

INTEGRATING A DISSOCIATIVE DISORDERS CURRICULUM INTO RESIDENCY TRAINING

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ABSTRACT

This paper will describe the complexities encountered in developing a dissociative disorders curriculum for psychiatric residents. A conceptualization of this educational process has been synthesized from the observational perspectives of both faculty and resident.

INTRODUCTION

The relatively recent appreciation of the high prevalence of severe abuse experiences in the lives of psychiatric patients demands new competencies of mental health professionals (Carmen, Rieker, & Mills, 1984; Brown & Finkelhor, 1986; Herman, 1981; Herman & vander Kolk, 1987; Russel, 1986). Very often clinicians and researchers have had little or no training in integrating this knowledge into the models that inform their work. Many remain ignorant of the "victim to patient process" and its central relevance to treatment (Rieker & Carmen, 1986). It is essential that this deficit is not perpetuated in the educational experience received by our current trainees. What one is taught in training often exerts a strong influence on one's observational capacities and clinical approach that persist throughout one's career.

There is a growing consensus that psychodynamically informed psychotherapy is the cornerstone of effective treatment of patients who have been victims of child abuse, and that many of these patients show dissociative symptomatology (Braun, 1986; Kluft 1984a, 1984b; Miller 1984; Putnam, 1986, 1989; Rieker & Carmen 1986). This obviously runs counter to recent trends in psychiatric education, which emphasize a psychobiological model while de-emphasizing the understanding of people in their full complexity. This is reflected by many psychiatric residency training programs no longer teaching psychotherapy. In many others, learning psychotherapy is encouraged but is either considered out-

side the residents' required duties or thought to be a skill one can intuitively learn on his or her own.

Residents who treat patients with severe dissociative disorders must navigate a complex web of personal, clinical, and institutional dynamics. Paradox pervades the experience. With regard to no other patient will the resident receive such polarized and contradictory messages from faculty and staff. I have heard this expressed by one resident with the image of being in a mine field yet not knowing who the enemy is. Another expresses it as "feeling as if I am being told I have done something wrong for listening and giving respectful consideration to my patient's disclosures."

The resident with little clinical experience often inherits the patients at the most extreme end of the dissociative spectrum, and often begins therapy with the patient in a decompensated state. The polarity of faculty and staff opinion concerning treatment of these patients most commonly intensifies when the patients are decompensated, and neither supportive nor intensive exploratory approaches are leading to a prompt or easy stabilization. Within this situation of confused helplessness the resident often suffers profound doubt. It is here that we must begin to provide our trainees coherent and informed teaching, supervision, and support.

THE CURRICULUM

Not every psychiatrist will be suited for or interested in psychotherapeutic work with dissociative disorder patients. At the same time it is an essential minimum for every psychiatrist to develop diagnostic skills and have a general framework for understanding the nature of these disorders and their treatment course, if only to identify them and make appropriate referrals for their care.

The special skills and knowledge required in the treatment of dissociative symptomatology cannot be assimilated without a broad education in clinical psychiatry and a sound foundation in psychodynamic psychotherapy. My remarks from here on will assume that these basics are being taught within the residency curriculum.

In our program's curriculum the first year didactic experience includes introductory lectures on the diagnosis and treatment of dissociative disorders, and the relationship of child abuse to dissociative defenses (Braun & Sachs, 1985; Kluft 1987; Putnam, 1985, 1989). The first year's clinical experience is based in an inpatient setting. During the course of these months all residents work with a number of patients from traumatic backgrounds with dissociative symp-

toms. Most have the occasion to follow one or more MPD patients.

This is an ideal time for residents to work alongside the more experienced therapists when they hospitalize their outpatients. This model of treatment is highly encouraged. If presented unambivalently to the patient it usually causes relatively few problems with confidentiality concerns and leads to a better coordinated treatment approach. Many outpatient therapists find that therapist and patient feel safer with others in the room particularly during abreactive work or when meeting unknown alters. Working together very quickly moves a resident's comprehension from a superficial intellectual understanding and speculation about dissociation to an observation of the dissociative disorders in different patients at different phases of their treatment. Questions move from fascination over phenomenology to more pragmatic clinical questions concerning therapeutic approach, pacing and containment of the treatment, transference and countertransference, and issues of responsibility (Kluft, 1988a, 1988b).

MPD patients with alters of different ages concretely illuminate for the resident levels of emotional and cognitive development, and the necessity of matching interventions to developmental capacities. This observational window into a treatment in progress can demonstrate the psychodynamic function or survival solution of each alter. This understanding helpfully demystifies the notion of "separate people" in one body and moves the resident to a more accurate conceptualization of MPD as a complex matrix of enduring personified, survival-necessary trance states within an extremely traumatized, overwhelmed individual (Kluft, 1988a; Putnam, 1989).

In general, first year residents who have worked alongside of more experienced colleagues appear more interested and confident about accepting dissociative disorder patients into their caseload as they begin their out-patient work in the second year. Potentially this allows for a three year continuity with such patients. This is not necessarily long enough for complete resolution of their difficulties, but is long enough for a meaningful and productive immersion in the therapeutic work for both resident and patient. In our program, during the second, third, and fourth years ten to fifteen hours per week are reserved for psychotherapy patients. Weekly supervision is provided. Although a variety of psychotherapeutic approaches are taught and encouraged, psychodynamically informed psychotherapy forms the core of the didactic and clinical psychotherapy teaching.

The second year didactic curriculum on dissociative disorders include specific lectures on the recognition and treatment of abused children, the effect of trauma on the self, the psychotherapeutic uses of hypnosis, and the cultural structures that sanction subordination of women and children.

In the third year the treatment of a dissociative disorder patient is followed longitudinally in a weekly year long case conference. This provides a more detailed examination of treatment in an on-going case and allows for group discussion of theoretical and clinical issues. There is again opportunity for work with new in-patients in the third and fourth

year. Work with this second "generation" of dissociative disorder patients often helps the resident consolidate his or her clinical skills.

Attendance at regional and national conferences on hypnosis, child abuse, and dissociation have proved invaluable to many residents. In most departments where most likely only a few faculty have expertise in this area, the minority viewpoint of these faculty (who within the department may appear somewhat radical) can be understood in a more normative context by residents who have had such broadening experiences.

CRITICAL ISSUES

Dividedness

Polarity of opinion in a department can best be moderated by education and careful clinical care. As clinicians attempt to work intensively with dissociative disorder patients for the first time, much can go wrong. This is true for residents and faculty, out-patient therapists and in-patient teams. It is easy to dismiss a method or approach as flawed when it is often more a matter of inexperience in its application or the patient is so crisis prone or decompensated that the most skillful interventions may be unevenly or only partially successful. There is also a natural dividedness between faculty and resident. Often the faculty develops a clinical model based on private patients which may not fit with the more impaired patients in the resident's caseload.

Secondly, as a profession we must be willing to examine our own psychodynamics with dissociative disorder patients. No clinician, no matter how dedicated, experienced, and self-examining will listen comfortably to a patient's disclosure of unthinkable suffering without attempts to de-intensify his or her own identification with the patient. Our need to not hear these experiences are nowhere more urgent than in response to the horror of those tortured as children. Our patient's defensive need to disconfirm their abuse in effect encourages the clinician's disbelief (Rieker & Carmen, 1986; Speigel, 1986).

Dissociation can be understood as confusion with a function. If an abused child can view the experience as occurring elsewhere, to "not me," in a different time, some semblance of hope in the world as a safe place can be maintained (Shengold, 1979). The polarization and confusion concerning dissociative disorders in the professions can best be understood in this light as countertransference. The intellectual debate for instance over whether MPD exists, and if it does, is it iatrogenic mirrors the concretization of the abused child's egocentric processing of trauma, "I am not sure if it happened, but if it did it was my fault." Just as the abused child struggles to trust his/her own perceptions against the threat of harm, abandonment, or disbelief, the psychotherapist working with a MPD patient often bears the burden of proving his/her competence.

Supervision

Careful individual supervision is central to the learning process. The clinical complexity of these patients mandates that the supervisor pay detailed attention to developing an

examining/reflective/creative/educative atmosphere that encourages the resident's learning.

Within even a well conducted, well supervised beginning therapy with a dissociative disorder patient, inevitably the resident becomes convinced that the suffering that the patient is starting to disclose has been, at least in part, caused by the therapist. It is commonly assumed that the pain did not exist in this intensity until it was spoken and that the patient's presenting symptomatic suffering is preferable.

To create illusions of one's power, to blame oneself for what one had no control over is what the victim and now therapist believe, to defend mutually against knowing and owning one's own helplessness. This guilt is often encountered, and is particularly common in empathically sensitive but clinically inexperienced therapists. Supervisory support and clarification of this dynamic can lead to growth and maturation, and non-support often leads to guilty retreat and future avoidance or counter-phobic aggressiveness towards other patients' traumatic disclosures or unspoken horror (Kluft, 1988a, 1988b). One resident expressed her maturation as "when I chose psychiatry as a specialty I perceived mental illness as a fascinating mystery, now I know for many patients their dysfunction has more to do with terrible misfortune than mysterious out-of-the-blueness."

Self-blame is but one manifestation of distorted notions of the therapist's power and responsibility. These blurred ideas, while reflective of the patients' projected experience with authorities, tend to be particularly confusing for the trainee who already tends to underestimate his/her helpfulness. For months one patient conveyed his experience in therapy with the unsettling accusation that "being here is like sitting in an electric throne." Only when the therapist resolved his own worry that he was not seducing or torturing the patient could he comfortably enter work with the patient's dissociative symptoms and structures. Only now could the patient convey his "four year old's" experience of both craving his father's special attentiveness that left him "feeling like a king," and abhorring the oral rape he repeatedly suffered that left him "fried" (Shengold, 1979).

There is commonly a resolution "I will avoid taking an authoritative or dominant stance with the patient to avoid reenacting the trauma." This too gentle approach often leads to a treatment setting with no leadership and misses the distinction between malevolent and benevolent authority that is central to the patient's own confusion. On a developmental level the patient is still waiting for someone to take charge in an effective, confident and protective manner.

Dissociative amnesic episodes within the therapy session quickly propel the therapist into the powerful position "I know more of you than you do," and "I know more of you than you intended." In effect, the therapist is "inside" the patient, or more accurately, inside the patient's trance. It is a difficult experiential learning for the therapist to grasp how to maintain a clearly defined sense of self, a clear definition of role, and clarity as to who is responsible for what within this merger (Kohut, 1971). One resident observed "I feel too powerful like I know too much, yet lost at the same time." The therapist is forced to function inside in a position

as powerful and essential as the position occupied by an abusive caretaker on whom the violated child is/was dependent. Within the reenactment of this subordinate status is the reparative wish "if I can only find someone more powerful than they who abused me then hope is found."

Within a merger transference it is very immediate that the patient's yearning and deprivation is experienced without boundaries by the therapist as if it were the therapist's responsibility to meet. In this unfamiliar relationship, the inexperienced therapist may and commonly does become convinced of the necessity of this expanded role and thus is unable to easily recognize the countertransference nature of what will become an ever enlarging confusion of role and loss of therapeutic posture. At this point empathic immersion ends and engulfment begins.

The therapist's understanding of this inside world can become dangerously literal, consistent with the concrete magical logic in which the patient's defenses are embedded. The most common example of this concretization is the therapist treating a MPD patient who considers each alter to have the social status and rights of an integrated individual. For instance, this therapist may assume a 20 year old alter who is promiscuous has the right to pursue her sexual desires since she is of age, despite the destructive effects this behavior has on the patient as a whole.

What empowers the therapist within this trance world is emphatic confidence. From this perspective hypnotic suggestion is merely emphatic confidence that is empathically comprehending the patient on this developmental level of concrete magical merger. For instance, to an abandonment sensitive, terrified four year old alter it is no reassurance to say "I will talk with you on Monday" but it may allay anxiety, and without an appreciated contradiction to say "you can stay right here and we'll talk when you come again." The therapeutic task is to be able to immerse oneself in this magical logic yet maintain rational leadership. Most residents are overly cautious when using trance-logic interventions until they begin to grasp the nature of this developmentally based reasoning.

A request on this developmental level may not be what on an adult level we assume it to be. An example from my own experience as a parent can illustrate this. My three year old was escalating his demands to go outside and "climb a tree like a monkey." He was not satisfied with my argument that it was 20 degrees outside and also bedtime. Just before a power struggle escalated I asked if he knew about make believe. He listened as I described a pretend tree in the living room that we then played on. Winnicott (1971) may have understood earlier that his request was his need for a moment's playful absorption/connection before facing the separation that sleep brings. Once contacted within this trance-like playspace or transitional zone he was asleep in five minutes.

For new therapists there is no prior template of professional experience to help define the nature and boundary of therapeutic interaction. Work with patients with severe identity disorders poses additional problems in this search for therapeutic self. Ideally the knowing of the patient moves comfortably between two poles, the empathically immersed

and the individuated other (Margulies, 1989). The psychodynamic understanding of a dissociative disorder patient often breaks down in this polarity, viewed from either too far out or too far in.

An MPD patient of mine that I had treated for about a year one day handed me a letter addressed to "Dr. Batson" in a child's handwriting, decorated with crayoned flowers. There was a vintage three cent stamp and the return address contained the name of an eight year old alter and the address of her childhood home. She told me the following story from her now adult perspective. "The doorbell rang and it was the mailman. He was smiling and he handed me this letter of which I knew nothing. He said 'Ms. A. it is wonderful to have someone on my route with such a delightful sense of humor. Those were the good old days when sending a letter didn't cost a quarter! I am sorry I can't deliver it for you.'" What I came to learn is that her proper description of her house with separate rooms for each alter was not just an internal representation but literally a large house in which she lived with each room containing alter-specific and era-specific belongings. It was only as she approached integration that the host personality realized that her home literally had a second floor which she could now "enter" for the first time. These are two very different ways in which the patient was known, both true from their own observational base. In many ways these two views illustrate the relativity of observation. Without careful supervision novice therapists tend to somehow lose the ability to move between observational sets. There are those who get stuck too far in and those that stay too far out (Kluft, 1988a, 1988b). Ironically, those that are too far in often are labeled "too far out."

A therapist too far in can then only experience problems the way the patient does. An MPD patient when asked why his bill was not being paid, replied that an alter continued to spend money frivolously and inappropriately. The resident insisted to me that she could not hold the patient responsible since it was the alter who had spent it. It took very careful supervision and encouragement of her individuation before she could come to say, "As a group you're responsible for the bill. I am confident this is a matter you can resolve. When I receive your check I'll call you to set up your next appointment." The therapy picked up two weeks later. I ask therapists to reflect on their image of self in these situations. A metaphor I use is being bent. The task of the therapist's individuation can then be understood in subjective terms as "what are the ways in which I feel constricted with this patient that I don't usually experience with other patients." At this point the therapist can more easily understand the therapeutic process as their personal "unbending" rather than just analysis of the patient. One resident working with a very complicated and initially non-compliant patient over the course of a very productive treatment understood the process of their individuation through her image of disentangling herself from the "barbed wire" in which she initially felt wrapped.

The most common means of never entering a therapeutic dialogue with a patient who has been hated is what I can best describe as obsessional contempt (Kluft 1988a, 1988b). There is a relentless attention to the details of the patient's

psychopathology which is seen as otherwise devoid of meaning (Rieker & Carmen, 1986). Coupled with this is a profound conceptual simplification (the intellectual equivalent of contempt) of the therapeutic interaction with no appreciation of the complex circularity of human relationship. Obviously, patients with severe identity disturbance are extremely observer-dependent, quite sensitive to and shaped by the attitudes of those in positions of dominance. In the extreme, this therapist is absolutely certain of what is real and cannot entertain alternatively defined realities (Margulies, 1989).

The supervisory task is very different when working with either an avoidant or engulfed therapist. The avoidant or too far out therapist often shows a very hesitant entry into the dissociative disorder patient's unsafe world. With every empathic connection there is a retreat. Patients tend to react with heightened feelings of abandonment and complaints of not being understood. Engulfed therapists often show a secondary post traumatic stress syndrome as they over-identify with the patient's horror. It is hard for either therapist or patient to find closure between sessions. The patient feels understood and is often convinced that the therapist is irreplaceable (Kluft 1988a, 1988b). The intensity of the work is particularly difficult for the patient to contain without access to a reasonably calm and confident therapist. In this regard Kohut (1971) described fragmentation as occurring when the intensity of one's affects escalate beyond the self's capacity for self-soothing and when merger with a secure self-object is precluded.

Group supervision is a very helpful adjunct. The discovery of countertransference attitudes that are held in common with their peers help normalize the complex personal affectual experience of the new therapists. As one resident told me, "countertransference used to be a concept, now it is a struggle that is three dimensional." There often are some differences along gender lines. Male residents are often frightened into passivity by their equating therapeutic assertiveness with a background countertransference imagery of feeling like a rapist or dictator. This often leads to a non-directive distant posture where the male therapist is afraid to ask questions about anything painful, and showing any empathy or warmth feels like a seduction of the patient. Women residents more often complain of a sense of shared pain and then depletion reflective of the female therapist's initial ease of identification with the patient's experience of subordination followed by the patient's ever escalating craving for empathic connection (Miller, 1976). Obviously, the above are generalizations that reflect issues relevant to lesser or greater degree in all clinicians. The group can also help a resident identify his/her own idiosyncratic reactions. Despite these important attributes, at the resident's level of training group supervision cannot offer the detailed attention that individual supervision provides and should not be a replacement for it.

DISCUSSION

Residents who have had reasonably productive therapeutic experiences all tend to cite three major areas of

learning and influence. First they develop an indelible understanding of the link between child abuse and psychopathology. A deepened respect for human ingenuity and the capacity to survive adversity is a treasured acquisition. In a general sense, these residents describe a new empathic capacity of searching for, finding, and comprehending the person behind the noise of the psychopathology. Difficult patients are less likely met with avoidance or contempt. Secondly, these residents often contend that their comprehension of the psychotherapeutic process comes to possess a new coherence that extrapolates to their work with all patients. Thirdly, there is an invaluable finding of therapeutic self. "I understand now what my role is, what is my domain and what is the patient's responsibility. To move from utter confusion to clearly knowing is what my patient and I both accomplished. It cannot be forgotten."

SUMMARY

"Does it exist or does it not?" is the dissociative disorder patient's "confusion solution." It has been reflected in the polarized debate over the existence or relevance of dissociative disorders. To not educate trainees to a disorder that is relevant in differing degrees in a significant percentage of psychiatric patients has become our countertransference acting out, in effect the profession's own dissociative disorder.

To view from the outside what is intolerable inside is what violation teaches us to do. This is true in the thoughts of the four year old being raped by daddy, "that me is not me." This is true in the arguments of those who refuse to listen, "child abuse is just imagination." To listen is to go inside. Inside is again intolerable. This is true for the victim turned patient. And this is at first true for the psychotherapist who cares to hear. To connect outside/inside is the nature of the patient's healing and the therapist's learning. This is where new therapists find their therapeutic selves. It is the responsibility of psychiatric educators to prompt and guide this evolution. ■

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