CLINICAL WORK WITH FAMILIES OF MPD PATIENTS: ASSESSMENT AND ISSUES FOR PRACTICE

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ABSTRACT

Partners and children of those who suffer multiple personality disorder may play important healing roles when they are able to be included in the therapeutic process. They can help map the system, provide emotional support, and contain episodes of rageful acting out. However, prior to beginning family therapy, the therapist must conduct a thorough assessment of family dynamics and individual members' strengths, coping skills, and levels of safety and trust in self and others. Themes of family treatment discussed in this paper include education, limit setting, contract development, mapping of alters, building a knowledge of the trauma history, creating family intimacy, recognition of individual needs, partners' issues, social skills training, and dealing with emotional impacts of multiplicity.

INTRODUCTION

Persons diagnosed as multiple personality disordered have experienced events which have disrupted their entire total life experiences. Their childhoods generally consisted of pain and suffering in a hostile environment from which they had no escape. Prior to their diagnoses, if they had conscious recall of their traumas, they attempted to interpret and assign meaning to what they remembered or sensed (Kahana, Kahana, Harel, & Rosner, 1988).

Multiples generally do not live in total isolation. They seek to have relationships, marry, have children, hold jobs—often before their multiplicity has been diagnosed. Their partners and children may play important healing roles if they are able to be included through therapy in the multiple's healing support system. Figley (1988) noted that the family is the most important supportive resource, if that family is able to mobilize itself and does not collapse under the strain of dealing with past traumas. Figley (1988) also noted that family members are frequently more able to detect changes of patterns of behavior or splits than are the multiples themselves.

In a safe environment, reasonably intact family members can urge survivors to talk about and even re-experience the traumas while confronting misperceptions or disturbed beliefs of guilt and shame. McCubbin and Patterson (1983) also discussed the social support functions of a family. They stated that support has three separate components: emotional support and care, esteem support of value and respect, and network support of mutual understanding and obligation. The family could also act as a buffer against further stress (Smith, 1983).

In many cases, though, a partner is not aware of the survivor's extensive abuse history, let alone the existence of separate and distinct alters. Instead, a partner may view the spouse as "spacey," changeable, unpredictable, or moody. He may observe his spouse acting childish at times or being someone he does not even know at others. Both partner and children suffer from what Figley (1988) calls "chiasmal effects"—the reactions that impact and infect family members. For example, a seven-year-old daughter of a multiple has developed school phobia because she fears that the alter that runs away will "come out" while she is at school. She wants to avoid coming home and finding her mother gone. However, if she stays home, she can, perhaps, stop that alter from appearing or, at least, intervene in a runaway episode through self-chosen bad behavior that would trigger a different alter.

Partners and children of multiples are forced, through virtue of their relationships, to deal with a variety of alters and the enduring impact of multiplicity. If they are kept in the dark and are not educated, if they are not included in therapy or as part of the safe world of the multiple, if their own issues concerning power, intimacy, abuse, and esteem are not examined and treated, true healing will not occur for the multiple or for the family system.

Controversy exists over who should treat the partner. Can the multiple's therapist be the couple therapist or the therapist for the partner as well? In my experience, if the partner is supportive, is willing to learn about multiplicity, and is also willing to work on his or her own issues, the answer may be yes. Sessions can be flexibly arranged to suit the material and family circumstances. Ninety-minute to two-hour sessions may include individual time with each of the partners and with the couple as well, when needed. Sessions might also include the children in family work or in individual sessions. The primary client, however, remains the multiple.

ASSESSMENT

A thorough assessment of family dynamics and the partner's and children's mental health must be conducted prior

to determining the extent of family involvement. Figley (1988) noted that family patterns of cohesion, adaptability, interpersonal social skills, and conflict resolution skills need to be considered and identified. Where does the family fall on a cohesion continuum ranging from fragmentation (and disengagement) to enmeshment (and no autonomy)?

Fragmentation .....Enmeshment
Disengagement .....No Autonomy

What has been the history of the current relationship? Have there been separations? What has been the quality of non-trauma related marital interactions (Carroll, Foy, Cannon, & Zweir, 1991)? How satisfied have the partners been with the marriage? Various instruments are available to measure these aspects of the relationship, including the Family Environment Scale (Moos, Insel, & Humphrey, 1974). How adaptable are family members? Are they able to respond to the system changes that are going to occur? How flexible is a partner's response to a change in the power dynamics in the family, particularly involving sexual expression or assertiveness? Does the partner allow the multiple space to work on healing, or is he too involved and too overprotective? Does he have a history of violence and aggression? What structure exists in the family? Where does the family structure fall on the continuum that extends from chaotic through flexible to rigid?

Another important question is how safe does the multiple feel in the relationship with partner and/or children? What would make her feel safer? What roles or rule changes would need to occur? Is there family violence? How much disclosure of information and emotion is permitted in the family? Is emotional expression valued? How much stress can the family tolerate in terms of abreactions of traumatic material? Who else in the family has had traumatic experiences that might be impacted and cause counter-transference reactions?

It is also important to assess the role that the multiple plays in the family. Is she viewed as the source of all family problems, and is the purpose of treatment just to "fix her" so that things can "get back to being the way they were"? To what extent do family members believe that she has destroyed what was thought to be "normal" family life, altering both functional and dysfunctional roles, meanings, and routines of the family? Are family members willing to revise their goals from "fixing" the multiple to "fixing" the family system?

It is also extremely important to assess a partner's strengths, personality traits, level of self-esteem, coping skills, tension-managing and releasing mechanisms, and level of safety and trust in self, in his partner, and the therapist. Questions for the therapist to seek to answer include the following: How committed is the partner to working on the relationship? How open to treatment is he? How much hope in the future does he see for the relationship and the continuation of the family unit? Does he see strengths in his spouse or is she a liability?

In initial interviews with the partner it is also important to evaluate, as McCann and Pearlman (1990) noted, self capacities and ego resources. How able is he to tolerate strong affect in himself and in his partner? To what extent does he emotionally anesthesize himself as a protective device? Is the partner aware of his unmet needs which are directly impacted by the multiplicity? How can he get those needs met? Can he use alone time to rejuvenate or does he fragment when alone? Can he calm himself and comfort himself when he is upset, frustrated, or feeling overwhelmed and in crisis? How able is he to regulate self-loathing when he falls short of his or his partner's expectations or when his own issues arise? Can he withstand rejection and even physical attack from angry alters? How much guilt does he assign to himself for what his partner is experiencing? How much compassion does he have? In other words, as Parson (1988) queried, can he serve as part of the therapeutic container for the multiple?

Murray and Kluckhorn (1953) identified numerous ego resources for both partner and multiple that help make healing easier. Intelligence, an ability to introspect, persistence, a fighting spirit, a strong sense of values, awareness of one's own psychological and emotional needs, the ability to distance oneself and gain a perspective when necessary, and the ability to establish boundaries and make positive decisions are important ego resources for the therapist to attempt to identify.

It is also necessary to learn as much as is possible about the partner's trauma history, particularly if that history involves serious abuse, post-traumatic stress reactions, outbursts of violence, or perpetration of abuse. If the interview reveals that the client has very poor ego resources and self-capacities, has an ongoing history of violence or perpetration, or is unwilling to look at himself, then partner work is generally not appropriate. Referral of the partner to, and use of, appropriate therapeutic resources would first be necessary.

THEMES OF TREATMENT

Education

When the therapist arrives at the diagnosis of multiple personality disorder, if the partner is a component of the multiple's supportive system and safety membrane, then it is important to share that diagnosis and discuss its impact with that partner and with older children. In my experience, children as young as six have been able to recognize different alters and to modify responses to those alters once they have been educated (on a simple level) about multiplicity. It is of utmost importance to educate family members about normal, predictable trauma responses.

Many partners are shocked by an MPD diagnosis and do not want to believe what they are hearing. As one partner asked, "Do you know what it is like to live with someone for eighteen years and suddenly realize that you don't know that person at all—that there are so many of them that you don't know how to relate and react?" Assessing where both partner and multiple lie on the belief continuum is part of this process. The belief continuum may be understood as extending from acceptance/belief, through minimization, to denial and rejection at its opposite extreme.

Much of the initial work with partners involves education about MPD. Normalizing the diagnosis and providing literature to the partner is extremely important. However, little has been written for partners (Maltz & Holman, 1987; Bass & Davis, 1987; Sachs, Frischholz, & Wood, 1988; Graber, 1991; Panos, Panos, & Alfred, 1990). Some partners may see the diagnosis as explanatory and validating while others view themselves as victims of the diagnosis. One partner wrote to me that "I married a person whose (history) would affect my life forever.... There was more emotional baggage than even entered my mind could have existed."

Acknowledging the existence of multiplicity changes the lives of the family. Suddenly partners and children must become aware of "who is out" and to whom they are talking. Helping partners to identify those alters and to recognize certain signs and evidences of switching, as well as what triggers the switching, is another part of the educative process.

Limit Setting

At times, the multiple may allow hostile, angry, perhaps homicidal or attacking alters to emerge. Their angry, raging outbursts may result in feelings of helplessness, fear, or even like rage in other family members (Williams & Williams, 1987). Some alters may intensely dislike and others may not even know the partner or children. Other hostile alters may view the partner as the enemy and, through transference, as an abuser or as representative of a group of abusers. It is important that the therapist help the partner or children to identify what period of time they are able to tolerate a verbal harangue or non-physical attack by an older, hostile alter before he/she attempts to get limits? Physical attacks are not to be tolerated. The reaction of the partner and/or children to hostile alters needs to be discussed and planned. If the partner has a low threshhold of anger and retaliates in a like manner to the hostile alter, a violent altercation may ensue, which can re-traumatize everyone involved.

It is therefore important to help the partner develop ways to cope with these hostile alters, ways that do not result in physical abuse for either partner or for the children. At the same time, the therapist assists the multiple to utilize constructive alters, including internal self helpers to regulate, interfere with or demand compliance of the hostile alter. One technique is to help both partners identify a means to bring back the host or internal self helper by a phrase, action, or behavior previously identified in therapy. If the alter refuses to respond to the identified technique, then the partner uses learned conflict resolution techniques and alternative ways to de-escalate the hostility. Removing knives from the kitchen and locking them up or leaving the house with the children could be possible responses.

Contracts

When an alter is present who acts out toward self, the therapist can help develop family and partner contracts concerning self-injury or self-homicide. The therapist may also teach partners crisis intervention skills and skills to help them deal with substance abusing or socially irresponsible alters. If the partner likes to smoke marijuana on a regular basis and an alter is present who is addictive, it is necessary to ask both partner and alter to become substance free and to get involved in a Twelve Step program. Establishing crisis responses, for example, deciding what to do should an alter become intoxicated and subsequently violent, lessens the fear of helplessness.

Another example of a needed response would occur if the partner comes home and finds a suicidal alter present. Pre-established routines for whom to call (therapist, hospital) and what to say build a sense of inner control and self-efficacy in the partner. As an example, if certain alters lock themselves in bathrooms with knives, the response of the partner becomes more assertive than if an alter sits in a corner, weeps, and says, "I wish I were dead." The partner and multiple, together with the therapist, can also develop a triage plan for when he takes her to an emergency room or a local dissociative disorders unit, if available. It is also important for the partner to remember what interventions have worked in the past— a warm bath, a phrase that returns the host, a certain record or movie or a pre-determined use of a grounding touch or significant tangible object.

Mapping the System

When all of the alters have not been identified, both therapist and partner become involved in the investigative mapping process. An alert, aware partner may get to know alters even before the host survivor is aware of their existence. As one client noted, "I never know who is going to be here when I get home from work. I may see three alters in ten minutes, or I have to ask myself, 'What personality is this?' " As another partner noted, this identification process can be "a challenge, adventurous at times, but never easy."

Building a Knowledge of the Trauma History

Partner, survivor, and therapist together discuss how much knowledge of the abuse he wishes to have as well as how many gory details of the traumas he can stand to hear. Does he want to know of each and every abuser or is the idea of sexual abuse revolting and unacceptable to him? Does the partner even believe that sexual abuse, let alone ritualistic abuse, occurred? Does the partner believe the multiple? How can he/she indicate belief and support?

Play and Intimacy

Partners may need help in learning how to respond to child alters who frequently do not trust, are hesitant to talk, and may need attention that, at first, appears to be "silly" and "babyish." One partner, for example, has learned that if he buys presents for the "little ones," he also cannot neglect the older alters. If they are not included in the "fun," they become angry and seek to retaliate against the "little ones" as well as him.

Partners may need to learn how to play with the child alters. For example, the therapist can help the couple think of ways that would allow both members to play (e.g., swinging, going for walks, bike riding, collecting pretty rocks). Playing together helps build trust in the adult partner. Also, the inner child of the adult partner gets reinforced through

this process.

Partners need to learn to deal with intimacy in the relationship in new ways. First, it is important to help family members identify their beliefs about intimacy. Asking both partners, and even several alters, to complete a belief scale such as the Williams-McPearl (1990) can help the therapist in this process.

Second, the partner needs to learn that if he asks for, suggests, or attempts sexual intimacy, there may be certain positions, sounds, or touches that cause dissociation or result in triggering a "little one" who fears sexual contact, to "pop out." This child alter may even view the partner as a perpetrator.

Unsuccessful attempts at intimate contact with a multiple can become very frustrating and cause extreme anger or feelings of helplessness and loss of control in the partner, particularly when switching is frequent. One partner has noted that "all of this stuff has inhibited my approach; I have to ask permission, now, if I can hold or touch my wife. Half the time I don't know where she is or who she is during making love and it just doesn't work."

Helping partners to find alternative ways to make love or even find acceptable sexual outlets or other avenues for fun is another part of this process. If it becomes impossible to have sex without causing a switch, is the partner then to use masturbation as an outlet? Is it acceptable within the relationship if he then rents pornographic movies to watch as a sublimation? Where and when can they be watched? If these and other similar issues are not addressed in therapy, then angry outbursts on the part of the partner may lead to fear, withdrawal, and terror responses in the small child alters. As we know, a terrorized child is less available to utilize the therapeutic process.

One partner stated: "Fun, what's fun? There may be moments of fun but it's really not fun and it's not easy. My advice: have as much fun as you can to distract, dissociate, to take a time out— take every opportunity to be humorous, it is essential for your individual survival and the survival of the relationship... have fun within whatever avenues as is legal, within the boundaries of self-acceptability."

Partners' and Children's Needs

Acknowledging the needs of the partner and the children in the family is another important issue to address. Whose needs are foremost and at what point in time? As Satir (1967) noted, needy persons with emotional hurt frequently seek out and find other needy, hurting persons as partners. However, neither member of the couple then has the inner resources to meet his/her own needs, let alone the needs of the other. The therapist can help establish contracts that address how the partner or children may say, "I have needs, too," or "I need a break."

Partners have the right to refuse to become co-dependent (and multiples have the right to refuse to allow partners to become co-dependent). Because the primary responsibility for self-healing rests with the multiple, not with the partner, that partner needs to learn when to say, "This is not my problem now," or "I cannot give anymore of myself now unless I get some of my own needs met." The multiple may also say, "I need space to work on my issues," or "I need time alone without your hovering and intrusion." Establishing this type of communication between multiple and partner or multiple and children requires an individualized approach to the family in conjoint and individual sessions.

More mundane needs and family issues must be dealt with in therapy as well. If it is essential that the multiple maintain employment if the family is to survive financially, then this family need must be addressed in therapy. Bills, budgets, and everyday responsibilities cannot be ignored by the couple or the therapist. Family roles and family rules, as well as family beliefs about basic survival, need to be made explicit and specific. If the multiple has been responsible for paying the bills and, at bill time, a child alter is out, does the partner then take over bill paying? What beliefs about safety and trust are challenged by this process? Who has power in the family to make decisions and when?

At times, according to Williams and Williams (1987), children in a family act out the family pathology. This is also true in a family where one member suffers MPD. One seventeen-year-old daughter of a woman multiple who gave a history of having experienced ritualistic abuse has recently decided that she wants to join a black magic cult. In spite of a house blessing, the daughter has kept occult paraphernalia in her room. Recently, when her parents told her she had to get rid of her black magic tools, she threatened suicide and has been repeatedly hospitalized. During the first hospitalization, her parents cleaned out her room. At other times in the past, she has planted things in the house (including her own cigarettes, dolls with eyes poked out) and then accused the alters of doing it without any conscious memory. She told her father that she has done these acts to "get back" at her mother for disrupting her life. She is presently committed to a state institution until her eighteenth birthday. She continues to express homicidal ideation toward the mother and now attests that she, too, is "hearing voices." She has no history of sexual or physical abuse. Thus, as Figley (1989) noted, the pattern of traumatic response in this family is being transmitted to the next generation.

Partners' Issues

As was previously noted, a partner also has his own issues and, frequently, a traumatic history of abuse which impacts the relationship. Partners may be in recovery and may or may not be involved in Twelve Step programs. Revelations of the multiple's traumatic material may trigger the partner's own previous abuses which must then be processed. If not, a recovering partner may be risking his own sobriety as he attempts to dissociate from what he now is learning or re-experiencing. One partner who recently celebrated one year of sobriety, after he was forced to ask for a temporary detention of his suicidal spouse, turned again to alcohol to escape his pain.

Partners also may have intense, angry feelings of revenge and hatred toward his own and his partners' abusers. These feelings and actual desires for revenge must be discussed and/or diffused.

Dealing with MPD must not become the only focus in a partner's life. If it does become the center of his existence, he becomes powerless and out of control of his own life. He may also become co-dependent if he uses his partner's multiplicity as a self-avoidance mechanism. This is particularly true if the partner envisions his primary role as trying to please of "fix" the alters and heal the pain of the multiple. On the other hand, the partner may also try to find ways to "control" the alters or become the caretaker for the entire system while ignoring his own issues or input into the system.

The therapist may ask the partner in an individual session or during a couple session to discuss how he believes the alters affect his life. To what extent does he feel controlled by them? What does he see as his role in his partner's healing process? What reactions, emotions, and memories do alters trigger in him? How much power does he believe he has over his own life or over the alters?

EMOTIONAL IMPACT

Anger

The emotional impact of MPD must also be explored. Partners and children need to be given permission to express their emotions within limits and specified non-harmful boundaries. One partner stated: "I feel as if I have been violated; all this does is interfere with our love and our life— I am angry." A partner may be extremely frustrated or may blame the multiple for disrupting his life. Children also have many angry feelings toward the multiple parent which may be expressed passively. Additional anger work can help them build more appropriate assertive responses.

Anger work with partners is also important if an angry outburst by a partner triggers a switch to violent alters. In one multiple, "Thomas," a hostile, extremely strong male alter attacks by kicking or slicing with knives when he/she is confronted physically or is yelled at. Thomas may also join with an alter called the "Crazy Lady" (who hates the husband) to attack the husband and blame him for any and all problems in the family. Helping the husband to modify his own angry outbursts and displays has resulted in a diminishing of Thomas's own need to protect the host personality. Helping him recognize the "Crazy Lady" and ask for the personality of the older, wiser helper to come out to subdue her also lessens the angry outbursts of the multiple.

The partner and children may be angry at the multiple and blame her alone for "putting them through all this." Suddenly their lives are changed forever. They have to be aware of so many different things—triggers, alters, PTSD, MPD. Their needs no longer can be met by a person who is not always "there." Thus, the partner or child who needs support and reassurance may no longer have available a major refuge or support system. Instead, the partner or even the child is forced to become the more stable person in the environment.

The partner may also become very angry when he learns of the abuse the multiple has experienced. He may want to avenge his partner or seek revenge from the abuser. He may feel frustrated when he realizes he cannot legally or safely lash out or physically hurt the abuser. Another partner wrote that "I am angered at her abuse and what it did to her and what it ultimately is doing to me, angered not at her but at her abuser who, hopefully, is rotting in hell. But there must be some anger in me that tells me I've been cheated from having a 'normal' life." Another said, "My hands are tied; if I did something, it wouldn't help anyway." Partners who are "fixers" or "doers" may be even more frustrated at their inability to "fix" the situation, let alone "fix" their partner.

Other partners are angry because they consider themselves to be a "victim of a victim"—as one partner wrote "unwitting victim, innocent bystander, an onlooker suddenly wholly involved in the incident not by choice or disposition but by happenstance." This feeling of deception and sandbagging or blindsiding may result in a less than sympathetic reaction by the partner.

The anger of the partner or the children needs to be accepted or acknowledged. They, too, have the "right" to be angry. Anger can be healthy if expressed in a healthy way. After all, their lives have suddenly changed and will never be the same. The reality of their knowledge of the past and the present, as well as their future expectations, have been challenged.

Pain

A partner may also feel great pain—the pain of knowing that a loved one experienced such horrors, the pain of counter-transference and sympathy. Helping the partner develop less overprotective, more appropriate empathic responses, therefore, is another goal of therapy.

Fear

A partner and children also frequently feel fear. They may wake up and find the multiple "in a corner, crying, afraid, a little animal who can't be approached, someone locked in a memory of abuse." Watching a multiple experience an abreaction of a memory can be "really, really hairy" for a child, as well as for an adult partner. Thus, a major goal of therapy is to help the partner and children deal with flashbacks and intrusive thoughts or nightmares. How can he reassure the multiple that he/she is safe? To what degree can a child help calm a child alter without feeling overly responsible, or guilty, if the alter is not calmed? These and other questions must be explored.

SOCIAL SKILLS TRAINING

Social skills training, or psycho-education, is also a part of the latter stages of therapy with multiples, their partners, and their children. This aspect of family work, according to Harris (1991) focuses more on solving presenting problems and taking concrete action. Hardley and Guerney (1989) stated that this aspect involves teaching expressive skills, empathic skills, discussion and negotiation skills, and conflict and problem-resolution skills. Figley (1989) added that healing includes helping the couple and family develop a sense of shared purpose, control, hope, and future orien-

tation. Coping with the trauma of multiplicity is easier if the family learns to manage tension, develops an external support system, takes out time to play, cooperates, reduces demands on members who have the highest levels of pain, uses humor, expresses emotions openly in a non-blaming manner, and reframes the situation into a positive growth-oriented, more manageable Gestalt.

There may be times or situations, though, in which the partner and even the children want to run away and escape. In reality, relationships must be extremely strong to withstand the test of multiplicity. If there is not a foundation of love, caring, and concern, it is quite possible that an unstable, egocentric partner will physically "split." As one partner noted, "it would be so easy to run." Treatment, therefore, as Parson (1988) noted, must help to develop the home as a place of sanctuarial safety from stress. Yet partners and children must also be helped to develop their own outlets and times for play. Partners need to be encouraged to take care of themselves in a non-narcissistic manner, by going to meetings, activities, physical outlets, getting rest, or just taking a break with friends.

CONCLUSIONS

A diagnosis of upsets the homeostatic balance in the family system. No matter how much power or control the partner or children try to exert, the multiple will never again become what he/she was before the diagnosis. Confusion, anger, frustration, ambivalence, and helplessness may replace feelings of security and safety as family members are unwittingly forced to deal with primitive alters and affect outbursts. A partner of a multiple cannot be available for every crisis, and cannot be expected to recognize every switch, every trigger, or every nuance of behavioral change. Instead, the therapist needs to help partners and children of multiples to recognize personal limits—when enough is enough.

The partner helps his/her spouse or significant other feel safe—safe enough to progress in his/her healing journey. Empathic listening, non-sexual touch, and supportive caring are part of this process. Still, the partner must be strong enough and have enough patience and resilience to be able to deal with repeated hostility, anger, rejection, threats, sexual abstinence, and hurt. As a partner noted, "I need to be sensitive and put myself in everyone else's (every alter's) position; I have to be empathy personified." To repeat, though, the therapist must never lose sight of the fact that the partner also has needs and issues as well.

Therapy with multiples and their partners must be flexible, creative, and focus on system-wide healing. Partners and children of multiples need to be given hope that their lives, someday, will again be more under control. Education that normalizes the traumatic response instills hope because it states that the survivor is not crazy. Development of successful social skills for the multiple instills hope as she learns to be assertive or communicative. The therapist who includes partners and children in practice, recognizing that multiples do not live in isolation, infuses hope into the evolving, changing, adapting family system. Family work will help that family with its legacy of trauma to become a resilient, responsive, cohesive, and balanced system. ■

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