A GROUP FOR PARTNERS AND PARENTS OF MPD CLIENTS PART III: MARITAL TYPES AND DYNAMICS

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ABSTRACT

This article examines the marital dynamics between MPD clients and their partners. It attempts to classify types of partners, describing seven categories: New Abusers, Caretakers, "Damaged Goods," Obsessives, Paranoids, Schizotypal Roommates, and Closet Dissociatives. Such a typology helps to broaden the therapist's awareness of the client's marital context, heightens understanding of homeostatic patterns in the marital relationship, and sensitizes the therapist to the potential for the undermining of the therapy by the partner or by the MPD mate. This sensitization facilitates the therapist's efforts to provide interventions that enhance the couple relationship, promote the growth of each individual, and prevent the sabotaging of the therapy by either partner.

INTRODUCTION

This article is the third in a series which is based on clinical observations of partners of MPD mates since the inception of a monthly group for partners in 1986. Details of the practicalities and process of the group (Benjamin & Benjamin, 1994a) and the thematic material (Benjamin & Benjamin, 1994b) that arises in such a group are described in companion papers.

Although the group later came to include parents of MPD clients, this paper is not about parenting or parenting dynamics. Rather, it is about the interactions of marital partners with their MPD mates. In cases in which the partner is both a parent of an MPD child and the partner of an MPD mate, we have looked at the marital interaction only. Additionally, we include observations on the relationships of committed, non-married couples, both heterosexual and homosexual.

The group itself has played a significant role both in the identification of the partner types and in the treatment of couples. We believe that the ability to differentiate the seven types of partners that we discuss in this paper has been a result of the opportunity to watch the interactions and listen to the stories of many partners of MPD mates in the group setting over an extended period. We do not think we would have been able to classify the partner types with as much clarity if we had only seen the partners individually or in marital sessions. Moreover, it is our opinion that the group facilitates marital treatment through the process of partners sharing with and confronting each other. We think it would be much more difficult for the clinician working with an isolated couple to motivate a partner to examine (and perhaps change) his or her contribution to the relationship dynamics.

This paper represents our beginning effort to conceptualize our classification of partner types and marital dynamics for couples in which one partner has MPD. Further investigation and empirical study will be needed to continue this effort, which we believe will aid the clinician in working with couples and families of dissociative clients.

LITERATURE REVIEW

The MPD literature has dealt with the issues of working with spouses and lovers of MPD clients. Sachs (1986) sees marital interventions as an important adjunct to individual therapy. She recognizes that the course of therapy of the individual client is bound to disrupt the marital homeostasis, and she advocates anticipating preparation for the MPD partner. Additionally, she warns of two potentially harmful situations: a spouse who is abusive to the MPD client or a spouse who sabotages the therapy. In the first case, she insists that it is essential to end the abuse. In the second case, she notes that the partner may either function as a "lay therapist" and try to manipulate personalities or the spouse may sabotage the therapy in some other way out of fear of losing favored personalities. When these issues are addressed, the primary therapy can proceed more smoothly, integration can be facilitated, and the marriage can be preserved.

Sachs, Frischholz and Wood (1988) note four goals in the treatment of the marriage with an MPD partner: education of the partner, dealing with disruption in the marital homeostasis, sharing thoughts and feelings, and preventing sabotage of the primary therapy. The authors recognize and discuss the potential for the disruption of the homeostatic marital equilibrium by the individual therapeutic process of

the MPD client and by the partner' s response to it.

Putnam (1989) suggests that MPD clients often marry mates with significant psychopathology such as depression, alcoholism, character pathology, or gender identification problems. He explains that a troubled partner may gratify his or her own needs by marrying a dissociative spouse. One frequently encountered dynamic is that of the partner who promotes dissociation for his or her sexual gratification. Another dynamic is that of the spouse who sabotages therapy through the influence of personalities who are resistant themselves to therapy, or does so in order to retain favored personalities.

Panos, Panos, and Allred (1990) emphatically state that marital therapy with dissociative couples is a "basic and necessary *part* of therapy, and not simply a supplement (p. 10)." They go on to assert that MPD is not by itself the problem of the marriage. Rather, each partner brings emotional baggage to the relationship. Additionally, they affirm that at different points along the way in the therapeutic process of the MPD client, the marital homeostasis is upset.

Williams (1991) recommends an assessment of the family and partner dynamics in the MPD marriage. While the diagnosis of MPD in one partner may upset the marital homeostasis, she points out that partners of MPD clients have their own issues. Partners may have their own histories of abuse and may be in the midst of a recovery process themselves. If MPD becomes the sole focus in the life of a partner, the partner runs the risk of avoiding personal issues and becoming co-dependent. Partners may take on the role of the "fixer" or "caretaker" of the MPD mate.

Over the years, authors in the MPD literature have observed and described some of the common interactions between MPD clients and their partners. They have noted that partners bring their own emotional issues into the marriage, that the diagnosis and the course of MPD therapy disrupt the marital homeostasis, and that the partner can be a potential saboteur of the individual therapy. More recently, a number of authors view marital therapy as being an integral part of the treatment of the MPD client (Panos, Panos & Allred, 1990; Williams, 1991; Benjamin & Benjamin, 1992). This paper is an attempt to elaborate on the theme of marital dynamics and types of marriages when at least one of the partners has MPD.

MARITAL TYPES AND INTERACTIONS

Marital typologies have been described extensively in the family therapy literature (Cuber & Harroff, 1968; Sager, 1976, 1981; Goldberg, 1974, 1989; Glick, Clarkin, & Kessler, 1987; Coleman, 1988). Repetitive patterns can help the therapist identify particular couple dynamics and provide interventions that: (1) enhance the couple relationship; (2) promote the growth of each individual; (3) prevent the sabotaging of the therapy by either partner.

In our MPD partners' group, we have consistently posed the question of what drew a partner to his or her MPD mate. Goldberg (1982) has focused on three questions in his discussion of the dynamics of marital interaction and marital conflict: (1) What are the circumstances of how the partners met? (2) What were the first impressions each of the partners had toward the other? (3) What attracted the partners to each other? He believes that the answers to these questions are as critical to understanding marital dynamics as childhood history is for understanding individual psychodynamics.

Over the course of more than seven years, we have observed seven types of partners in our partners' group. Of course, this classification, like any of its type, is simplistic and limited in its comprehensiveness. Nevertheless, it provides a framework for describing and understanding partner interactions and reactions in the relationship and in the group. Moreover, an appreciation of partner types may help the clinician swing the pendulum of possible marital outcomes towards optimal solutions for the couple. Hopefully, both the group member and his MPD partner can grow in treatment, the relationship dynamics can improve, and the children can benefit through the breaking of the transgenerational chain of abuse (Benjamin & Benjamin, 1992; 1993). 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 MPD clients. Conversely, the recognition of partner types helps the clinician to recognize manifestations of a partner's sabotaging behaviors on an MPD client's individual treatment. Such an understanding can help the therapist comprehend why an MPD client may not be progressing in therapy, and point to possible remedies via marital interventions.

Relationship Dynamics

The complimentary relationship between the marital partners often serves to complicate and impede attempts at treating the member of the coupleship who presents for therapy. In such instances, marital dynamics function to protect and maintain the symptomatology of the "Identified Patient." As family therapists, we resist labeling the MPD client as the "Identified Patient." It is the family system that is truly our client, and we view all members of the family unit as suffering.

Additionally, as Sager (1976, 1981) has cautioned, marital relationships are dynamic, not static. Consequently, as the individuals mature and external circumstances impinge on the couple, the couple system always has the potential to change. Certainly, therapy itself acts as a stressor on a relationship, and it is the job of the therapist to orchestrate the direction of the change so that it leads to growth toward health in each partner and in the couple rather than damaging either partner, the relationship, or the therapy.

Marriage Outcomes

Goldberg (1974) has described the types of partners of alcoholic clients and explained how each type contributes to maintaining an unhealthy family homeostasis which perpetuates the couple's dysfunction. Analogous to Goldberg's characterization of couples in which one (or both) partners are alcoholic, one can postulate three possible outcomes to a marriage in which one partner of the coupleship has MPD:

TABLE 1
Types of Partners

1)	New Abusers
2)	Caretakers
3)	"Damaged Goods"
4)	Obsessives
5)	Paranoids
6)	Schizotypal Roommates
7)	Closet Dissociatives

(1) The family dynamics of the couple will overwhelm the attempt to treat the MPD client and therapy will be thwarted. Covertly and unconsciously, the partners will collude to sabotage treatment which threatens to upset the homeostasis of the family system. (2) One or the other of the partners will denounce the pathological relationship and will leave the marriage. This may occur if the MPD client gets well and the partner does not . It may also occur if the partner tires of the behaviors of the MPD client and decides to leave and seek a healthier relationship. Of course, if the partner does not gain sufficient insight from this experience or from therapy, it is quite likely that he will repeat the pattern with a new partner — sometimes even with a second MPD individual! (3) An optimal outcome occurs when both the MPD client and partner grow in therapy and come to delineate their boundaries better, achieving both improved functioning and insight into their previous dysfunctional patterns. An added benefit occurs if the couple can get well in time to alter their child-rearing practices and help their children to escape the legacy of the transgenerational chain of abuse so common in families with an MPD member (Benjamin & Benjamin, 1993).

Types of Partners

In our clinical experience, we commonly see seven types of partners whom we here tentatively, informally, and somewhat whimsically label: New Abusers, Caretakers, "Damaged Goods," Obsessives, Paranoids, Schizotypal Roommates, and Closet Dissociatives. There is considerable overlap with many of our group members having an admixture of these characteristics.

1) New Abusers

Often the MPD client recreates childhood trauma by choosing a partner who is much like an abuser from his or her past. This vulnerability to revictimization has been described by Kluft (1989, 1990) as the "sitting duck syndrome." Krugman (1987) points out that often the trauma victim who has been abused violently believes that the person who provides love also inflicts hurt. The victim then seeks love in a familiar manner and thereby re-enacts that dynamic. The partner obliges by being that new abuser. For example, an MPD client who was seeking to escape from an abusive, alcoholic, and financially irresponsible father married the first man who raped her and beat her up. Understandably, we were not enthusiastic about including a so openly abusive spouse in our group and were relieved when he declined to schedule a screening interview. In cases where a partner is currently abusive, admission is not offered. Our first step is referral of that spouse for individual psychiatric treatment. Most frequently, the abusive spouse is a substance abuser, and this will involve treatment in a substance abuse program.

Although the blatant abuser is excluded from the group, we may still see elements of this type of orientation in an MPD patient's partner. Frequently, a group member has revealed that he has been abusive in the past, that he has been in some sort of treatment or a participant in an AA or NA program, and shared that he is remorseful and ready to work on marital issues. In these cases, the formerly abusive relationship remains an important dynamic to be examined.

2) Caretakers

In our experience, this type of partner is extremely common. Consciously or unconsciously, he has sought out a person for whom he can be the caretaker. Not infrequently, the partner has previously been in difficulty himself and now is in the recovery phase of his own formal or informal treatment. Now sober or reformed, he believes he has all the answers and is ready to help the victim spouse who may have previously had to put up with his abuses. Often this "caretaking" stance serves to cover up his own insecurities which were previously handled by dysfunctional or addictive behaviors. The MPD partner initially allows this symbiotic fusion to allay anxieties and vulnerabilities from childhood (Krugman, 1987). The more socially acceptable "caring" is expressed by caring for a sick partner.

Often, the Caretaker is highly educated and tends towards intellectualization as a defense. He may use self-help jargon to describe himself and his partner. This person may, in fact, be a therapist or a member of another helping profession (such as the clergy) or a paramedical field (e.g., technical worker in a hospital, etc.). Over the years our group has been populated with so many nurses that group members themselves have often joked about being a group for recovering and impaired RN's!

The therapist-member stance often leads to the Caretaker's demonstrating rivalry with the group leader, or even instigating a power struggle to dominate and monopolize the group. We have especially experienced this kind of competition between male partners and the male co-therapist. One Caretaker member even left the group to found his own MPD partners' group, on a self-help model, in his home locale.

This type of member frequently has severe difficulties when his partner begins to get well and needs him less. As she asserts herself more she may start to reject his domineering attempts to keep her in a one-down role. The partner may begin to worry that the MPD mate may abandon

him. Indeed, the MPD client may declare herself to be integrated and abruptly leave the partner, decide to be gay, or brand him as the true "sicker" partner. One woman, who was a highly trained nurse, cried bitterly that her abusive, alcoholic MPD spouse had rejected her by moving out when he was feeling better. Her love and caring felt suffocating to him, and he refused to accept it any longer.

3) "Damaged Goods"

The title of this category is not meant to be pejorative; rather, it is a *double entendre.* The partner is a "good" person who secretly believes that he is in some way "damaged" or undesirable; i.e., stupid, unattractive, under-educated, from a terribly dysfunctional family, from a low socio-economic class, or from an ethnic background which he finds unacceptable or shameful. He is thrilled that a beautiful, intelligent, articulate, artistic, educated, etc. MPD client would choose him as a mate. In fact, he may not have noticed for many years that his mate had MPD, and rather, saw her as overly functional and care-giving to him. The diagnosis of MPD completely baffles him.

The identified client is so pleased that anyone would treat her non-abusively that she is more than willing to overlook even considerable faults just to have a friend and mate. This partner may have "damages" that range from the imperceptible, troubling only to his own self-esteem, to the grossly obvious. However mild the degree of "damage," the partner as in other spouse types, frequently lives in secret mortal fear that as the MPD client improves, she will reject him for someone "better." This fear may be consciously or unconsciously expressed as a resistance to the MPD client's progress in therapy.

Fortunately, this type of partner usually flourishes in our group and gains in self-esteem. He finds he can contribute and be a partner to both the recovery of his MPD partner and to the post-recovery successful functioning of the family unit. Often these individuals choose to enter individual therapy in order to explore issues arising from their own families of origin and take considerable responsibility for their parts in the marital dynamics.

4) Obsessives

A legendary and classic pattern well known to marital therapists is the obsessive-hysteric couple (Glick, Clarkin & Kessler, 1987). In this case an obsessive, overly tight, achievement-oriented but emotionally constricted partner (stereotypically the obsessive male) marries a "hysteric," a histrionic, emotionally lively and labile partner (stereotypically female). She provides the spark and entertainment in his life even as he protests that he has to constantly save her from her inadequacies and indiscretions. In fact, that endeavor may become his chief purpose in life, and he knows no other way to live. Although he may complain bitterly of this burden, he also secretly lives in terror that he will lose the familiar and reassuringly normal pattern of his life if his wife becomes healthier.

Like the Damaged Goods partner, he may secretly be a saboteur of his partner's therapy, but like the Caretaker, he tends to be well defended intellectually against facing this dilemma.

In the following three types, the partner is also clinically impaired although this is not at first clear to either the therapists or the outside world. Everyone believes that the MPD client is more obviously "sick."

5) Paranoids

This partner shares the view that the world is a hostile place and that outsiders threaten hurt. He may also be from a dysfunctional or even frankly abusive background and, therefore, covertly ill. This pattern may overlap with type 7, the Closet Dissociative. More frequently, he is seen as socially appropriate although sardonic and cynical. He readily identifies with the MPD partner who takes on the victim role. He may crusade angrily to get "the abusers" both from the MPD partner's family of origin and from society at large.

This type of partner frequently extends his hostile world view to include his wife's therapists. He is certain that they can never be sufficiently understanding of the injustices done to his victim mate. Unfortunately, he also tends to resist any recovery from the victim stance for the MPD partner because if the MPD client improves, he might lose his ally in resenting the world and thus his *raison d'être.* Unfortunately, paranoid partners are usually quite unwilling to look at their own issues.

6) Schizotypal Roommates

Quite estranged and withdrawn from society, this type of partner lacks social skills. He is untroubled by the impairment of his partner as he is glad to have someone, however disabled, with whom to share his isolated world. The two partners function as more or less friendly roommates without true intimacy or much sharing in the relationship. The schizotypal roommate meets the MPD mate's needs to avoid painful issues (Krugman, 1987). The MPD partner's sexual inhibitions (or even complete abstinence) are of little or no consequence to this partner. He is often equally sexually disinterested or dysfunctional. Like the Damaged Goods partner, he may view the MPD partner to be the best he could have hoped for. He may not even notice that the MPD partner is ill. Rather, he may consider their mutual withdrawal and lack of functioning in society as a normal state of affairs.

Sometimes, this type of person may be immersed in an addiction, depression, or even psychosis. No one complains about the symptoms until the therapist of the MPD client notices that something is terribly wrong with this alleged non-client in the pair. At this point, the Schizotypal Roommate still may or may not get help. Even if he enters the group, he may be an unenthusiastic participant, motivated only by a sense of obligation to the MPD partner.

7) Closet Dissociatives

In our experience, it is relatively common to encounter couples in which both partners are dissociative. Obviously, such a pairing may occur when two partners find each other in a treatment or self-help setting. However, there are also

situations in which one partner is overtly dissociative while the other is covertly dissociative – that is, "in the closet" or hidden.

In these latter cases, the partner is frequently mystified when we ask why the couple was attracted to each other in the first place. Often the partner vaguely answers that they "understand each other." The MPD client may be far advanced in treatment when, with an increasingly sophisticated understanding of her own disorder, she begins to notice that her partner has similar characteristics. Most notably, the partner may have substantial time gaps in childhood or rapid mood switches which may be disavowed if they occurred during memory lapses. More recent memory gaps may be explained away by a more overt problem, such as an addiction which has been covering up a less obvious dissociative disorder.

As stated previously, in the group selection process, such members would not ordinarily be accepted (Benjamin & Benjamin, 1994a). Although they are searched for diligently in the screening interview, we, nevertheless, are sometimes disconcerted to discover belatedly that a group member also has dissociative symptoms. As explained in the section on selection, because we have reason to believe that this will be disruptive to the group process, we have asked such persons to leave the group.

Homeostatic Marital Patterns

The purpose of this typology is not to "label" partners in a negative manner, but to point out that partners often play a vital role in helping the client to maintain certain behaviors. This awareness is crucial in helping clinicians appreciate that the MPD client and partner operate as a complimentary system to maintain not only marital patterns but patterns of relating to others. The New Abuser partner helps to maintain the victim stance of the MPD client. The Caretaker keeps the MPD mate in a dependent role. The dependency of the Damaged Goods partner pushes the MPD mate to over-function. The Obsessive partner needs to be available to rescue the emotional and unpredictable MPD partner in order to give purpose to his life. The Paranoid partner colludes with the MPD mate against a hostile and unfriendly world. The Schizotypal Roommate finds that the distant partnership with an MPD mate meets his need to maintain a superficial relationship. Finally, the Closet Dissociative is able to hide his own impairment because his MPD mate fails to notice or protest.

The homeostatic pattern of the partnership with an MPD mate often serves to keep the MPD client from progressing in therapy and the partner from looking at his or her own contribution to the couple dynamics. For example, a high-achieving MPD client with a Damaged Goods mate realized that part of the reason that she sexually abused their child over a period of several years was because her mate needed to see her as so competent that he failed to observe that her needs were not being met in the couple relationship. Consequently, she reverted to incest with her child, effectively making the child her sexual partner (repeating what had been done to her by her own father).

At many points along the way in the therapy, the couple's homeostasis is challenged: the initial diagnosis, times of the recovery of memories, at integration, and during recovery. While the homeostatic balance is stressed, the couple continues to face the broad issues of marital interaction. Goldberg (1982) defines these issues as power, nurture, intimacy, trust, fidelity, life-style, and sense of order. The partner typology offers the clinician some ways to conceptualize the balance of power in the relationship, who takes care of whom, how comfortable partners are with emotional closeness, how trusting of each other partners may be, how faithful partners are to each other, and how compatible the couple's styles of living, thinking, feeling, or dealing with anxiety may be. The fidelity issue is especially critical. In MPD couples, it includes both concerns about sexual exclusivity and extrasexual infidelities such as placing some person (most notably, the therapist) or something (frequently, an addiction) above the partner in importance.

CONCLUSION

Clinicians face a number of challenges when working with married MPD clients or with couples in which one of the partners has MPD. These include maintaining the stability of the marriage during homeostatic disruptions, preventing sabotage of the therapy, and encouraging the kinds of changes in each partner that will lead to both individual growth and growth in the relationship. An appreciation of partner and marital types broadens the therapist's knowledge about the context in which the client with MPD and her partner operate. Moreover, it heightens awareness of homeostatic patterns and sensitizes the therapist to the potential for undermining the therapy by the partner and/or by the MPD mate. Finally, it may be used as a therapeutic tool to optimize the clinical outcome for the individual with MPD, for the partner, and for the couple. ■

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