

A GROUP FOR PARTNERS AND PARENTS OF MPD CLIENTS PART I: PROCESS AND FORMAT

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ABSTRACT

A group for partners and parents of clients with MPD provides an effective system of support and education. It enhances a sense of community, reduces the effects of stigma and secondary traumatization, and allows for the sharing of issues and concerns in a non-threatening environment. The group is a key part of our family treatment approach to dissociative disorders. This paper outlines a rationale for such a group, its history, format, and a summary of the process including co-therapy issues, parallel process dynamics, combined individual and group therapy issues, members' reactions to the group, and the effects of the group on the therapist.

INTRODUCTION

A Rationale for Supportive Work with Victims of Trauma

Multiple personality disorder (MPD) has been described as a variant of complex, chronic post-traumatic stress disorder (PTSD) with childhood onset (Herman, 1992). Sufferers of MPD, therefore, are a subset of the larger category of sufferers of trauma. According to Herman (1992), psychological trauma engenders feelings of terror, helplessness and entrapment with the accompanying core expressions of disempowerment and disconnection. The trauma literature unequivocally points out that trauma itself is contagious. McCann and Pearlman (1990) discuss the "vicarious traumatization" of people who work with trauma victims. They elaborate on how exposure to the trauma of others disrupts belief systems about trust, safety, power, independence, the "goodness" of people in general, and intimacy. Additionally, exposure alone may disrupt the memory system of the helper with flashbacks, intrusive thoughts, and dreams, as well as invoke uncomfortable feelings such as sadness, anxiety, or anger. Dyregrov and Mitchell (1992) have studied how the helpers of traumatized children suffer helplessness, fear and anxiety, existential insecurity, rage, sorrow, grief, intrusive

images, self-reproach, shame, guilt and changes in their system of values after exposure to child victims.

Other authors point out that family members of trauma victims also may suffer secondary victimization from contact with the traumatized person (Figley & McCubbin, 1983; Figley, 1985, 1988; Donaldson & Gardner, 1985; Maltz & Holman, 1987; Courtois, 1988; Carroll, Foy, Cannon & Zweir, 1991; Harris, 1991). In an effort to acknowledge the high stress in relationships with partners who have suffered severe trauma, a number of authors have written books or sections of books specifically for the partners of such victims (Lew, 1988; Davis, 1991; Graber, 1991; Gil, 1992).

In recent years, in response to the stress in the families of trauma victims, attention has been paid to the treatment of trauma victims' families. As early as 1971, Giarretto established a comprehensive treatment program for incest victims in Santa Clara, California which included self-help groups for both victims and family members (Giarretto, 1976; Giarretto, Giarretto, & Sgroi, 1978). Sgroi and Dana (1982) emphasize the treatment of mothers of incest victims and the simultaneous use of individual, dyad, group, couples, and family therapy in parental incest cases. Courtois (1988) also acknowledges the importance of family intervention and groups for partners and loved ones of incest survivors. Follette (1991) offers a treatment design for couples in which one is a survivor of childhood sexual abuse. Authors in the fields of child abuse and incest (Donaldson & Gardner, 1985; MacFarlane & Waterman, 1986; Maltz & Holman, 1987; Mara & Winton, 1990), torture trauma (Fischman & Ross, 1990), and holocaust trauma (Fogelman & Savran, 1979; Danieli, 1988) all recognize the need for work with family members of victims. Harris (1991) offers a model for family intervention in cases due to a post-traumatic stress reaction in a family member and Carroll, Foy, Cannon and Zweir (1991) recommend specific instruments to assess marital and family adjustment in a family with a member who suffers with PTSD.

An early precedent for the establishment of a group treatment plan for partners of a family member with a psychiatric illness was the establishment of Al-Anon, a self-help group for wives of recovering alcoholics (Al-Anon Family Groups, 1986). The idea for Al-Anon started in 1935 and evolved into a Family Group Movement for partners of alcoholics from 1951-1954. By 1957, Al-Ateen groups were forming to support the teenaged children of alcoholics. Currently, Al-Anon groups total over 16,700 in the United States and 28,000 world-wide, Al-Ateen groups total over 2,000 groups in the United States and over 3,000 world-wide, and Al-Alon

Adult Children groups total over 1,300 in the United States (Al-Anon Family Group Headquarters, Inc., personal communication, July 6, 1993).

In the MPD literature, a number of authors have published articles about family interventions (Beal, 1978; Davis & Ocherson, 1977; Brown, 1983; Levenson & Berry, 1983; Fagan & McMahon, 1984; Sachs, 1986; Kluft, 1986; Putnam, 1989; Sachs, Frischholz & Wood, 1988; Panos, Panos, & Allred, 1990; Williams, 1991; Benjamin & Benjamin, 1992a, 1992b, 1994). Although the group treatment modality itself has been used or recommended with dissociative clients themselves in the published literature (Caul, 1984; Coons & Bradley, 1985; Putnam, 1989; Caul, Sachs & Braun, 1986; Kluft, 1989a; Hogan, 1992), very little has been written about groups for significant others. Nelson (1988) presented a paper on how to develop a support-education group for significant others of clients with MPD and Farber with Hayse-Gregson (1992) have come up with an eight-week topic-oriented group treatment protocol for partners of abuse survivors. Brittain and Merriam (1988) describe the use of three group formats for significant others of survivors of child sexual abuse: a drop-in model, an educative course, and a workshop design.

The trauma literature suggests, and our own clinical experience confirms, that family members of an MPD client often "catch" the post-traumatic stress symptoms of their loved one. Family members frequently report feeling helpless, anxious, and isolated after learning of the diagnosis of MPD. Of course, it would be simplistic to suggest that the partners are merely unwitting victims of the trauma survivor. Partners themselves bring into the relationship their own unmet needs which are in a homeostatic balance with their loved one's needs. The issues of why partners may be attracted to their MPD mate in the first place and how marital dynamics operate in MPD couples are discussed in a companion paper (Benjamin & Benjamin, in press-b).

The idea of using a group format to support loved ones of MPD clients arose out of three very practical considerations. The first was the need to include the family in treatment without having the MPD client give up time in individual sessions. Because the course of treatment of MPD is often lengthy and the resources of time and money are limited, it seemed more efficient to see the family members on a regular, routine basis in a group format. The second was a need for a basic psychoeducational orientation about how to deal with common themes relating to a spouse with MPD (Benjamin & Benjamin, in press-a). A group setting allowed for a way to teach a number of people at the same time. Finally, the group provided mutual and consensual support and validation.

THE GROUP

History of the MPD Partners' Group

Because of our own observation of family members' struggles due to behaviors of their loved ones, the diagnosis of MPD, and the course of therapy, we decided in 1986 to begin a support group for partners of MPD clients. The history of the group can be divided into three phases.

Phase I

Initially, we invited all of the spouses of MPD patients within our own outpatient population. The offer of group support for a situation in which many people felt lonely and fearful was appealing for most. The group began with five members: one female and four males. Originally, we were quite strict about adhering to the criterion of including only spouses (married husbands and wives) of clients we were seeing in individual treatment. An exception was made to include one member married to a client who was well known to us but in treatment with a colleague.

After the first six months, we abandoned this restrictive admissions criterion. We realized that to populate the group entirely from clients we were seeing within our own practice would not be feasible. Also affecting our decision to revise our selection criteria were the requests of other therapists to refer spouses of their clients to our group.

Phase II

Phase II began with the decision to accept referrals from other therapists. We also began to accept members who were not married but living together in long-term (five to seven years), committed heterosexual relationships. Later yet, we became comfortable inviting the siblings of MPD clients (although none actually joined), and the non-abusive parents of adolescent clients. Finally, due to persistent requests, we admitted homosexual partners including one gay man and several lesbian partners. We prepared the existing group for this eventuality, and found surprisingly little discomfort from the straight members of the group (including several blue collar macho types who apparently did not realize the new members were gay until after deciding they liked them as individuals).

Additionally, we decided that the breakup of the marital relationship need not disqualify a member to continue in the group. We felt that established members of the group deserved support as they went through a divorce process. Of course, if children were involved they would continue in an ongoing co-parenting relationship with the MPD ex-spouse so their contact with the MPD client would continue long after the end of the marriage.

Phase III

The third phase of the development coincided with the 1988 opening of a specialty treatment program for Dissociative Disorders at a local hospital. Because the junior author was a principal founder of this unit, and served as a consultant and an active treating therapist, suddenly a much larger pool of applicants was available for the group. Now, we were deluged with many new referrals who clamored for inclusion. These referrals threatened to overwhelm the ability of the group to absorb them.

These new members markedly changed the character of the group in several ways. As might be expected, older members tended to become less frequent attenders when faced with the sudden influx of new, less experienced members. This mixture of members led to a situation of differing expectations. The newer members regarded the group

as an aid to the adjustment to the diagnosis whereas earlier members accepted the group as a component of long-term outpatient care with family participation as a recommendation of the therapists.

Eventually, these tensions were resolved after several shifts in the composition of the group. In the long run, the group functioned smoothly as an amalgam of clients from all three sources. However, as will be discussed later, it remained an issue that some clients saw one or the other of us in combined therapy while others saw other therapists individually and saw us only as group therapists.

SELECTION OF MEMBERS

Screening Procedures

We used formal screening interviews as are standard practice in outpatient psychotherapy groups (Yalom, 1975, 1985) with clients who were referred by other therapists. We directly admitted appropriate clients who were in individual treatment with one of us. The group has always had a large preponderance of male members with the number of female members ranging from a few to one, and occasionally to none.

Exclusion criteria

The principle exclusionary criteria were threefold:

- 1) the absence of a relatively good "fit" with the group;
- 2) if the member appeared to be a perpetrator of abuse of the MPD partner or child;
- 3) if the member was dissociative.

Regarding relative "fit," we looked at education, level of therapeutic sophistication, socioeconomic status, and the applicant's attitude toward group work. In spite of contraindications along these lines, some people joined the group anyway and functioned well. Still others joined and dropped out when their misgivings were confirmed.

A strong contraindication was that the applicant might be the abuser of the partner or the MPD child. Naturally, this was often hard to determine accurately in advance. Applicants were frequently accepted in spite of the fact that their behavior toward the MPD client had been less than exemplary. However, we absolutely excluded anyone who we feared had played a primary role in the etiology or perpetuation of the MPD patient's condition.

Our concern about having an openly dissociative member in the group has to do with the potential splitting of the group into two camps: the dissociative members vs. the non-dissociative members. The focus of the group has historically been how to live with someone who has MPD, and for partners, the exploration of why the partner got involved with the dissociative mate. Many marriages of people with MPD are eventually discovered to have two dissociative partners (Lindsley, 1986). Also, many of our child and adolescent cases prove to be examples of transgenerational MPD

with at least one parent who shares the diagnosis (Kluft, 1984b; Coons, 1985; Braun, 1985). Therefore, we try to carefully screen potential group members, partners and especially parents, for covert dissociation.

More problematic has been the issue of what to do when an already accepted group member him/herself discovers dissociative symptoms which were not apparent during the membership selection process. The overall principle has been that we fear that dissociation would be disruptive to the process of the group or inhibit discussion about the dissociative significant other. We have, on occasion, asked a member to leave the group when evidence of dissociative symptoms became apparent. These unfortunate events caused both rancor in the expelled member and embarrassment for the leaders and other group members. Confidentiality issues were a complicating factor since we felt constrained from fully explaining why the member would not be continuing with the group.

TYPE OF GROUP

Support Group

The group is conceptualized primarily as a support group although it has some elements of a therapy group (Yalom, 1985; Sadock, 1989). A fuller discussion of group types will not be included here. The psychotherapy aspect is purposefully diluted by the once-a-month frequency of meetings. Many of the members have previously been involved in Alcoholics Anonymous (AA) or Al-Anon programs so the idea of a group for support is congruent with their belief systems. Although our group is emphatically not a Twelve-Step type program (Henry & Robinson, 1978), the inclusion of many members already acculturated to use a group for support has helped set a tone for the group. Members who have participated in a 12-Step program view the group as a legitimate way to deal with a "problem": a significant other family member. However, we work to redefine this problem by looking at their reactions and their interactions with MPD mates and by asking the question of why they got involved with an MPD partner in the first place. These efforts are aimed at formulating an understanding of the couple as a marital unit and understanding their relationship dynamics. The issue of relationship dynamics is discussed in a complementary paper on partner types (Benjamin & Benjamin, in press-b).

PROCESS OF THE GROUP

The MPD partners' and parents' group is an open-ended process group that meets once-a-month on a Sunday evening. It has met without interruption for over seven years with considerable but gradual turnover in membership. Participants are aware that new members may join the group during an intervening month. We ask that members attend a termination session before leaving the group for good. The group meets in the larger play therapy room that adjoins the individual therapy rooms in our office suite. Beverages and candies are served at each meeting.

Groundrules

As the co-therapists of the group, we believe that part of our function is to encourage a cohesive group process in which people respect and listen to each other. A few ground rules are reiterated at the beginning of nearly every meeting, and especially when a new member joins:

- 1) Everyone has either a partner or a child who suffers with MPD. Consequently, all members have something in common. However, because each person comes from a different family with different values, attitudes, and beliefs, there are also differences. We ask that each person respect these differences.
- 2) While support and education are certainly group goals, we ask that members try to keep the focus of the sharing on *themselves* rather than on the MPD family member.
- 3) We request that members tell us in advance if they cannot attend a meeting and the reason why.

Naturally, in spite of ground rule #2, stories about MPD partners and children come up as part of the members' experience. However, the purpose is *not* to scapegoat the MPD loved one but to examine how the member is handling his side of the relationship. Wherever appropriate, the psychodynamic and family of origin roots of the interaction *for the member* are explored. In their group for significant others of abuse survivors, Brittain and Merriam (1988) see an inherent conflict in trying to keep the focus of the group members on themselves when so many issues that come up pertain to their survivor-partners. In our group, however, this has not been a significant problem. The firm groundrules and the group culture maintain the emphasis on the individuals in the room. If a new member begins to narrate extensive stories about his MPD partner's history, invariably another participant will remind the person that the focus is supposed to be on him. The leaders or more experienced group members then may ask the individual how that story has affected him or his relationship with his partner.

Goals

In general, the tone of the group is warm and supportive with a minimum of intrusiveness or psychodynamic interpretation. The co-therapists are directive to the extent that there is a push to get members away from looking at their MPD family member as the "sick" one. The members are invited to focus on *themselves* and the effects on them of living with an MPD family member rather than on what is happening in the MPD client's therapy or life in general.

Because it is described as an arena for education and support rather than solely a psychotherapy group, members often come in with specific questions about MPD. Although at times, we do give some direct "expert" answers, we try whenever possible to use the resources of the group to answer members' questions and concerns. Specifically, questions

directed to the therapists about how to handle a child's or partner's behaviors are usually redirected to the group in order to tap the "wisdom" of the group (Yalom, 1985). In that way, group members are encouraged to share their personal experiences. Older group members gain self-esteem from helping others understand and master concepts.

The group leaders do endeavor to provide links between members by pointing out similarities between situations or issues. The co-leaders intervene to answer the questions more directly only if the answers which are elicited from the group members miss the mark therapeutically. This may happen particularly if a member is perceived as needing more support or empathy than is being provided. After a therapist models such an interaction, other members are often freed up to join in with increased support and understanding of his issue.

Co-therapy Team

The trauma literature supports the notion of having a co-therapy team for a group of survivors (Cole & Barney, 1987; Walker & Nash; Courtois, 1988; Sgroi, 1989; Fischman & Ross, 1990; Koller, Marmor & Kanas, 1992). There are many benefits to having team leadership especially with a population that has suffered trauma: mutual support, shared observation and processing of material, and the potential for a lessening of the intensity of anxiety in the transference (Courtois, 1988). Additionally, two therapists can pick up each other's blind spots to decrease the interference of counter-transference (Sadock, 1989).

For groups of all women, many therapists prefer a female-female co-therapy team (Herman & Schatzow, 1984; Sprei, 1987) while others are not adverse to a mixed co-therapy team (Paddison, Einbinder, Maker & Strain, 1993). Yet other authors stick with the female-female recommendation because constraints in their therapy setting make it impractical to have a male therapist as part of the team (Goodman & Nowak-Scibelli, 1985). Some argue that a female-male team allows participants to work out gender-related issues with a leader from each sex (Tsai & Wagner, 1978; Ganzarain & Buchele, 1986; Coons & Bradley; Mara & Winton, 1990). In their groups for significant others of survivors of sexual abuse, Brittain and Merriam (1988), endorse the use of a male-female co-leadership team to provide modeling of a constructive couple relationship, and, in longer term groups, to furnish a "substitute" partner with whom to explore conflictual relationship issues. Sadock (1989) notes that transferences are not necessarily gender-specific and that regardless of gender a therapist can evoke opposite gender transferences in a client.

The co-therapists in the MPD partners'/parents' support group are a married couple. The female-male co-therapy team may replicate a surrogate family for participants (Yalom, 1975, 1985; Sadock, 1989). Additionally, the fact that the authors' team is married and has children together provides modeling of a couple relationship. Frequently, the co-therapists respectfully dialogue and offer differing perspectives on an issue. Communication between therapists offers hope to group members that giving and receiving is possible in a

cooperative, non-exploitative relationship. Usually the female therapist takes a more nurturant, supportive stance while the male co-therapist tends to be more confrontive. This may simply reflect differing therapeutic styles rather than a gender difference.

Parallel Process

Often a parallel process occurs in which the leader and a group member replay in group what goes on dynamically in the marriage of the member and the MPD partner. The partner who is needy and co-dependent with an MPD spouse may look to the leader to give care in a co-dependent way. Another example is the parallel fascination with trauma material that both the partner and the therapist may experience when a client regales both with some particularly tragic or gory stories. A most common parallel process dynamic (although not presently in the group because of our own experiences with mistakes of this sort in the past) is that of the partner of a newly diagnosed client displaying an over-fascination and pandering to the alter system much like a neophyte therapist often does when working with his first MPD client. A partner needs to be gently disabused of this tendency, preferably by group process rather than by direct feedback from the leaders.

Combined Individual and Group Therapy

At any given time, some members are in individual therapy with one of the co-therapists while others are not. Partners and/or children may or may not be in individual treatment with one of the co-therapists. Partners of some of the members are in the MPD mothers' group (Benjamin & Benjamin, 1992b). Indeed, it is consistent with our family treatment approach to have several different points of intervention with a given family.

Many other authors have written about the pros and cons of combined individual and group therapy (Stein, 1964; Porter, 1980, 1993; Rutan & Alonso, 1982; Yalom, 1975, 1985; Gans, 1990; Lipsius, 1991). Amaranto & Bender (1990) write about individual psychotherapy as an adjunct to group psychotherapy. Some members of the partners'/parents' group enter the group while concurrently in individual therapy either with one of the co-therapists or with an outside therapist, but many more get involved in individual psychotherapy either with one of the co-therapists or with an outside therapist as a result of insights gained in the group.

In our experience, we have found that having a therapeutic relationship with the group member, with the member's partner, or with a member's child has increased the commitment of the group member to the group. Those members whose only connection with us is the group have tended to attend only transiently. However, the fact that different kinds of therapeutic involvement outside of group exist between the therapists and group members may contribute to some members' rivalry with the therapist over the MPD client or competition in the group for the leaders' attention.

Members' Reactions to the Group

While the style of the partners'/parents' support group is not to interpret transference material that comes up for the clients, the therapists' own understanding of the transference material contributes to an appreciation of the process in the group. According to Yalom (1975; 1985), a co-therapy team enhances the range of transference reactions. Some common transference reactions in an adult female incest survivors' group were: splitting of the therapists into "good" and "bad," sibling transferences, mother-daughter transferences, and self-transferences or projection (Sprei, 1987).

Herman (1992) points out that trauma survivors have a characteristic "traumatic transference" in the therapeutic relationship. Terror and helplessness are two key feelings that always accompany trauma, and they tend to get played out in the therapy dyad. In our partners'/parents' group, it seems that some members "catch" the feelings of fear and helplessness and demonstrate them in the group. Some of the member responses that we have observed include:

Helplessness. The sense of helplessness often accompanies learning about the diagnosis of MPD of a loved one or living with a symptomatic partner or child. Helplessness may contribute to the participant's idealization of the therapist and of veteran group members as "experts." This may reflect parental transferences toward both the therapist and older, more experienced group members.

Hopelessness. The sense that living with an MPD partner or child is an endless process without hope of remediation tends to invoke a need to be rescued from an unbearable situation.

Anxiety. Typically, new group members enter the group with a great deal of fear and anxiety about the diagnosis, the process of therapy, the symptomatic behaviors of the MPD client, how they will manage daily living, and whether or not, in the case of partners, the relationship will last. The anxiety gets played out through the asking of lots of questions, monopolizing the floor without noticing the needs of others, or through being silent. Anxiety tends to evoke caregiving behaviors from group members and from the leaders.

Rivalry. In part because many of the MPD partners or children are seen in individual treatment with one of the co-therapists, often group members act out rivalrous feelings with the leaders for the MPD client. Sometimes a member is rivalrous with other members because of a need to feel special. The fact that some group members are in individual therapy with one or the other of the co-therapists may contribute to the sense of competition.

Over-idealization. Often new members enter the group with magical and grandiose expectations that the co-therapists will have all the answers. After they realize that we do not always have answers, they are freer to engage in seeking the support of others in the group.

Scapegoating of the leaders. Partners and parents of MPD clients are often very angry at their situations, at the perpetrators of trauma, at therapists who have misdiagnosed or hurt their family members, or at themselves if they have been unaware of abuse that was happening during the relation-

ship with a partner. Sometimes this anger is directed at the therapists who they may accuse of letting them down.

Intellectualization. Frequently, a way of avoiding the affective intensity of the traumatic material is to keep discussions at an intellectual level. From time to time, a member (usually a female) of the group has exhibited profound sadness with crying. Group members tend to be overwhelmed and uncomfortable with strong feelings and try to re-establish a more cerebral mode. The person who is crying tends to apologize for "disrupting" the group. The extreme discomfort of the group tends to mobilize the therapists into the role of rescuers.

Secretiveness. Often group members replay traumatic dynamics by withholding information from other members. A participant may relate a long story and neglect to disclose a key element. For example, for many months a member confided to the group about the deteriorating status of his relationship with his wife who was in the process of moving out and divorcing him. It took nearly six months for him to finally disclose the detail that, in fact, his wife was leaving him for a woman with whom she had been already having a homosexual affair for some time.

Effects of the Group on the Therapist

The trauma literature points out that therapists are affected by listening to traumatic material (Watkins & Watkins, 1984; Danieli, 1980, 1984; Coons, 1986; Kluft, 1984a, 1989a, 1989b; McCann & Pearlman, 1990; Comas-Diaz & Padilla, 1990; Dyregrov & Mitchell, 1992). Sprei (1987) notes that in groups of adult incest survivors, the therapists may defend themselves from the pain by minimizing the material, trying to rescue clients, expressing anger at the perpetrator, or being fascinated with sexual details without sufficient attention to the consequences.

Some of the responses that commonly come up for the co-therapists in our group are:

Parental Stance. Often the helplessness, hopelessness, and anxiety of group members evoke a parental response in the therapists. The refreshments that they provide could be viewed as "feeding" the hungry group members.

Rivalry. The rivalry on the part of some group members for the attention of the MPD partner or child when the MPD client is in individual therapy with a leader may evoke rivalrous feelings in the leader. Frequently, the leader may have more knowledge than the group member of both the events which have happened to the MPD client and also of the important intrapsychic material of the MPD client. Awareness of these details may contribute to feelings of power.

Guilt. Hearing traumatic stories and stories of dysfunctional marriages can lead to feelings of "bystander guilt" (Danieli, 1984) in the leaders. Additionally, having more knowledge of the intrapsychic material and the acting out behaviors of the MPD client than the partner has the potential to make the leader feel guilty.

Frustration. Listening to repetitive stories of over-giving to the MPD client on the part of the partners or parents may lead to an incredible sense of frustration. One partner shared how he continued to financially support his wife, pay for her

therapy, leave work to care for her, and listen to her upsets even after she left him for a lover, sent him divorce papers, and had a court order served to keep him out of her house after she tried unsuccessfully to re-seduce him.

Annoyance/Withdrawal. When a member continues to behave in ways that compromise physical or mental health, therapists may feel annoyed at the member. Continued annoyance can lead to withdrawal or distancing behaviors. Withdrawal can also occur when members deal with their issues through intellectualization.

Helplessness. The sense of helplessness and inability to cope on the part of the group members may lead to a sense of helplessness on the part of the leaders. In the presence of a group of people who seem to have few resources for maintaining healthy relationships, the leaders may feel overwhelmed and de-skilled.

Rescuer Fantasies. The partners and parents present themselves as victimized individuals. They have been victimized by the intrusion of trauma and MPD in their lives. Faced with a room full of victims, the therapists tend to fantasize about how to rescue them.

Fascination. The family life of members who live with an MPD client is often full of crises. The therapists may have a tendency to get caught up in the details of a way of life which can seem exciting and very dissimilar to their own more mundane lifestyle.

Anger. Therapists may feel angry that the group members have been secondarily victimized by the abusers who hurt the partners' MPD loved ones. Perpetrators were often able to cover up and continue their lives leaving the MPD client and her mate (or parent) to pick up the pieces. Additionally, the obliviousness of some partners to the abuse of their children early on in the marriage may evoke angry feelings in the therapist.

The co-therapy relationship provides a context for the therapists to process and resolve issues that come up during the group. Therapists can point out blind areas to each other and help to bring unconscious dynamics into awareness. Additionally, therapists can overcome counter-transference dynamics by obtaining expert supervision, and attending conferences, workshops, and study groups with knowledgeable colleagues.

SUMMARY

The partners' and parents' group of MPD clients provides an efficient way to help participants gain access to information, find support, and share with others who are in a similar situation. It helps to break down a sense of isolation through the building of a community. It reduces the effects of secondary traumatization and the stigma of having a family member with MPD, while contributing to the well-being of others by bearing witness to their pain. Additionally, a group format can be a less threatening milieu in which to address partner and parent issues than in individual or couples therapy sessions. Themes of fairness and unfairness in familial relationships may be addressed in a communal setting which replicates the family with the female-male co-

therapy team. Specifically, co-leaders can model both parental nurturing and limit-setting with group members as well as relationship-enhancing modes of communication.

The partners' and parents' group is a key part of our family treatment approach to dissociative disorders. From a family systems view, the whole family is viewed as the client, and the group helps to heal the system. From the point of view of a more traditional, individual psychodynamic and hypnotically augmented treatment scheme, it can be viewed as an important adjunct and aid to the therapy by its synergistic effect on addressing and correcting the marital and family dynamics. Both perspectives recognize the value of a group for partners and parents of MPD clients. ■

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