkin R, Braun B, Kluft R. The dilemma of drug therapy for multiple personality disorder. In Braun BG, ed. Treatment of multiple personality disorder. Washington, DC: American Psychiatric Press; 1986: 107-132

92. Loewenstein RJ. Rational psychopharmacology in the treatment of multiple personality disorder. *Psychiatr Clin North Am* 1991; 14: 721-40

93. Torem MS. Psychopharmacology. In: Michaelson LK, Ray WJ, eds. Handbook of dissociation: Theoretical, empirical, and clinical perspectives. New York: Plenum Press; 1996: 545-661.

Correspondence: Richard P. Kluft, M.D. 111 Presidential Boulevard Suite 238 Bala Cynwyd, PA 19004 United States of America Telephone: 610-667-3250 Fax 610-667-3374 E-Mail: RPKluft@AOL.com