A GROUP FOR PARTNERS AND PARENTS OF MPD CLIENTS PART II: THEMES AND RESPONSES

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ABSTRACT

Over more than seven years, common themes have emerged in an adjunctive group for partners and parents of MPD clients. Those themes include: the diagnosis, how the family member "ought" to behave, anger, the sense and fear of loss, self-caring and setting limits, how much to trust the MPD client, the struggle to avoid becoming a ""therapist" family member, how to deal with the outside world, marital and sexual issues, how the therapeutic relationship of the MPD client affects the non-MPD group member, family of origin issues, credibility of the MPD client, the non-MPD family member as "monster," existential and spiritual issues, and changes in the relationship upon recovery. This paper examines these themes and therapist responses to the issues of self-care and exploitation, sexual dysfunction, sadistic ritual abuse, the repressed memory controversy, criticism of the MPD client's therapist and parenting.

INTRODUCTION

This paper serves as a companion to one on the format and process of the partners' and parents' group (Benjamin & Benjamin, 1994). It elaborates on the common themes and identifies the common concerns of family members of MPD clients. These basic themes emerged right from the beginning of the group and re-emerged consistently over the course of the seven year history of the group as new members have come and gone (Benjamin & Benjamin, 1992). We will attempt to elaborate on each of these themes and delineate some responses to issues which we deem either controversial or worthy of a directive stance.

As we explained in Part I (Benjamin & Benjamin, 1994) of this series, it is our preference to use the group process to answer concerns raised by group members. Clearly, however, our underlying attitudes and biases about what constitutes answers within the range of acceptability color our steering of the group process as the co-leaders. Many of these underlying assumptions flow from our overall family treatment approach to the therapy of the dissociative family (Benjamin & Benjamin, 1992) and from the philosophical tenets of contextual therapy elucidated by Boszormenyi-Nagy and colleagues (Boszormenyi-Nagy & Spark, 1973; Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Spark, 1984; Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991). For purposes of our discussion, the use of masculine and feminine pronouns is arbitrary as there are both male and female partners in the group and we see both male and female multiple personality disorder (MPD) clients.

COMMON GROUP ISSUES

The Diagnosis

Typically, when partners or parents enter the group, they bemoan the many false starts and disappointments they have suffered because of the usual delay in the diagnosis of the partner or child's dissociative disorder. They may experience both anger and confusion over previous misdiagnoses. They may initially fear that they cannot trust this new therapy. They often go through a grieving process as they become aware of the loss of time involved before they were able to start the MPD family member on the right track.

Concomitant with the grief over lost time, they also grieve over the diagnosis, and it may take a long time before they can accept it. They may experience feelings of shock because of the alleged rarity of the illness, at least according to the non-believing therapists who were previously consulted. Stress and feelings of being overwhelmed may emanate from a struggle between relief at finding out what is wrong and a strong wish to deny it.

They need to educate themselves about what MPD really means for their family life. As they learn more about the disorder, they become more aware of personality switches and how to identify the common triggers. When acceptance finally does come, however, they must face a life where they experience stress at every critical stage in the therapy: when the MPD client explores repressed memories, as new personalities or layers of personalities surface, as the MPD client improves, etc.

How to Behave

One of the first steps toward acceptance of the diagnosis by a family member is the attempt to appreciate the disorder: to conceptualize that the person involved is not a

whole person, but behaves as though she is many different people. It can seem incomprehensible at times, but without this appreciation, it is not possible to truly understand the complexities of the issues faced by everyone in the family.

Once the family member understands the disorder, the very practical question comes up of how a family member "ought to" relate to alter personalities. Should the family member call the alters by their designated names or should the name of the host personality be used across the board? What does one do if a child alter comes out and demands a bottle or a bath?

One female member of the group had to manage the dilemma of a horny teenage alter of her male MPD spouse coming out and demanding sex while previously the host personality had requested a moratorium on intercourse due to sexual fears and inhibitions. In her case, ethics prevailed, and even though the thought of sex was appealing, she did not want to proceed with behavior that might later be denounced as exploitative.

If an opposite gender alter who desires sex emerges, the partner is faced with finding himself in the predicament of being in a homosexual or heterosexual situation that may feel displeasing or uncomfortable. If a physically and/or verbally abusive personality takes over, the family member has to figure out how to protect him or herself and the children. Consequently, hearing what other people have to say about setting healthy boundaries is a major theme in the group.

Early on in the treatment process, we suggest to members that they meet and accept the MPD client's alters. As therapy progresses, members are encouraged to insist on accountability for behaviors from the entire system of alters.

TABLE 1
Common Group Issues

- the diagnosis
- how the family member "ought" to behave around the MPD client
- anger
- the sense of loss and fear of loss
- self-caring and setting limits
- how much to trust the MPD client
- the struggle to avoid becoming a "therapist" family member
- how to deal with the outside world
- marital and sexual issues
- parenting issues
- how the therapeutic relationship of the MPD client affects the non-MPD group member
- family of origin issues
- credibility of the MPD client
- the non-MPD family member as "monster"
- existential and spiritual issues
- changes in the relationship as the MPD client recovers

Anger

Because of the complicated nature of the situation, the task of coping with anger becomes an enormous one for a family member of an MPD client. What does a family member do with the anger experienced at an alter who may or may not be around later to deal with the anger provoking issue? Should a family member be expected to sit on his or her anger for fear of triggering a switch in personality? And where does the anger for the whole situation go? Where can it get expressed safely so it does not poison relationships inside the family?

Finally, as the causes of the multiplicity become clear, the family member must inevitably face the anger toward the source of the dissociative disorder. Often it has to do with the client's family of origin so that relationships with in-laws must be reassessed. In the case of a parent with a child who has MPD, the parent may have the gut-wrenching task of examining him or herself and the partner for possible complicity in allowing the causative trauma to occur or to continue unchecked.

The Sense of Loss and Fear of Loss

Many partners believe that their families have been unfairly and irretrievably damaged by the abusive actions of others. They are angry that their children may have been harmed. They often feel that they have lost the kind of life and marriage that they expected. They may feel overcome by an uncontrollable sense of grief. Additionally, they fear (not unrealistically) that their partner or child will never get well, will be chronically disabled, will be hospitalized long-term, will be disfigured, or will commit suicide.

Several older group members lamented that the time that they had with their partners post-childrearing was not the way that they expected it to be. Instead of traveling and recreating together, they worried about self-injurious behaviors, hospitalizations, and potential suicides, not to mention the medical and therapy bills which might be ruinously expensive.

Self-caring and Setting Limits

The issue of how to take care of oneself in the midst of a stressful marital situation is one that comes up over and over again. It is often hard for group members to understand the connection between caring for the self and setting limits. People who live with an MPD client can easily get drawn into a pattern of overgiving, which they perceive as "caring" (Benjamin & Benjamin, 1992). The idea of setting limits on giving may at first seem cruel to a partner. Consequently, accepting the suggestion of setting limits and then learning

how to set limits frequently becomes a major task for the partner. The group offers feedback to members both to credit them when they set appropriate limits and question them when they are giving too much.

One group member, whose MPD wife left him, spent months trying to figure out how to win her back, how to be "nice" to her, how to prove to her that he adored her. After sharing his anguish month after month with the group, he finally came to the realization that his wife no longer loved him or wanted him and that it was time to take care of himself. Another woman spent months bemoaning the abusive situation she lived in with her MPD husband. When she finally made the decision to leave him and take care of herself, the group supported her through the difficult aftermath of the separation.

People who had given up hobbies and avocations to take care of an MPD mate, realized, with the help of other group members, that without their own diversions and enjoyments, they could easily burn out and become embittered.

Trust

The two major components of trust are consistency and predictability. Neither one is characteristic of the MPD client. A family member may begin to question his trust in the MPD client. Will the MPD client be socially appropriate or will the couple have to withdraw to some extent from society? Can the MPD client be trusted with pills, knives, and alcohol in the house or does everything have to be locked up or discarded for fear of suicide attempts? Does the spouse have to moonlight as a private security guard or babysitter for an irresponsible or self-injurious MPD mate? The family member may come to the realization that while in some areas he may be able to trust the MPD client, in other areas he cannot. Trust levels tend to fluctuate. Realizing that trust cannot be gauged in black and white terms is useful for group members to learn.

Becoming a "Therapist" Family Member

Often family members fall into the "trap" of becoming a therapist to their MPD mates or children. As the MPD client learns to share with the partner more of the dissociative phenomena, the client can become more and more dependent in an inappropriately therapeutic way on the partner. If a family member is playing therapist for twenty-four hours a day, this kind of posture can quickly lead to burnout. While more often than not, the family member comes to some kind of realization that he needs to set some boundaries, we have also seen partners who were zealous to be their mate's therapist. One of the original members of the group left after the third session as he proclaimed himself to be his wife's true therapist. He ultimately sabotaged her therapy by conducting *his* "sessions" for free in the attic. She herself soon ceased to be involved in individual therapy for her MPD; rather, she continued to see the psychiatrist only infrequently for support around marital and parenting concerns with the underlying issues still simmering but pushed to the background.

The Outside World

Often the MPD client is not as clearly sick to the outside world as a person who suffers a physical illness such as emphysema or cancer. The MPD client looks okay to most people and likely looked normal to the partner at first. However, as the family member begins to become more aware of the MPD client's limitations, and as the MPD client becomes more overtly symptomatic as she goes further into therapy and the recovery of traumatic memories, the family member often finds himself having to help the MPD client deal with the practicalities of everyday living. The family member may have to begin writing notes, keeping calendars, and reminding the MPD client of appointments.

For the parent of an MPD child, the whole issue of helping the child maintain stability while in school looms large. The parents have to determine which counselors, teachers, and school officials to confide in.

Group members are affected by the many interactions that their MPD partners have with others outside the family: employer, co-workers, neighbors, and friends. Sometimes the family member feels compelled to cover up or make excuses for the behaviors of the MPD client. This issue confronts the whole idea of how responsible the family member is for the MPD client.

A group member who was engaged to and living with an MPD client epitomized this dilemma with a story. His fiancee had been repeatedly arrested for chasing men on the street while she brandished a knife. One of her personalities sought to re-enact an early traumatic episode in which she fought back against her attackers by randomly assaulting males. One day, while he was at work, he received a call from his fiancee. She had been picked up by the police for attempting to stab a man in a public park. She begged him to go to the police station to sign a document which said that she could go free if he, the group member, would vouch to be responsible for her good behavior. After he assured her that he would come as soon as he could leave work, he hung up the phone and was horrified with the magnitude of his pledge for her behavior. Was he willing to be held ultimately liable if she succeeded in murdering someone? While he did get her out of the police station, he made a conscious decision not to sign the good conduct papers. This story, although an exaggerated example of excessive caretaking, served as a shocking wakeup call and cautionary note to the other members of the group. While a family member can appropriately care for and support an MPD client, at some point, there is a limit to the amount of responsibility that is reasonable to accept.

Marital Issues

Another issue with which group members characteristically come to grips in the course of the group is wondering why they were attracted to their MPD partner in the first place. This question invariably forces them to confront themselves and their own issues and needs. Interestingly, while some people only knew one personality at the start of the relationship and were attracted for whatever reason to that personality, other people knew about their partner's multiplicity before the marriage or long-term relationship began

and then elected to stay involved. The latter individuals tend to fit into the "caregiver" category of spouses (Benjamin & Benjamin, in press). They may believe they can "save" the MPD client. In fact, however, once living the chaotic lifestyle of the MPD client, they frequently find themselves in a situation in which their giving never seems to be enough for the MPD mate.

Often during group sessions, members wondered out loud if the kinds of dynamics in operation in their marriages were directly the result of one of their partners having MPD or if they would be at play even if the spouse did not carry this diagnosis. Many members were frustrated because their idealized images of meaningful intimacy, open communication, and successful problem resolution in their marital relationships were not fulfilled.

Some group members confessed to fantasizing what it would be like to be free of the MPD client while others worried about losing the MPD mate. One of the group members had been left by his MPD wife during the process of her recovering from the disorder. Much of his time in the group was spent in doing grief work around his loss of her. Before he terminated with the group, he was much more reconciled to leading a life in which he did not have to care for her anymore. Another group member went through a separation and then divorce from her MPD mate. She used the group to get through that difficult time and to help her manage her continuing involvement with her ex-husband over the care of their children. A lesbian member of the group struggled to come to terms with a difficult decision to separate from her long-term partner during the course of her partner's therapy and accelerating drift into chronic dysfunction.

Sexual Issues

Sexuality is a common group theme since MPD clients have usually suffered sexual abuse, molestation, or other forms of physical abuse. The incest literature amply elaborates on the consequences of early abuse to later sexuality (Maltz & Holman, 1987; Courtois, 1988; Dolan, 1991).

Sexual dysfunctions are quite prevalent in the couples represented in the group. Spouses complain both of their partners avoiding sex altogether and of their demanding excessive and compulsive sex. Many members have lamented bitterly about how in the middle of the sex act, the spouse has switched to a terrified child who cries that he/she is being abused. One woman complained that her MPD husband wanted sex compulsively and frequently, but invited her to have intercourse in a boyish adolescent way which turned her off. The parents of adolescent MPD clients often have to grapple with the problem of children who act out repetitively through promiscuous sexuality as a sequela to their previous sexual abuse.

Parenting

For those couples with children, parenting issues are usually a major area of concern, particularly when the primary parental figure is the MPD client. Kluft's (1987) study of the parenting patterns of seventy-five MPD mothers demonstrated that 45.3% were compromised or impaired and 16% were grossly abusive. In our group, the main caregivers of children have been both male and female MPD clients. People in the group have children ranging in age from newborns through young adulthood. Several couples experienced pregnancies and deliveries during the life of the group.

The issues in parenting when one suffers from a dissociative disorder merit a complete article in their own right. Some of these issues, which we (Benjamin & Benjamin, 1992) have enumerated previously, include how the MPD client's parenting is affected by switching between alters, loss of memory, inconsistencies in relating to children, competitive feelings toward children, the impact of the parent's child alters, the inadequacy of family of origin parental role models, conflicts in the marital relationship, social problems that limit the ability to socialize the children, guilt for inadequacies, other complicating symptomatology that accompanies the MPD, and adjustments on recovery. All of these issues make it difficult for the MPD client to focus on the needs and demands of the children.

Because the MPD client is so needy, the non-MPD spouse has an additional burden for the childrearing beyond the pressure to care for the MPD mate. One spouse in the group literally feared for the safety of her children because her husband would drink several beers, switch personalities, and insist on driving the children to their various activities. She reported that his behavior with his children while on these jaunts was unpredictable and inappropriate. Another spouse had the experience of having his wife, in her persecutor personality, initiate sexual contact with their five-year-old son. Another member of the group had fears that his school-aged son, who identified very closely with his MPD mother, was already dissociative himself. A father of an MPD teenager belatedly realized over the course of a year in the group that his wife also suffered from MPD.

For the members of the group who were not yet married to their MPD partners or who were married but had not yet had children, listening to others who were engaged in these discussions often gave them a new perspective on the risks for children in a dissociative family. Additionally, this topic often gave rise to the "how" and "why" questions of the origins of MPD in the group member's mate and to the dynamics underlying why these group members had been attracted to dissociative mates. It was learned in our group that many of the non-MPD family members had come from alcoholic families and that the dynamic of enabling, which was modeled in their families of origin, was often at play in the interactions with the MPD partner.

How the Therapeutic Relationship of the MPD Client Affects the Non-MPD Group Member

Family members of MPD clients must face the effects on them of the client's relationship with her therapist. Because of the complicated nature of the disorder and the profound transferences that develop (Wilbur, 1984), clients become extraordinarily focused on their therapists. The partner may feel excluded and relegated to second class status. Family members can feel isolated, alone, and shunted aside as the client recovers memories and reappraises her life in the ther-

apist's office. Moreover, as Follette (1991) notes in her marital work with sexual abuse survivors:

> Many survivors report that their partners wonder why they cannot disclose more about their problems to the partners. Some partners have wondered aloud whether the client would need therapy if she could just bring herself to confide more in him. (p. 69)

Many times a group member requests family sessions with his MPD mate or an MPD child. Depending on the orientation of the primary therapist or on the situation, this option may or may not be available. A father of an adult MPD child desperately wanted to have his daughter's therapist include him and his wife in a session with their daughter. The therapist felt that a family session would not be productive since the young MPD woman was working on the task of individuation from her parents. This denial of the father's wishes catalyzed the father's entrance into individual therapy whereupon he could examine his own personal issues and why it was so hard for him to let go of his daughter.

Conversely, too much inclusion can cause resentment and burnout. One spouse used to insist on going to appointments with her MPD husband. Occasionally she was invited into a session at the end, but, by and large, she just sat in the waiting room. After a year of accompanying her husband to therapy, she decided finally to let go and stop attending. Her MPD spouse was greatly relieved. He stopped drinking on his own after months of resisting her urging him to stop. Finally, he felt that the therapist was his, not hers. She, in turn, realized that she had a magical belief that her very presence would "keep things under control."

Another issue that often comes up for group members is the upset of the MPD client over the family member's attendance at group. Sometimes the resistance has to do with sharing the MPD client's therapist with the other family member. Other times it may have more to do with the MPD client's fears of what the family member might reveal in the group. Many times phone calls have come in that a family member cannot attend a group because the MPD client is "having a bad day," is suicidal, is thinking about hurting the children, etc. The MPD client may overtly attempt to sabotage the partner's involvement in the group by acting out on days of the group meeting. One MPD client prevented her spouse from attending group by fabricating the story that the therapist had phoned to cancel the group meeting.

Partner's Family of Origin

Focusing on their own needs and issues has often pushed partners to look at their families of origin. They wonder about what developmental issues drew them to a partner with MPD and they muse about what emotional baggage they bring into the marital relationship and parenting. A number of members came from alcoholic families in which they were either abused or neglected. Frequently, members opted for individual therapy to help them sort out their own pasts.

Credibility

Group members who have heard the horrific and graphic stories of their MPD partners' abuses often begin to wonder if they should really believe them. Skepticism intensifies for members when revelations of yet more traumatic memories seem to follow in a never ending stream. The advent of the False Memory Syndrome movement and the proliferation of media attention to their charges of iatrogenic causation have also recently added to the questioning process (Goldstein, 1992; Loftus, 1993). One partner lamented to the group that his wife's alters grew exponentially instead of decreasing even with a prolonged hospital stay. But another member shared that his wife began to get better when he started believing her.

The Non-MPD Family Member as "Monster"

Members get upset when they feel as though they are the targets for the hostile feelings that their MPD mates have toward their earlier abusers. Members feel that they expend so much energy caring for the MPD partner and the household that they do not deserve to be treated as though they were "monsters." On the flimsiest of clues, MPD clients have alleged that their partners were members of ritual abuse cults. They seem to have projected onto their current partners feelings derived from fears, fantasies, and earlier abuse experiences, and/or attributes of their earlier abusers.

Existential and Spiritual Issues

Group members often ponder how there could be so much evil in the world. They question why their partner was hurt and why they have become heirs to the problems that these hurts have caused.

Frequently, issues around organized religion come up. One member shared how her new affiliation with the Quaker religion gave her comfort because she felt that they welcomed committed homosexual couples. Another member talked about how he and his MPD wife mutually decided to leave the Catholic church (under whose auspices she felt she had been abused) in favor of a Protestant denomination. Another member talked about how he felt he could be spiritual only with nature because it was uncorrupted by organized religion which he blamed for his wife's troubles. Several members shared about how their contributions on various church committees made them feel that they were promoting good in the world as a way to combat the pervasive sense of evil that they experienced through the eyes of their partners.

Recovery

Recovery of the MPD client brings with it its own set of changes in the familial homeostasis. A number of partners worry that the marriage might not survive the recovery of the MPD partner. This issue is especially threatening in members who perceive themselves as defective or whose self-esteem is based on the caretaking of the MPD partner (Benjamin & Benjamin, in press). As recovery of the MPD partner progresses, they may fear the loss of formerly valued alters (e.g. oversexed alters or cuddly child alters) who played key roles in cementing the relationship.

RESPONSES TO ISSUES

Overall, our stance to group members is to be warm and empathic. We tap into the wisdom of the group (Yalom, 1975) when issues arise. However, there are times when we do take a more directive stand.

Self-Care and Exploitation

When we see that a partner is clearly and unequivocally being exploited in the relationship with a partner or with an adult child, we will voice that observation in the group. We then invite the person to think about this issue and consider options for making changes in the relationship. Especially partners who are characteristically "caregivers" find themselves in this predicament (Benjamin & Benjamin, in press).

Sexual Dysfunction

Issues around sexual dysfunction arise frequently. Our general attitude and position on sexual issues is that each individual couple is so different that it would be clinically unwise to explore the issues in great depth in the group. However, we do point out that members have a right to be upset and that it is a legitimate issue to take to the therapist of the MPD partner. If a partner says that all sexual relations have ceased in the relationship for an extended period, we point out the problematic nature of the situation and refer the partner to deal with it in individual therapy.

Sadistic Ritual Abuse

Frequently issues around sadistic ritual abuse (Tate, 1991; Sakheim & Devine, 1992; Victor, 1993; Perin & Parrott III, 1993) surface in the group. In general, we follow Kluft's (in press) approach by being even-handed about neither denying the validity of the allegations nor of encouraging or inciting the MPD client to become overly enthralled with details of possible cult involvement. We try to calm family members and foster a wait-and-see attitude of whether this will persist as an important theme in treatment or later be disavowed by the MPD person as material that was more metaphorical in nature or knowingly or unknowingly imitative of other clients.

Specifically, we sometimes have the unique advantage based on our family treatment approach of having collateral information that influences our opinion and aids in helping the partner sort out the likelihood of such claims having historical reality. For example, in two contrasting cases in which we saw the fathers in the spouse group and had been working with their children, we came to diametrically opposite conclusions. In one case, the child eventually recanted stories of having been involved with her mother in an organized abuse group and revealed that she was feigning MPD symptoms herself in order to align with the MPD mother. In the other case, the child repetitively, graphically, and, in front of several different consultants, discussed and demonstrated in his play therapy multigenerational incest and ritualized sadistic abuse. Having this information certainly influenced our approach to the concerns of the fathers. While trying to avoid direct refutation of the views of the MPD client's individual therapist, we did highlight for the first father the inconsistencies between the child's and the mother's reports, and for the second father, we pointed out the congruency between stories revealed by child and mother.

This story of the two fathers should not be taken as a mandate for advocacy or investigatory work. The interviews with the children in each case were not done for the sole purpose of trying to validate the abuse stories of another family member. Rather, these are examples of where our family treatment approach provides us with information that would not otherwise be available. The safest course in the absence of such corroborating evidence is to be evenhanded and generally supportive, not to fan the flames, but rather to reassure the family member by saying that over the long-term of the therapy, these matters would become clarified.

The Repressed Memory Controversy

The recent controversy being raised over the issues of the validity of repressed memories and the possibility of confabulation (Goldstein, 1992; Loftus, 1993) were personified in our group when a member who joined was devastated by the accusation by his grown child who had MPD that he had sexually abused her. She had previously implicated a more distant family member for whom more independent confirmation existed. She now added to the list her father who was our group member. Both because of the supportive nature of the group and because others in the group had previously been accused by partners of behaving like their abusers (as described in the section "Family Members as 'Monsters'"), members were sympathetic. Although we had done careful screening around just this issue before he was accepted into the group such that we were comfortable that he did not meet our exclusion criteria for abusers (Benjamin & Benjamin, 1994), we supported him in arranging individual therapy to explore this issue in greater depth.

Criticism of the MPD Client's Therapist

A thorny issue arises when either the partner or parent in the group is openly critical of the MPD client's therapist or if other group members are faultfinding in their feedback. This is difficult enough when it is a colleague or referral source who is being reproached. It becomes frankly embarrassing when one or the other of the group co-leaders are publicly taken to task for stands that they have taken in individual work with the MPD client or child. This is a drawback to doing a combined individual and group treatment approach.

When an MPD client's therapist is questioned, we usually try to reassure the family member when what is described sounds like the ups and downs of conventional therapy. On the other hand, if what is being described sounds like unorthodox treatment or a therapy that has gone badly awry, we suggest to the family member that expert second opinions with an objective outside therapist be sought.

When we are the therapists being chided, it is a much more complicated matter. Sometimes we realize it is a mat-

ter of rivalry with the therapist (Benjamin & Benjamin, 1994) and try to briefly and good-naturedly diffuse the issue in group or else see the individual alone to discuss it further. We readily admit that we are fallible, and as in the preceding situation, we liberally suggest second opinions for people who are dissatisfied.

When the nature of the criticism is couched as a vehement attack, we have to intervene more strategically to prevent disruption of the group. A fairly standard intervention is for the non-attacked group leader to interrupt rather than have the attacked co-leader respond personally and defensively. Usually other group members will then intercede to suggest the inappropriateness of the individual issue upstaging the group's business. It can generally be agreed to refer the issue to a separate individual session to be resolved. In rare instances, the group member has chosen to leave the group because of intractable anger at or rivalry with the group leader.

Parenting

Another issue on which we take a clear stand is parenting. We see the parenting subsystem as a key intervention point for disruption of a cycle of transgenerational dysfunction (Benjamin & Benjamin, 1992). Consequently, we take parenting concerns very seriously. We often provide information about child development and childrearing. We will suggest therapeutic assessment of children in the family if the children have not already been evaluated (Benjamin & Benjamin, 1993).

CONCLUSIONS

The group format for partners and parents of clients who have MPD is an efficient way for helping people to air issues and concerns that come up for them over the course of their loved one's treatment. The availability of a group often reduces the number of couple or family sessions needed. It is indirectly helpful to the client with MPD in that it provides support and education for key people in the person's life. Even in cases in which a couple ultimately opts for separation or divorce, the group continues to care for the partner and supports a constructive co-parenting relationship if children are involved.

We speculate that a group for partners and parents could be set up in a variety of other ways. It could be held with serial sessions in a time-limited, closed membership format such as six to eight week short-term cycles. It could be attached to either a multipractitioner outpatient or partial center or to a specialty inpatient unit where there are a significant number of appropriate clients.

Finally, over the course of a long-term group for partners, the clinician has the opportunity to observe certain types of partners and their ways of interacting. Marital types and dynamics are discussed in an adjunctive paper (Benjamin & Benjamin, 1994b). ■

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