TREATMENT OF DID AND DDNOS PATIENTS IN A REGIONAL INSTITUTE FOR AMBULATORY MENTAL HEALTH CARE IN THE NETHERLANDS: A SURVEY

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ABSTRACT

To survey the number and characteristics ofDID and DDNOS patients treated at a Regional Institute for Ambulatory Mental Health Care in the Netherlands, their treatment goals and treatment course, and the organizational investment, semi-structured interviews were held with therapists about all patients diagnosed with D1D or DDNOS during a three-month period (May 31, 1993 - August 31, 1993), and a study of these patients' files took place. One hundred one patients received a dissociative disorder diagnosis, i.e., forty-one the diagnosis of DID and sixty the diagnosis of DDNOS. On average, these patients received the dissociative disorder diagnosis after a treatment period of over two years. Most therapists followed a basic stage-oriented treatment model. In the majority of cases, hypnosis was an important adjunctive technique. For more than half of the patients (DID:53.7%; DDNOS:60.0%), therapists reported stabilization and symptom reduction as the treatment goal. For one-third (DID: 39.0%; DDNOS: 31.6%), the focus included treatment of traumatic memories as well as reintegration and rehabilitation. This objective was chosen within one to three years of stabilization and symptom reduction. Average treatment length was six years, most often with a frequency of one session a week. In 10% of all cases, a second therapist joined the treatment. Therapists reported concern with regard to: boundary issues, co-therapy, diagnostic issues, (contra) indications for treatment of traumatic memories, attachment problems, cooperation with other agencies, underdevelopment with regard to dissociative disorders in child and adolescent mental health care. The emphasis on supportive therapy only and the use of secondary therapists may perhaps be different from clinical approaches elsewhere.

INTRODUCTION

In the past decade, the dissociative disorders field in the Netherlands has closely followed North American clinical and scientific developments (Boon & Draijer, 1993; van der Hart, 1993; Vanderlinden, 1993). An increasing number of clinicians in both outpatient and inpatient treatment settings are diagnosing and treating patients with dissociative disorders, in particular, dissociative identity disorder (DID, formerly multiple personality disorder [MPD]) , and research in this important area is receiving more and more attention. As this patient population presents a "formidable challenge to the mental health treatment system" (Putnam & Loewenstein, 1993, p. 1051) , it is also felt in the Netherlands that systematic evaluation and research of current treatment practices and their effectiveness is urgently needed.

In one of the pioneering institutes in this clinical field in the Netherlands, the Regional Institute for Ambulatory Mental Health Care Amsterdam South/New West (Riagg Z/NW), an increasing number of patients have received the diagnosis of DID or DDNOS in recent years. In response to this development, a so-called dissociation team was created within the department of adult mental health care, consisting of clinicians specialized in diagnosis and treatment of these patients. However, also an increasing number of other therapists became involved in the treatment of one or more DID/DDNOS patients. Because it was felt that a disproportional amount of time and energy was directed toward the treatment of these patients, serious questions regarding the treatment intensity, goals, and effectiveness were raised by the institute's management as well as by clinicians (both within and outside the dissociative disorders field).

A few outcome studies done by North American leading authorities in the field indicated favorable treatment outcome for patients with DID (Coons, 1986; Kluft, 1982, 1984, 1986, 1994) , in particular, the studies done by Kluft. However, Kluft (1994) observed that very recently increasing numbers of clinicians in the field have been taking a more guarded and even rather sombre and disillusioned view of the prognosis of DID, despite earlier optimistic reports on therapeutic progress. This view is reflected in opinions of clinicians in the Riagg Z/NW, both with more and less experience in the treatment of DID/DDNOS patients. Like elsewhere, there exist

within the Riagg differences of opinion regarding the feasibility of therapies aimed at the treatment of traumatic memories and at integration. Therefore, it was felt that a first attempt should be made to assess specific characteristics of the population of patients with DID and DDNOS diagnosed as such, and the nature, course, and goals of the respective therapies. Also, the organizational investment of the therapists involved and the institute as a whole in the treatment of this clinical population would have to be investigated.

In the initial phase of this study, it became apparent that therapists treating DID/DDNOS patients were very interested in the following areas, which subsequently became an extra focus in this study: a) the relationship between the number of treatment years at the Riagg Z/NW and the treatment purpose formulated by the therapist, b) the relationship between this treatment purpose and the treatment course, and c) the differentiation between DID and DDNOS patients on the relevant items of this study.

In this study, the treatment of DID/DDNOS patients is described in terms of Janet's stage-oriented treatment model (van der Hart, Brown, & van der Kolk, 1989), which is not only mostly used by the therapists of the Riagg Z/NW, but is also gaining recognition in the field of post traumatic stress and dissociative disorders at large (Herman, 1992; Horevitz & Loewenstein, 1994; Kluft, 1993). This treatment model consists of three clearly delineated phases, which in practice often overlap: 1) stabilization and symptom reduction; 2) treatment of traumatic memories; and 3) reintegration and rehabilitation.

METHODS

Instruments

A semi-structured interview for each patient was held with therapists treating DID/DDNOS patients at the time. The concerning therapists represented different mental health disciplines (psychiatry, psychology, and psychiatric nursing). The interview contained such topics as diagnostic assessment, purpose and nature of the treatment, treatment phase, treatment frequency, treatment course, organization of the institute concerning DID/DDNOS treatments, and collaboration with other institutes.

Also *a file-study* per DID/DDNOS patient took place, assessing client data, clinical reference and admittance, diagnostic assessment, crisis contacts, psychiatric hospitalizations, medication, and treatment history.

Subjects and Procedure

All therapists of the departments Adult Mental Health Care, Youth and Adolescent Department, and Psychotherapy of the Riagg Z/NW were sent a letter informing them of the research study and seeking their consent to participate. They received a form on which they could state if they treated DID/DDNOS patients at that moment and how many. The researcher called the therapists who answered affirmatively and a date was set for administration of the semi-structured interview.

During a three-month study period (May 31, 1993-August 31, 1993), a file-study for each DID/DDNOS patient was performed and an interview held with the concerning therapist. Files were studied preceding the interview-administrations.

Data-Analysis

The nature of the data obtained by the research study was for the greater part descriptive. In order to summarize these data, frequencies, means, percentages, and standard deviations were calculated. To differentiate between DID patients and DDNOS patients, both groups were compared with each other on the relevant items. A statistical procedure (T-test) was not deemed appropriate because of statistical restrictions in the case of a population study (Baarda & de Goede, 1991) . Correlational analyses were used to determine the relationships between treatment years and treatment purpose, and between treatment purpose and treatment course. Additionally, therapists offered some relevant points of discussion during the interviews, which are included in this study.

RESULTS

Patient Characteristics

Number of Patients

In the period of this study, altogether 101 dissociative disorder patients (41 DID patients, 60 DDNOS patients) were treated at various departments of the Riagg Z/NW. Adult Mental Health Care (including the dissociation team) constituted 58.8%, Psychotherapy 20.5%, and Youth and Adolescent Department 20.6%. This was 4% (DID: 1.6%; DDNOS: 2.3%) of the total number of patients who were treated individually in these departments over the same period. It is unknown if the number of 101 patients indicated the real prevalence of DID/DDNOS patients in the Riagg Z/NW, because the findings of this study depended on the responses of individual therapists rather than formal, standardized research procedures. Patients in group psychotherapy were excluded from this survey, and mental health professionals affiliated with the department of Geriatrics and the AIDS Team as well as the Intake Team were not contacted.

Clinical Presentations

The DID and DDNOS patients came into therapy with a diversity of complaints: depression, anxiety disorders, phobias, eating disorders, somatic complaints, etc. Apart from these more general complaints, for considerably more DID patients than DDNOS patients, therapists subsumed the initial complaints under the typical symptom clusters of dissociative disorders: amnesia, depersonalization, derealization, identity confusion, and identity alternation. This picture was

TABLE 1
Comparison with Four Prevalence Studies on Childhood Trauma

	Putnam et al. (1986)	Ross et al. (1989)	Ross et al. (1990)	Boon & Draijer (1992/93)	Present Study (1993)	
	DID	**DID**	**DID**	**DID**	**DID**	**DDNOS**
Childhood physical and/or sexual abuse	97.0%	88.5%	95.1%	94.4%	83.0%	58.3%
Childhood sexual abuse	83.0%	75.0%	90.2%	77.5%	78.0%	46.7%
Childhood physical abuse	75.0%	74.9%	82.4%	80.3%	80.5%	33.3%

more vague for DDNOS patients: initially, they presented with more general complaints as mentioned above and less with typical dissociative problems.

The mean number of fourteen alters of the DID-patients found in the present research (SD = 3.0, range = 140+) is similar to the mean number of fourteen (alters) found in other research studies (Boon & Draijer, 1993; Putnam, Guroff, Silberman, et al., 1986; Ross, Norton, & Fraser, 1989; Schultz, Braun, & Kluft, 1989).

Trauma History

Although the clinical presentation and life circumstances of DID/DDNOS patients varied, all of them reported a history of chronic traumatization similar to the findings of large research studies (Putnam et al., 1986; Coons, Bowman, & Milstein, 1988; Ross et al., 1989; Ross, Miller, Reagor, et al., 1990; Boon & Draijer, 1993).

Table 1 shows a comparison with three other prevalence studies on childhood trauma (Putnam et al., 1986; Ross et al., 1989; Ross et al., 1990).

The results of these studies are fairly similar. However, in the present study, the percentage of reported childhood physical and/or sexual abuse, particularly in the case of DDNOS patients, is considerably lower than the same findings of the other studies. Most DID patients **in** the present study were ***both*** sexually *and* physically abused.

Table 2 shows more specific information on both explicit patient reports and therapists' suspicions of childhood traumatization.

Compared to DDNOS patients, DID patients obtained a higher percentage of sexual and/or physical abuse. They reported also much more often sexual and physical abuse by relatives, sexual abuse by third persons, Satanic and other ritual abuse, and the start of prolonged abuse before the age of six. DDNOS patients reported more often prolonged abuse beginning after the age of six. Table 2 shows that neglect in the childhood of DID and DDNOS patients was the most often mentioned form of childhood traumatization.

Although the existence of external corroboration of these trauma reports was not systematically investigated, some therapists reported that the patient's relatives, general physician, or friends had confirmed the traumatization. In several cases (10 patients, 9.8%) , there was also legal evidence, such as conviction of perpetrators, and physical evidence such as external and internal scars.

When therapists suspected childhood traumatization not explicitly reported by the patient, they referred to a combination of many clinical signs observed in the treatment of these patients, such as amnesia for large childhood episodes (which could not be explained as infantile amnesia) and dissociative episodes during treatment sessions in which trauma seemed to be re-experienced. These patients reported furthermore particular dreams, images, and drawings with traumatic content, which they did not explicitly describe as their own traumatic experiences. Therapists generally refrained from actively investigating the true nature of these manifestations.

TABLE 2
Patient's Reports on Childhood Traumatization

	TOTAL			DID			DDNOS		
	N	%	%	N	%	%	N	%	%
Sexual abuse by relatives	60	59.5	**67.3**	32	78.0	**85.4**	28	46.7	**55.0**
Sexual abuse by non-relatives	55	54.5	**59.4**	27	65.9	**70.7**	28	46.7	**51.7**
Physical abuse by relatives	54	53.5	**57.4**	31	75.6	**78.0**	23	38.3	**41.7**
Physical abuse by non-relatives	27	26.7	**29.7**	11	26.8	**29.3**	16	26.7	**30.0**
Neglect	75	74.3	**75.2**	31	75.6	**78.0**	43	71.7	**71.1**
Satanic/Ritual abuse	7	6.9	**13.9**	7	17A	**29.3**	0	0.0	**3.3**
Cultic (Not Satanic) /Ritual abuse	3	3.0	**7.9**	3	7.3	**12.2**	0	0.0	**5.0**
Sexual/physical abuse by preceding helper	5	5.0	**5.0**	3	7.3	**7.3**	2	3.3	**3.3**
Traumatic abortion	8	7.9	**7.9**	5	12.2	**12.2**	3	5.0	**5.0**
Total	101	100.0	**100.0**	41	100.0	**100.0**	60	100.0	**100.0**

**Percentages printed in boldface include cases in which the patients did not explicitly report this type of trauma while the therapists presumed their existence, based on many clinical signs.*

***Treatment History** and Preceding Diagnoses*

The average DID/DDNOS patient. within the Riagg did not present the clinical picture of a long treatment history and many preceding diagnoses, as described in the existing literature (Boon & Draijer, 1993; Coons, 1986; Kluft, 1985; Putnam et al., 1986; Rivera, 1991; Schultz et al., 1989). Boon and Draijer (1993) found an average of eight years of preceding treatment in their sample of DID patients, while in the present study a mean number of over two years (DID: 3.5., DDNOS: 2.5, SD-3.00, range: 0-12+) was found. Patients in the present study also received fewer preceding diagnoses compared with the DID patients in the study of Boon and Draijer. A quarter of all patients had never been in treatment before; more than half had never received psychiatric inpatient treatment and had not previously received a psychiatric diagnosis.

FIGURE 1
Indications and Contraindications Pertaining to a Treatment Focusing on Integration, as Mentioned by Therapists of the Riagg

Indications	Contra-indications
1. Sufficient motivation	1. Integrational focus is surrounded by ambivalence or even against the explicit will of the patient
2. Sufficient ego strength (e.g., capacities to grow, introspect, and form a trusting relationship)	2. Instability
3. Positive therapeutic alliance	3. Insufficient therapeutic alliance
4. Supportive social environment	4. Other priorities in treatment focus, such as child-rearing, finishing study, job maintenance
5. Traumata too intensive to be covered	5. Continuous abuse during treatment
	6. Intellectual incapacity because of age or disease

Treatment Phase and Treatment Purpose

More than half of all 101 treatments appeared to be in the phase of stabilization and symptom reduction, and more than one-third in the phase of treatment of traumatic memories or the phase of personality reintegration and rehabilitation. A minority of therapists (n - 12) did not conceptualize their treatment approach in terms ofJanet's three-stage model.

The treatment purposes, formulated by the therapists, varied from "getting acquainted" to full personality integration. In general, more than half of all the treatments were focused on stabilization and symptom reduction, and one-third on integration (including the treatment of traumatic memories) . The most frequently mentioned argument to limit treatment to stabilization and symptom reduction was "instability of the patient. " Most often mentioned arguments for "integrationalism" (Kluft,1993a) were "sufficient motivation" and "sufficient ego strength."

Correlation analyses show that an integrational therapy was increasingly aimed at in the first three years of treatment ($r = .33$, $p = .002$). After three years of treatment, this purpose was formulated less and less often.

Treatment Course

Several authors stress the importance for clinical practice of conducting treatment outcome studies (e.g., Boon & Draijer, 1993; Horevitz & Loewenstein, 1994; Kluft, 1984, 1986, 1993a, 1994) , for example, to determine which patients improve with therapy aimed at integration and which patients are better offwith treatment limited to stabilization and symptom reduction. Far from being a controlled-outcome study, this study paid some attention to the relation between reported treatment purpose and treatment progress. The latter was charted by asking therapists which signs of progress and which complications or setbacks they observed in their treatments. A favorable treatment course implied that therapists reported signs of progress and fewer complications. Correlation analyses and further comparison showed that in the case of a favorable treatment course, therapists focused more frequently on an integrational treatment. The reverse was also found to be true: if therapists had focused on an integrational treatment, a favorable treatment course was reported more often (see Tables 3 and 4).

Compared to DDNOS patients, the diagnosis was more often shared with DID patients (DID: 90.2%; DDNOS: 46.7%) . The treatment goal for DID patients was more often personality integration (DID: 39.0%; DDNOS: 23.3%), and these

TABLE 3
Correlations Between Severity of Treatment Complications and Nature of Treatment (In This Succession: From Supportive Therapy to a More and more Comprehensive Therapy)

	DID	DDNOS	TOTAL
1. Continued abuse during treatment		-.21 p = .5	
2. Secondary complications (e.g., counter-productive social relationships, financial problems, counterproductive contacts with other health professionals)	.32 p=.02		
3. Complex transference phenomena	.38 p=.07	-	.27 p=.08
4. Disruptive behavior in therapy			
5. Counterproductive behavior outside therapy			
6. Therapist reports very little complications	.26 p=.05		.16 p-.05

therapies were found more often to be in the phase of treatment of traumatic memories and personality reintegration than was the case with DDNOS treatments (DID: 43.8%; DDNOS: 33.3%) . Therapists reported more complications and, at the same time, more progress with DID patients than with DDNOS patients.

TREATMENT INTENSITY, LENGTH, AND FREQUENCY

The DID/DDNOS treatments within the Riagg Z/NW are intensive and of long duration, with a mean frequency of once a week. Therapists prognosticated a mean treatment length of six years. A secondary therapist joined the treatment in one-tenth of all cases. At the time this survey was being done, six DDNOS patients (10%) and fifteen DID patients (36.6%) were receiving very intensive treatment with a frequency of two to three times per week; often with crisis contacts, telephone calls, and in collaboration with a second therapist.

Therapists reported more on intensive treatments and collaboration with secondary therapists for DID patients than for DDNOS patients. Compared to DDNOS patients, DID patients received more medication, had more contact with crisis services, were more often hospitalized, and had more contacts by telephone or mail with their therapists.

Therapist Information

Reflecting on their treatments during the interview, therapists formulated several clinical concerns:

1) *Investigative issues:* Several therapists expressed the need for protocols and more cooperation with justice and police authorities on investigative issues, in particular with regard to suspected ongoing abuse.

2) *Collaboration with psychiatric clinics:* Although observing increasing collaboration with psychiatric clinics, therapists would still like to see an intensification of this collaboration in order to guarantee the continuation of care.

3) *Boundary issues and the burden of treatment:* Some therapists mentioned problems with setting clear treatment boundaries and limits. A few therapists reported feeling overwhelmed and exhausted because of the many crises and suicidal attempts of some of their patients. Others mentioned that their therapies of other patients

TABLE 4
Correlations Between the Level of Treatment Progress and the Nature of Treatment (In This Succession: From Supportive Therapy to a More and More Comprehensive Therapy)

	DID	DDNOS	TOTAL
1. An increase in the quality of life*	.34 p=.015	-	.28 p-.002
2. A growing working alliance		.34 p = .004	
3. Development of trust		.27 p=.018	
4. Development of insight	.46 p-.001	.22 p=.04	.32 p=.oo1
5. Acknowledgement of the diagnosis	.28 p= .04	.21 p=.05	.3 p=.001
6. Trauma-treatment takes place	.54 p=.00	.53 p=.00	.56 p=.00
7. Fusions have occurred	.39 p=.006	-	.26 p=.001
8. Total progress (composite of variables 2-7)	.37 p=.009	.33 p=.005	.44 p=.00

**Increase in quality of life contains: significant decrease in crises; increase in structure of life; retaking of responsibilities; breaking the abusive relationships; formulation of boundaries; cooperation between alters, leading to crises-reduction; the client lives more and more integrated.*

began to suffer under the demands from DID/DDNOS patients. Several therapists detected the symptoms of burn-out in themselves. Problems with setting clear boundaries led some therapists to seek consultation or supervision, and others to limit the number of DID/DDNOS patients in their caseload. Nevertheless, most therapists saw the multidisciplinary Riagg, with its many possibilities for case consultation and crisis interventions, as the best equipped outpatient treatment facility in the Netherlands for DID/DDNOS patients.

4) *Standardized screening and diagnostic procedures:* Some therapists wished that all new patients would be routinely screened using standardized instruments such as the *DissociativeExperiences Scale (DES)* (Bernstein & Putnam, 1986). Such scales could also be used to determine which patients should be further interviewed with the *Structured Clinical Interview for the DSM-IV Dissociative Disorders (SCID-D)* (Steinberg, 1993; Boon & Draijer, 1993), or the *Dissociative Disorders Interview Schedule (DDIS)* (Ross, 1989). These therapists mentioned the risk of both under-diagnosis and over-diagnosis of this diagnostic category when standardized instruments

are not used in current assessment procedures.

5) *Intensity and frequency of sessions:* Therapists differed widely in opinion with regard to the in tensity and frequency of the treatment. Some therapists, usually seeing their DID/DDNOS patients once in two weeks or less, expressed reservations about a higher frequency (e.g., more than once a week), because they feared it would increase the likelihood of crises. Others, however, reported a decrease in crises with a more frequent treatment contact. For many therapists, the question remained how to determine for each individual case the optimal treatment intensity and frequency.

6) *Co-therapy*. Although all therapists agreed upon the need for a substitute therapist in case of absence of the primary therapist, they differed in opinion about co-therapy, in which a second therapist is actively engaged in the treatment. Opponents of co-therapy mentioned the risk that patients will split or encourage splits between their co-therapists. Supporters were less afraid in this respect, mentioning this as a risk with only a minority of patients. Co-therapists were content with their collaboration and experienced it as very useful for their patients -- provided that mutual agreement was reached among all parties involved regarding role and task definition.

7) *Attachment-related problems:* Therapists often reported struggling with problems related to the patient therapistrelationship. They referred to patients' difficulties and confusion in maintaining boundaries; "clinging" behaviors; battles for control; rapid shifts in trust and distrust; re-enactments of the abusive relationship within the therapy; withdrawal. Several therapists reported complex (counter) transferential relationships with their patients, which overwhelmed them at times. Differing in the interpretation of these issues, some therapists discussed them in terms of "regression," "dependency," "splitting," while others interpreted the same difficulties in terms of Bowlhy's attachment theory (cf. Barach, 1991). Connected with this, therapists approached the problems differently; this varied from reducing the frequency of treatment sessions to an intensification of the treatment and an increase in availability for the patient.

8) *Child and Adolescent DII)/DDNOS:* Therapists of children and adolescents with DID/ DDNOS felt that diagnostic and treatment procedures for adult DID/DDNOS patients were not automatically applicable for children and adolescents. They expressed the need for developing specialized knowledge and care more suitable for these young patients. Early detection and treatment of DID/DDNOS were highly valued.

DISCUSSION

This study has several limitations. Because we approached therapists instead of patients, the real prevalence of DID/DDNOS-patients within the Riagg remains unknown. The detection of DID/DDNOS depended on the therapists, and not on systematic and standardized diagnostic research, although many therapists had used the DES and/or the SCID-D or DDIS. Based on results of a prevalence study of dissociative symptoms within the Riagg 'L/NW (Cohen, Wallage, & van der Hart, 1992), we hypothesize a higher prevalence of dissociative patients in the Riagg than found in our study. Using the DES, Cohen et al. (1992) found that 7.5% of all newly referred patients scored above the DES cut-off score of 30, which indicates serious dissociative psychopathology.

Because this study pertained to all known DID/DDNOS patients within one institution (i.e., a population study), some sample-based statistical operations (T-test) could not be executed (Baarda & de Goede, 1991).

With regard to the data pertaining to the relationship between treatment length and treatment purpose, relationship between treatment purpose and treatment course, and the differentiation between DID patients and DDNOS patients, no response categories were formulated in advance. Their construction was based solely on the actual responses given by the therapists in this study. This may imply that the results thus acquired are less significant than would have been the case if systematic categorization preceded the actual interviews. Kluft (1994) presents a very valuable instrument for evaluating therapeutic progress, i.e., the CSDS *Dimensions of Therapeutic Movement Instrument (DTMI),* with which we became acquainted only after the completion of this study.

It was found that the treatment history of patients within the Riagg was considerably shorter than the long treatment histories mentioned in the existing research literature. This is probably related to the fact that there is a growing awareness and expertise with regard to diagnosis and treatment of dissociative disorder in the Riagg Z/NW.

In the present study, the clinical picture of DID patients, in comparison with DDNOS patients, was generally more pronounced in at least four dimensions: trauma history, complaints and psychiatric symptoms, nature of treatment, and treatment course. For instance, they reported more complications during treatment but also more progress. Further

study seems to be needed to look into the question whether the DDNOS subgroup with little progress conforms to Kluft's (1994) category of low trajectory patients or whether therapistvariables are significant in this regard. One possible therapist variable is familiarity and clinical experience with regard to diagnosis and treatment of dissociative disorder patients. For instance, it could be postulated that novices in this field diagnose DID patients as having DDNOS *and* report less progress because of their inexperience with this difficult patient group.

We also saw that for more DID patients than DDNOS patients the diagnosis had been shared explicitly. Perhaps those treating DDNOS patients were uncertain concerning the correctness of the diagnosis, or decided not to share the diagnosis because of a particular therapeutic orientation; e.g., a minimization strategy (also mentioned by Kluft [1993a] and Fine [19931: "Leave it alone and it will go away."

For most of their DID/ DDNOS patients, therapists in this study did not opt for an integration-oriented treatment. Therapists seemed to be careful in their choice and argued in favor of this choice in terms of (contra)indications (cf. Boon & van der Hart, 1994). The findings of this study show that an integrational approach, based on indications such as motivation, ego strength, social support, etc., was indeed feasible. There was a positive relationship between treatment purpose and treatment course, (i.e., a more encompassing treatment goal corresponded with more treatment progress). However, this does not demonstrate a causality between the two variables: the choice of an integrational treatment purpose per se is not the cause of the progress of the patient. Factors such as ego strength and motivation, which play their part in the treatment choice, also influenced progress. Although this association cannot be causally interpreted, the indication for an integrational approach seemed to be based on reasonable considerations. Therapists in this study expressed an awareness of Kluft's (1993) findings that fully integrated ("unified") patients are far better off than are less integrated patients. However, they believed that for many DID patients this treatment goal is not feasible even in the long run, and therefore opted for an "adaptational " (treatment stage 1 only) approach. Further research regarding the indications for integrational versus adaptational treatment is urgently needed. Kluft's (1994) observations regarding different "trajectory subgroups" based on the DTMI *(The CSDS Dimensions of Therapeutic Movement Instrument)* seem to be extremely relevant in this regard. He showed that, using the DTMI, it would be possible at an early treatment phase to identify which patients belong to an optimistic, high trajectory group and which patients belong to a low trajectory group. Patients with a high trajectory show, for example, a high quality therapeutic alliance, a capacity for rapid mobilization and adaptive change, and a major focus on integration. In the low trajectory group, it is hard to establish change and self-efficacy because of an intense preoccupation with concerns other than integration. Our more tentative findings seem to support the importance of Kluft 's differentiation between high trajectory and low trajectory groups of DID patients. The clinicians in our study generally based their decisions for either an integrational approach or an adaptational approach on many of the characteristics which Kluft associated with the high trajectory group and the low trajectory group, respectively (see Figure 1).

Our findings also indicate that the clinicians opting for an integration did so within the framework of the basic stage-oriented treatment model for post-traumatic stress, recently also adopted in the field of DID. This model is indicative of a general consensus that a first stage aimed at stabilization is the necessary foundation for trauma-work (Brown & Fromm, 1986; Herman, 1992, Horevitz & Loewenstein, 1994; Kluft, 1993; Parson, 1984; Putnam & Loewenstein, 1993). During this stage, time is taken to establish safety, support, and structure in the therapeutic alliance. On this basis, therapists determine if an integrational treatment can he realized. In the treatments aimed at integration, including the treatment of traumatic memories, the stabilization stage had a duration of one to three years.

Although most of the therapists in our study followed this basic stage model for post-traumatic stress, thereby often including various hypnotic techniques, a few did not do so. Often based on consultations with specialists, these clinicians had discovered the dissociative pathology in their patients and used elements of the trauma/dissociation model in their therapies. However, they were basically following another theoretical approach. We have too little data to determine the effectiveness of these approaches, but there were some signs that not explicitly incorporating the stabilization stage in therapy was related to more reports of crises and problems with crisis and anxiety reduction as compared to therapists explicitly basing their approach on the stage-model for post-traumatic stress.

It would be of importance to analyze the treatment process of DID patients with an alleged Satanic or ritual (non-Satanic) background in comparison with DID patients without this background. The treatments of these `cult'-patients, which have been increasing in the last years, seem to require a different approach to cope with many complex dilemmas. In the three cases (out of twelve) in this study in which this issue became apparent in the course of an integrational approach, therapists shifted the treatment focus back to stabilization and symptom reduction only. Kluft (1994) reported that patients with a background of ritual abuse appear to progress "quite unevenly and unpredictably over the short run and about half as rapidly as patients who have never made such allegations" (p. 67).

Finally, Kluft (1994) mentioned the importance of the clinical axiom that the treatment of the DID patient is only as good as the quality of the therapeutic alliance. Many of the clinicians in our study connected problems with regard to this alliance with the frequency of sessions. We observed

differences in opinion with regard to the optimal frequency in these cases as well as a lack of a generally accepted theoretical basis for the resolution of these problems in. the therapeutic alliance. It seemed that the trauma/dissociation model did not provide sufficient theoretical insights and solutions for these issues. Recently, various clinicians have emphasized the importance of insights from attachment- and object-relations theories to explain and clarify difficult adult relationship patterns in survivors of sexual or physical abuse. An interpretation of these patterns in terms of dissociative/ post-traumatic pathologywould not be enough (Blizard & Bluhm, 1994; Nash, Hulsey, Sexton, Harralson, & Lambert, 1993). In our opinion, a comparison between these distinctive theories would be an important conceptual theme in the development of treatment models for DID/DDNOS patients (cf. Barach, 1991; Blizard & Bluhm, 1994; Briere & Runtz, 1993). ■

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