Advances in the treatment of dissociative identity disorder: An algorithm for evaluation and intervention with special attention to the role of hypnosis

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Recent advances in understanding Dissociative Identity Disorder (DID) have identified three subgroups of DID patients in terms of severity of psychopathology and three subgroups of DID patients in terms of their capacity to respond to specific DID treatment. After reviewing these findings and their implications for treatment, a novel algorithm for the treatment of DID which was derived from these observations will be proposed, and its use explored. The uses of twenty-two types of hypnotic intervention associated with the treatment of DID in conjunction with this algorithm will be discussed.

It is a curious and painful irony that in the United States, recent major advances in the diagnosis and treatment of dissociative identity disorder (DID) have occurred in close proximity to both the rise of economically and politically- driven efforts to contain health care expenditures and a backlash against the psychotherapy of the victims of trauma, especially with regard to concerns about the accuracy of memories of reported childhood traumata. The controversies that surround DID in these contexts often obscures the progress that has been made in learning how to help these patients, and/or leads to a dismissive disregard of a considerable body of accumulated clinical wisdom (Kluft, 1999a, p.17). As a result, DID patients continue to be misdiagnosed, often by choice, and frequently receive treatments which are unlikely to lead to the improvement of their conditions.

The purpose of this communication is to contextualize and then present an algorithm for the treatment of DID that takes into account many recent advances that remain little known outside of the dissociative disorders field. These advances include a deeper appreciation of the clinical heterogeneity of DID patients both in their presentations and in their responses to treatment, and a keener understanding of the role of supportive interventions in maintaining their safety and functioning.

DID Subgroups

In the first few years of the modern era of DID treatment, there was a widespread belief by many therapists that DID patients were an intelligent, creative, and covertly strong

group of trauma survivors who could, with empathic and skillful psychotherapy, achieve improvement and integration. Within a very few years, however, Kluft (1984) was able to identify the characteristics of different subgroups of patients who progressed more or less well in treatment, and both Kluft (1984) and Caul (1988) were able to describe similar clusters of features with prognostic implications. More recent contributions by Ross and Dua (1993), Horevitz and Loewenstein (1994), Kluft (1994a & b), and van der Hart and Boon (1997) also delineate subgroups.

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, these are straightforward and respond to treatment with aclarity.

The 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 is rockier, with more crises, and follows a slower and/or more tumultuous course.

The third group, referred to as "enmeshed" by Horevitz and Loewenstein(1994), as "poor prognosis" by Caul (1988), 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 other psychotic conditions (Kluft, 1999a, pp. 14-15).

Some authorities, such as Boon (1997), have taken the approach that a patient's history and presenting symptoms will allow the assessment of prognosis and the assignment to a particular approach to treatment at the time of assessment. Conversely, my own research (Kluft, 1994a & b) suggests that such decisions are best deferred for 6-12 months to allow the therapist to assess the individual 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" (Kluft, 1999a, p. 15). Scoring the treatment response of DID patients with the DTMI (Dimensions of Therapeutic Movement Instrument) reveals yet another three DID subgroups, a high-trajectory group that either begins at a high DTMI score, or increases its score from baseline levels quite rapidly; a middle-trajectory group that improves its score slowly, often with up and down fluctuations along the way; and a low-trajectory group that makes only slow progress, if any, by DTMI indices (Kluft, 1994a, b).

Although more often than not, anecdotal experience indicates that these two ways of grouping patients will come to similar conclusions about a given DID patient, there are many exceptions, and the consequences to the patient of being misclassified can be quite serious. Patients who can make a good appearance, but are unable to withstand

Tab. 1: The Triphasic Treatment of Trauma (Herman, 1992)

1. Safety
2. Remembrance and Mourning
3. Reconnection

Stages in the Treatment of Dissociative Identity Disorder (Kluft, 1991)

1. Establishing the Psychotherapy
2. Preliminary Interventions
3. History Gathering and Mapping
4. Metabolism of the Trauma
5. Moving Toward Integration/Resolution
6. Integration/Resolution
7. Learning New Coping Skills
8. Solidification of Gains and Working Through
9. Follow-Up

the rigors of the treatment, may be destabilized; conversely, a patient who makes a very sick appearance and is not given the opportunity to try a treatment that can lead to a definitive cure may be unnecessarily condemned to chronic invalidism. For example, one woman who appeared very disturbed and had been in state hospitals with a schizophrenic diagnosis for 13 years, once diagnosed with DID responded rapidly to treatment, integrated, obtained a Ph.D. in psychology, and became both widely published and successful in her chosen field.

The Algorithm

The algorithm represents a systematization of the literature's findings about the treatment of DID and the research on subgroups. Its recommendations are completely consistent with contemporary approaches to the treatment of DID as represented in mainstream texts such as the American Psychiatric Association's *Treatments of Psychiatric Disorders - III* (Kluft, in press).

The treatment of DID is a stage-oriented trauma treatment. The classic triphasic model for the treatment of trauma promulgated by Herman (1992) and a typical list of the stages of DID treatment (Kluft, 1991) appear as Table 1. In the definitive treatment of DID Herman's stage 1, Safety, consists of the first three stages of the DID model. In the supportive treatment of DID, Safety consists of the first two stages of the DID model. History gathering and mapping may be contraindicated except for the exploration of focal problems. In the definitive treatment of DID, Herman's stage 2, Remembrance and Mourning, consists of the fourth stage of the DID model, and partially overlaps the third. In the definitive treatment of DID, Herman's stage 3, reconnection, consists of the remaining DID stages 5 through 9. In the supportive treatment of DID, Herman's second and third stages are not pursued in a systematic manner, and such work

Table 2: An Algorithm for the Treatment of Dissociative Identity Disorder

I. Initial Assessment of the Patient
- A. If patient is motivated for treatment, go to II
- B. If patient is not motivated for treatment
  1. If patient is in distress/dysfunction, institute general supportive treatment and reassess periodically to reconsider options
  2. If patient is not in distress/dysfunction, discharge patient

II. Attempt to Achieve the Goals of the Phase of Safety
- A. If achieved, go to III
- B. If not achieved successfully, or if difficulty is encountered, review elements of Protocol (See Table 3)
  1. Address elements of Protocol
  a. If successful, go to III
  b. If unsuccessful, continue attempts at resolution
  If successful, go to III
  If not successful and patient is in distress/dysfunction, institute general supportive treatment and reassess periodically to reconsider options
  If not successful and patient is not in distress/dysfunction, discharge

III Attempt to Achieve the Goals of the Phase of Remembrance and Mourning
- A. If achieved, go to IV
- B. If not achieved successfully, or if difficulty is encountered, review elements of Protocol (See Table 3)
  1. Address elements of Protocol
  a. If successful, go to IV
  b. If unsuccessful, continue attempts at resolution
  If successful, go to IV
  If not successful and patient is in distress/dysfunction, institute DID/DDNOS focused supportive treatment (Boon, 1997) and reassess periodically to reconsider options
  If not successful and patient is not in distress/dysfunction, taper contacts and periodically reassess

IV Attempt to Achieve the Goals of the Phase of Reconnection
- A. If achieved, go to V
- B. If not achieved successfully, or if difficulty is encountered, review elements of Protocol (See Table 3)
  1. Address elements of Protocol
  a. If successful, go to V
  b. If unsuccessful, continue attempts at resolution
  If successful, go to V
  If not successful and patient is in distress/dysfunction, combine DID/DDNOS focused supportive treatment (Boon, 1997) with gentle exploration of difficulties surrounding proceeding to integration or resolution and reassess periodically to reconsider options.
  If not successful and patient is not in distress/dysfunction, taper contacts and periodically reassess to reconsider options

V. Address Residual Difficulties in Postintegration Therapy and Treat Remaining Comorbid Concerns
- A. If achieved, go to termination/follow-up status
- B. If not achieved successfully, or if difficulty is encountered, review elements of Protocol (Table 3) and completely reassess patient
  1. Address elements of Protocol and findings on reassessment
  a. If successful, go to termination/follow-up status
  b. If unsuccessful, continue attempts at resolution
  If successful, go to termination/follow-up status
  If not successful and patient is in distress/dysfunction, combine supportive treatment (Boon, 1997) with gentle exploration of difficulties surrounding proceeding to resolving residual difficulties and reassess periodically to reconsider options.
  If not successful and patient is not in distress/dysfunction, taper contacts and periodically reassess to reconsider options.

Table 3: Checklist for Suboptimal Progress by a DID Patient (Kluft, in press)

Process/Interaction Variables

Is the therapeutic alliance sufficiently strong to approach the work that must be done with security, safety, and stability?
Is there difficulty in the therapist-patient match?
Are the stance, pace, and modalities of the therapy optimally matched to the patient?
Is the patient apprehensive about dealing with traumatic material?
Is the patient fearful that working with alters will mean a loss of control?
Has the treatment completed the tasks of the stage of safety before moving on to trauma work?
as mapping or another form of inquiry discovered major alters?
Have the relevant alters been brought into the therapeutic process and alliance?
Does the patient need a moratorium?
Are life goals so compelling that the patient does not have sufficient motivation and/or energy for DID treatment?
Has the patient withheld crucial feelings about the therapist and/or the therapy?

Therapist Variables

Is the therapist too rigid to work well with DID?
Is the therapist competent in or willing to learn the modalities useful with DID?
Is the therapist too apprehensive to work comfortably with DID?
Does the therapist have enough experience (in general and) with DID to work well with the patient?
Does therapist skepticism or credulity interfere with his/her efforts?
Are countertransference issues proving problematic?
Is the therapist having difficulty working with the alters?

Patient Variables

Has comorbidity been identified and addressed?
Is the patient reluctant or non-compliant re: advisable assessments and interventions for comorbid conditions?
Does the patient have adequate ego strength to advance beyond supportive work?
Is the patient too pain-phobic to accept the healthy masochism essential for treatment?
Does fantasy-proneness complicate the treatment? If so, can it be controlled?
Is the patient willing to allow exploration of his/her "third reality" and retain adherence to external reality?
Are alters fearful of therapy, resisting the therapy, or sabotaging the therapy?
Are alters fearful that integration means their "death"?
Does the patient have a dysfunctional preoccupation with knowing "the truth"?
Is the patient's loyalty to known or alleged abusers interfering with treatment?
Does the patient fear punishment for making revelations?
Are there powerful shame-driven pressures toward secrecy and privacy?
Does the patient fear loss of control over rage if abuse is discovered/acknowledged?
Do cultural factors provide impediments to dealing with the treatment?
Are attachment issues making the patient so fearful of loss that this dominates them?
Are previous experiences problematic?
Are there difficult negative transferences, such as the traumatic transference?
Is the therapist perceived as either an abuser or a failed protector?
Was the patient exploited by, disappointed by, misdiagnosed, or treated suboptimally in a prior therapy?
Are issues of control interfering with progress?
Is a fear of dependency impeding therapy?
Is a modality of therapy or a medication being refused due to control or dependency issues?
Does the patient have a characterologic as well as a symptomatic dissociative psychopathology?

External Factors

Are logistical difficulties resulting in suboptimal treatment arrangements?
Is the patient deeply upset by media representations of DID, abuse, or related issues?
Are third parties interfering with the therapy?
Is revictimization occurring?
Are intercurrent stressors compromising the therapy?

Tab. 4: Hypnotic Interventions Useful Specifically with DID

1. Accessing Alters
2. Alter Substitutions
3. Reconfigurations
4. Ideomotor Questioning
5. Provision of Sanctuary
6. Bypassing or Attenuating Intense Affect
7. Slow-Leak Techniques
8. Curtailing Abreactions
9. Fractionated Abreactions
10. Facilitating Abreactions
11. Gathering Historical Data
12. Time Sense Alteration
13. Distancing Maneuvers
14. Facilitating Integration
15. Temporary Blendings of Alters
16. Integration Rituals
17. Recheck Protocols
18. Symptom Relief and Symptom Substitution
19. Teaching Autohypnosis
20. Suppressive Measures
21. Trance Ratification
22. Relapse Prevention

Tab. 5: The Stages of the Algorithm

1. Initial Assessment of the Patient
2. Attempt to Achieve the Goals of the Phase of Safety
3. Attempt to Achieve the Goals of the Phase of Remembrance and Mourning
4. Attempt to Achieve the Goals of the Phase of Reconnection
5. Address Residual Difficulties in Post-Integration Therapy and Treat Remaining Comorbid Concerns

Tab.6: Hypnotic Interventions From Table 4 Associated with Initial Assessment of the Patient

1. Accessing Alters (under certain circumstances)
4. Ideomotor Questioning (under certain circumstances)

Tab. 7: Hypnotic Interventions From Table 4 Associated with Attempt to Achieve the Goals of the Phase of Safety

1. Accessing Alters
2. Alter Substitutions
3. Reconfigurations
4. Ideomotor Questioning
5. Provision of Sanctuary
6. Bypassing or Attenuating Intense Affect
8. Curtailing Abreactions
11. Gathering Historical Information (with appropriate cautions)
12. Time Sense Alteration
13. Distancing Maneuvers
15. Temporary Blendings
18. Symptom Relief and Symptom Substitution
19. Teaching Autohypnosis (with caution)
20. Trance Ratification

Tab. 8: Hypnotic Interventions From Table 4 Associated with Attempt to Achieve the Goals of the Phase of Remembrance and Mourning

1. Accessing Alters
2. Alter Substitutions
3. Reconfigurations
4. Ideomotor Questioning
5. Provision of Sanctuary
6. Bypassing or Attenuating Intense Affect
7. Slow-Leak Techniques
8. Curtailing Abreactions
9. Fractionated Abreaction
10. Facilitating Abreaction
11. Gathering Historical Information (with appropriate cautions)
12. Time Sense Alteration
13. Distancing Maneuvers
14. Facilitating Integration
15. Temporary Blendings
18. Symptom Relief and Symptom Substitution
19. Teaching Autohypnosis (with caution)
20. Trance Ratification

Tab. 9: Hypnotic Interventions From Table 4 Associated with Attempt to Achieve the Goals of the Phase of Reconnection

1. Accessing Alters
2. Alter Substitutions
3. Reconfigurations
4. Ideomotor Questioning
5. Provision of Sanctuary
6. Bypassing or Attenuating Intense Affect
7. Slow-Leak Techniques
12. Time Sense Alteration
13. Distancing Maneuvers
14. Facilitating Integration
15. Temporary Blendings
16. Integration Rituals
17. Recheck Protocols
18. Symptom Relief and Symptom Substitution
19. Teaching Autohypnosis (with caution)
20. Trance Ratification
22. Relapse Prevention

Tab. 10: Hypnotic Interventions From Table 4 Associated with Address Residual Difficulties in Post-Integration Therapy and Treat Remaining Comorbid Concerns

4. Ideomotor Questioning
5. Provision of Sanctuary
11. Gathering Historical Information (with appropriate cautions)
12. Time Sense Alteration
17. Recheck Protocols
18. Symptom Relief and Symptom Substitution
22. Relapse Prevention

will be avoided except when it is necessary to address it to resolve a problem.

The algorithm (Kluft, in press) was constructed so that if the goals of any particular stage of treatment cannot be achieved, obstacles to success are systematically reassessed and addressed. All treatments, if they start at all, begin with initial safety phase concerns, supportive efforts to make the patient feel safe, and to build the patient's strengths.

The algorithm proposes an ongoing monitoring of the therapeutic process based on the clinical realities with which the therapist-patient dyad is confronted. Whenever difficulties are encountered, the therapist can use the Protocol (Table 3) (Kluft, in press) to study the problems at hand. There are only a small number of issues that require further comment.

The first is that at some early stages the recommendation is made to depart from further DID evaluation or DID therapy and to institute general supportive psychotherapy, while in later stages the recommendation is made to institute DID/DDNOS (Dissociative Disorder Not Otherwise Specified) focused supportive treatment. This is because once a relationship has been formed with alters, and the patient has lowered some of his or her dissociative defenses, the supportive treatment should address the alters when appropriate, and respond to their concerns in order to move the treatment forward. Often an ego-state therapy approach (Watkins & Watkins, 1997) is most helpful under these circumstances.

The second is to emphasize the importance of ongoing reassessment. Many middle-trajectory patients and low-trajectory patients spend considerable periods of time in an apparent impasse before they are able to move forward. If the therapist does not bear this in mind, many patients who could improve dramatically will not be given another opportunity to move toward a definitive resolution of their conditions.

Fitting Hypnotic Interventions to the Algorithm

Many hypnotic interventions useful with DID patients are also useful with other groups of patients; however, a certain group of interventions have become associated with the treatment of DID (Kluft, 1992, 1994c). This group of techniques is listed in Table 4. Although enough overlaps and atypical and unusual circumstances occur in the treatment of DID to make generalizations difficult, it is possible to offer some comments about which hypnotic efforts are likely to be associated with which stage of the algorithm. The major stages of the algorithm are listed in Table 5. The successive tables indicate which hypnotic interventions are associated with each stage.

Discussion

This algorithm expresses an approach to the treatment of DID and allied forms of DDNOS that is consistent with the findings of mainstreams contributors to the treatment of the dissociative disorders. It is offered both as a guide to clinicians and as an ombudsman for the protection of the interests of dissociative disorders patients. It is especially designed to address the problems and uncertainties that surround the treatment of the so-called middle group or middle-trajectory dissociative patients.

Most high-functioning or high-trajectory patients ultimately do well in DID-oriented therapeutic approaches. Experienced and expert DID therapists will bring them to health more rapidly than the novice or neophyte, but genuinely concerned and motivated therapists willing to learn to deal with this patient population can be very effective with this strong and dedicated subgroup. Most low-functioning or low-trajectory patients will require either a completely supportive approach or a long period of supportive therapy before they are stable and strong enough to be considered for a definitive treatment. More of this group will stabilize rapidly or gradually become stronger with the experienced and expert DID therapist, but most will be well served by a dedicated therapist of any level of experience.

However, middle-group and middle-trajectory patients do dramatically better with the expert and experienced therapist, largely because such clinicians are less likely to be misled into despair or indifference or burn-out by their frustrating prolonged courses, and less likely to mistake their often dramatic fluctuations in function and stability for definitive improvement or serious deterioration. For therapists struggling with this group of DID patients, the use of the algorithm and protocol can be extremely helpful in monitoring the progress of the therapy and guiding the choice of interventions.

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