UTILIZING PARENTING AS A CLINICAL FOCUS IN THE TREATMENT OF DISSOCIATIVE DISORDERS

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ABSTRACT

Parenting is a potent resource in both the individual and family treatment of Dissociative Disorders. A focus on parenting helps to build the therapeutic alliance and establish a safe base. It subtly shifts the client's attention to childhood experiences and the parenting that he or she experienced. The therapist's empathy and crediting of the client is echoed in the relationship between the dissociative parent and his or her child. The therapist promotes bonding and attachment, sensitizes the parent to the child's needs, and increases the parent's sense of self-efficacy. Through involving the parenting partner, the therapist promotes cooperation and reduces conflict. Therapy is aimed toward teaching affect regulation, decreasing negative affect, and increasing positive affect among family members. Utilization of extrafamilial support is also encouraged. Attention to parenting serves both to stimulate progress in individual therapy and to interrupt and correct dysfunctional transgenerational patterns.

INTRODUCTION

In a previous paper (Benjamin & Benjamin, 1994c), we proposed a rationale for working with the parent-child unit in a dissociative family. We looked at various perspectives on parenting from five different fields of knowledge: psychodynamic theory, attachment theory, infant development, affect theory, and family systems theory. Additionally, we have discussed at length the concepts of Boszormenyi-Nagy and colleagues (Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Spark, 1973 & 1984; Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991), and we have explained the application of his principles of Contextual Therapy to the treatment of Dissociative Disorders (Benjamin & Benjamin, 1994a). Drawing on these discussions, we now suggest a list of benefits that accrue from a therapeutic focus on the dissociative parent-client's parenting. In our estimation, it helps to achieve several objectives listed in Table 1. Pronouns used to refer to client-parents are completely arbitrary. Although we may frequently use feminine pronouns because we work with more mothers than fathers, the principles are equally applicable to fathers.

The achievement of these goals not only holds the potential to interrupt the intergenerational cycle of abuse or neglect that seems so ubiquitous in dissociative families, but also provides concrete ways to intervene and actually improve parenting. The resulting sense of self-esteem and self-efficacy that then occurs may provide the hope necessary to propel the client forward in her own journey of healing.

TYPES OF INTERVENTIONS

Individual Therapy

Therapists can deal with parenting issues in the individual therapy of the client. Fisch (1984) has noted that dealing with parent-child issues is a less threatening mode than interpreting transference material in the beginning stage of therapy. A few authors (Braun, 1986; Putnam, 1989; Kluft, 1993) have elaborated on the stages of therapy for the dissociative client. The initial stage entails building trust and establishing safety between the therapist and the client. Especially because of the many traumas that the dissociative client has already endured, this early phase of therapy is often difficult. Attending to problem areas in the client's parenting operates as a "here and now" way of establishing rapport by demonstrating interest and concern.

Because of the damaged nature of the self in dissociative clients, it seems reasonable to postulate that these parents view their children as self objects. Therefore, when the therapist can show regard for the children of the client, it may be internalized by the client as empathy for her. Because the client usually did not experience sufficient empathy in her own childhood, having the therapist empathize with her children feels good at a deep level, thereby promoting the therapist-client relationship.

Discussing child-rearing is another way for the therapist to credit the client for her accountability for her children. Boszormenyi-Nagy and colleagues (Boszormenyi-Nagy & Spark, 1973 & 1984; Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991) view crediting as a way to give ethical worth to a person. The dissociative client, who may blame herself for her own abuse or neglect, often finds it

TABLE 1
Benefits That Occur With a Therapeutic Focus on the Dissociative Parent-Client's Parents

1) Build a therapeutic relationship
2) Provide leverage for therapeutic change
3) Develop a sense of empathy in the client, thereby facilitating empathy in the parent-child relationship and in the intra-alter system
4) Facilitate a client's ability to credit herself, thereby fostering an ability to credit in the parent-child relationship and in the intra-alter system
5) Build a therapeutic "secure base" for the client, thereby fostering a secure attachment in the client's child
6) Promote bonding of the client toward her child
7) Promote the participation in parenting of the non-dissociative parent
8) Reduce negative affect in parenting resulting in more positive outcomes for childrearing
9) Increase a sense of self-efficacy in the parent which may increase pleasure in parenting
10) Teach affect modulation in the parent, thereby reducing excessive negative affect in the childrearing
11) Reduce conflict in the marriage
12) Sensitize the client to the ethical needs of the child
13) Focus the client on her own past traumas, and specifically, on the affect associated with those traumas

difficult to accept messages of worth from the therapist or from anyone else. However, the therapist can commend her caring for her children as evidenced by her willingness to improve her own parenting. This acknowledgement is a concrete way for the therapist to credit the client. It becomes less likely for her to discount or reject that credit if it is earned in this demonstrable manner.

Boszormenyi-Nagy and colleagues (1981; 1991) have also noted that dealing with parenting provides therapeutic leverage to propel a client forward in the therapy. While we may ultimately want the client to make changes for herself, a client who feels worthless may initially need outside motivation. Knowing that helping herself will also help her children can provide that impetus. Progressing in therapy will allow her to enjoy watching her children grow, allow her to be more fully present to interact with and protect her children, and model for her children the ability to care for oneself.

The "secure base" (Bowlby, 1988) in the therapeutic relationship that is built for the client through empathizing and crediting, the consistency of the therapist, and the non-threatening nature of the therapy, will ultimately allow the client to begin to take intrapsychic risks. Finding ways to empathize with and credit intrapsychic alters (Benjamin & Benjamin, 1994a) only occurs after a client has felt empathized with and credited. Practicing how to give empathy and credit to one's own children also may help the client with these processes on an inside level.

Finally, an essential benefit of concentrating on the parenting of the client is that it indirectly focuses the client on the ways in which she herself was parented. Remembering childhood traumas and the ways in which they were handled is a critical part of the healing process. Each developmental stage that her child goes through stirs up unresolved issues from her own childhood (Benedek, 1959; Benedek, 1970; Jessner, Weigert, & Foy, 1970; Winnicott, 1970; Mahler, Pine, & Bergman, 1970; Anthony, 1970a, 1970b; Kestenberg, 1970; Galinsky, 1981). The therapist can utilize this material to help her get in touch with what life was like for her when she was four, five, six, ten, or fifteen years old. Comparing how she manages her child at each stage with how she was dealt with can help to stimulate material for therapy.

Dissociative disorders present the peculiar problem of disruption in the continuity of a person's behavior, affect, sensation, and knowledge (Braun, 1988a, 1988b). In the early stages of therapy, knowledge of past information is enough. Later on, however, it needs to be integrated with affect and sensation. Fraiberg, Adelson, and Shapiro (1975) have emphasized how important it is for trauma victims to remember the past with the associated affect. They assert that only by experiencing this affect will the person not revisit the trauma on their own children.

In later stages of therapy, the therapist can stimulate missing affect by asking the client how she thinks her own child might have felt if she were treated in ways similar to the dissociative parent. For instance, to the client who is unable to remember the feeling that accompanied her father's brutal murder of her pet dog, the therapist might ask: How do you think your six-year-old child might feel if her dad murdered her pet dog? Encouraging, empathizing, and crediting different alters as they report different aspects of the same event contributes to blending and ultimate integration of parts.

As the therapy progresses and hostile alters feel freer to come forward, the empathic and crediting stance of the therapist begins to erode the negative affect. Wearing down neg-

ative affect in therapy reduces it in the child-rearing at home. Reciprocally, progress in dealing with children models skills in dealing with alters and the psychodynamic issues that they represent.

Direct Parent-Child Interventions

It is customary for family therapists to include children in therapy sessions (Boszormenyi-Nagy & Spark, 1973 & 1984; Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991; Combrinck-Graham, 1986; Zilbach, 1986; Combrinck-Graham, 1989). The client's having children of any age present provides the therapist with unique opportunities. First of all, it allows the therapist to directly observe parent-child interactions. Many authors in the MPD field advocate assessing children for the presence of a dissociative disorder (Kluft, 1984, 1985; Braun, 1985; Sachs, 1986; Putnam, 1989). Certainly, having parent and child together for a session is a first step in this process.

In the case of parents and infants, having parent and baby together gives the clinician the chance to observe the bonding-attachment process. Fraiberg, Adelson, and Shapiro (1975), in their classic article "Ghosts in the Nursery," have eloquently described how a therapist can conduct therapy using the parent-infant pair:

> Everything that transpired between mother and baby was in the purview of the therapist and in the center of the therapy. The dialogue between the mother and the therapist centered upon present concerns and moved back and forth between the past and the present, between this mother and child and another child and her family, in the mother's past. The method proved itself. (p. 395)

Later, they discussed how through observation of the developmental needs of the child, they helped their client see the connections between the past and the present. They endeavored to promote a more secure attachment in the baby and a responsiveness in the mother:

> In a natural, informal, non-didactic way, Mrs. Adelson [the therapist] would comment with pleasure on Mary's [the baby] development and weave into her comments useful information about the needs of babies at six months or seven months, and how Mary was learning about her world, and how her mother and father were leading her into these discoveries. Together, the parents and Mrs. Adelson would watch Mary experiment with a new toy or a new posture, and with close watching, one could see how she was finding solutions and moving steadily forward. The delights of baby watching, which Mrs. Adelson knew, were shared with Mr. and Mrs. March, and, to our great pleasure, both parents began to share these delights and to bring in their own observations of Mary and her new accomplishments....
>
> The talk would move at one point or another back to Mrs. March herself, to her present griefs and her childhood griefs. More and more frequently now, Mrs. Adelson could help Mrs. March see the connections between the past and the present and show Mrs. March how "without realizing it," she had brought her sufferings of the past into her relationship with her own baby.
>
> Within four months Mary became a healthy, more responsive, often joyful baby....
>
> Mrs. March had become a responsive and proud mother. (pp. 397-398)

The authors went on to observe that promoting the bonding process between parents and baby was just the beginning of therapy. Through that process, the clinician could credit the parents, build their self-esteem, and ensure enough trustworthiness in the therapeutic relationship that the psychotherapy of the mother could continue. The baby continued to be the focus of the therapeutic work. Through the relationship of mother and child, the therapist was able to help the mother re-experience the feelings of loss, grief, and rejection in her own childhood. She was also able to make transference interpretations about the mother's anxiety on seeing a male therapist who was part of the treatment team. Therapy ended when the baby was about two-years-old. The parent-child relationship had continued to improve and the therapist felt that the mother had made significant therapeutic change.

A similar process can be used with a parent and child of any age. Although it is impractical for a child to come to all therapy appointments, involving a child in sessions from time to time affords the therapist the opportunity to make developmental observations, to look for contributions that the child is making to the family, and to promote the parent-child relationship. The therapist must remain keenly aware that concern by the therapist toward the child creates a situation of implicit disloyalty for the child (Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991). The consequences of such a loyalty bind can be avoided if the therapist remains partial to each person in the therapy session. The therapist can instruct the parents through modeling empathy and giving credit. The therapist can also modulate affect and show warmth to all family members. Parenting skills such as listening and problem solving can be demonstrated in sessions.

Having children in a session reminds the parents of their accountability to their children. Cotroneo (1986) noted that in families in which there has been an intergenerational legacy of abuse, children are frequently parentified or expected to extend care to their parents at the expense of their own care and development. She reviewed three main presentations of parentification. The first involves parental anxieties and fears from the parents' own childhood losses and abandonments. The parents transmit that legacy of fear to the child by exacting a severe loyalty expectation to the exclusion of the child's own developmental needs. The child joins the parents in viewing the outside world as alien and

hostile. A second kind of parentification is that of a split loyalty. When conflict exists in a marriage, the child is often forced to choose between one or the other of the parents. This kind of choice imposes a terrible ethical burden on the child and can lead to self-destructive or suicidal behavior. Finally, a third type of parentification is not acknowledging a child's efforts to give to the family. A child who is held accountable to inappropriate expectations and who is criticized for not carrying them out eventually believes that he is not competent to please others. He may repeatedly seek out other relationships where he sacrifices himself in order to please others.

Parentification robs children of future resources for trust (Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991). When the therapist observes parentification of children, the therapist can work with the whole family together and with the parents separately. When the whole family is together, the therapist needs to acknowledge everyone's contributions to the family. Children need an opportunity to express how they see their role in the family and whether or not they feel fairly treated. Parents need to be encouraged to accept the age-appropriate contributions of children without criticizing or blaming them.

The work in parent-child and family sessions may stir up memories and feelings for the dissociative client that can be used to further individual treatment. Especially common are fairness issues. When the therapist treats each family member fairly and with due consideration, and he encourages parents to treat their children fairly, the dissociative client is often upset. She may be reminded of how unfairly she was treated as a child. At the same time, encouraging fair treatment among family members gives the client the behavioral option of showing similar consideration to the struggles of the intrapsychic alters. Acknowledgement and crediting of internal parts paves the way for intrapsychic cooperation, a necessary prelude to integration.

Marital Partners as Parents

Usually the course of treatment for dissociative disorders disrupts the marital homeostasis (Sachs, 1986; Sachs, Frischholz, & Wood, 1988; Putnam, 1989; Panos, Panos, & Allred, 1990; Williams, 1991; Benjamin & Benjamin, 1994b). We believe that to ensure an optimal outcome for the entire family as well as for the individual client with a dissociative disorder, marital therapy is a necessary part of the overall family treatment plan (Benjamin & Benjamin, 1992). Accountability to children may provide therapeutic leverage for change in the marriage and within each individual partner (Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991). Boszormenyi-Nagy and colleagues (1981; 1991) see parenting as inseparable from marriage. When parents can work cooperatively on their child-rearing, they reduce negative affect in the family and deparentify the child. Additionally, working on the child-rearing furnishes the couple with a concrete task to accomplish together. Usually there is high motivation for achieving success.

Because the dissociative parent has so many symptoms that interfere with parenting (Kluft, 1987; Benjamin & Benjamin, 1992, 1994c), the non-dissociative parent can be encouraged to become more directly involved in the parenting. However, it should be noted that the partners often have significant emotional problems of their own (Putnam, 1989; Benjamin & Benjamin, 1994b). Consequently, they may need to be guided in how to play a constructive role in the parenting team. In order to provide support for the parents and extrafamilial role models for the children, parents may seek to utilize support networks outside the marriage. Sachs (1986) has advocated parenting support groups and other community support networks for the MPD client. The partner may also reduce stress by locating appropriate support organizations sponsored by churches, schools, or other community organizations. Finally, the parents can manage the healthy growth and development of their children by looking for school, church, and community organizations that offer programs to enhance the talents and special interests of their children (Benjamin & Benjamin, 1994c).

The Sexually Abusive Parent

In some cases, the dissociative parent has sexually exploited a child. In Kluft's (1987) study of parental fitness, 16% of his sample were grossly abusive (physically or sexually) to their children. Dissociative clients may find themselves in a peculiar predicament: just as amnestic barriers preclude knowledge of traumatic events in their own childhood, the same barriers may preclude the knowledge of their mistreatment, including sexual exploitation, of their own children. Thus, paradoxically, as they improve sufficiently to remember their own past and their past behaviors towards their children, they are horrified to remember that they have also been perpetrators of abuse.

Where parental abuse of the child has occurred in the distant past, the parent needs to acknowledge it, face it, grieve, and seek to work it through with the child (including the adult child), who may or may not remember it himself. This kind of resolution has the potential to be healing for both the parent and the child. It also serves to diffuse the time bomb of revelation later when the child eventually does remember it. Frequently, this recollection occurs in adulthood when the grown child is dealing with her own children. Finally, resolution with the child is a step in breaking the intergenerational chain of abuse which is most likely to occur when childhood traumas are not remembered and worked through (Fraiberg et al., 1975; Hunter & Kilstrom, 1979; McCord, 1983; Main & Goldwyn, 1984; Zeanah & Zeanah, 1989; Kaufman & Ziegler, 1987; Liefer & Smith, 1990; Oliver, 1993)

If the abuse is ongoing, it is legally mandated in many jurisdictions to involve child protective services. This intervention is often traumatizing for the client-parent and the family. When therapist and client can talk over the reporting procedure and do it together, or better yet, when the client can report herself, she may feel more in charge of the proceedings. Regardless of how it is handled, however, it means that the client will be investigated, and the exposure will activate feelings of shame. The client-parent may even view the therapist as a kind of perpetrator for summoning

the agency. Nevertheless, when agency intervention is required, we believe that in many cases reporting can be handled in a way that strengthens the client and the family.

Outside intervention sends many messages to the members of the family. It says that the abuse must stop. It lays secrets out on the table so that children and parents can talk about them. It gives children a way to call for help if necessary. It is an opportunity to credit the client-parent for her courage in revealing secrets and in taking responsibility for the safety of her children. It has the potential to become a first step in rebuilding trust in the family.

Through the course of individual therapy, the official reporting or the necessity of resolving previous abusive acts with a child may also activate fairness issues. The client-parent may feel resentful that she had to report herself or ask forgiveness from a child when she had not experienced agency intervention or acknowledgement from her own parent. This upset is an occasion for the therapist to sensitize the client to ethical issues (Boszormenyi-Nagy & Spark, 1973 & 1984; Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991; Cotroneo, 1986; Van Heusden & Van Den Eerenbeemt, 1987). The client, in her sexual abuse of her child, was trying, often at an unconscious level, to rebalance an old debt to her that was owed by her own parents who mistreated her in some way. The way in which she attempted to make the past more just for her was unethical and hurtful to her child, to herself, and to her partner. In fact, if it had continued, it would have been a way to pass on the legacy of child abuse to the next generation. Through the reporting of the abuse either officially or with the decision to make amends, the client opens up new options for herself, her partner, and her children. Her accountability is a statement of her readiness to rebuild trust among members in the family. She earns constructive entitlement through her caring for her children. Her ability to give to others interrupts the cycle of destructive relating and puts her on a path toward accumulating self-worth. Feeling better about herself because of her contributions to her family and to posterity helps to anchor the course of individual therapy. Stopping and/or dealing with her own abuse of her children has the potential to add new meaning to her life as she realizes the impact of her actions on future generations.

Over a period of months, the client-parent may need special help in rebuilding the parent-child relationship. In addition to understanding how she has used the parent-child dyad as a substitutive context in which to rebalance the debts owed her by her own childhood betrayers, she needs to rectify the situation at the interpersonal level. This rebalancing is accomplished by telling the child that the parent is fully responsible and the child is not to blame. It may require numerous parent-child sessions as well as family sessions with the non-abusive parent to complete this task. All family members need an opportunity to air their feelings, perspectives, and concerns. The therapist needs to maintain a stance of multidirected partiality with all participants (Boszormenyi-Nagy & Spark, 1973 & 1984; Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991; Benjamin & Benjamin, 1994a). This attitude means that the therapist is accountable to all individuals in the room and anyone outside of the room who might be potentially affected by the intervention. The therapist sides with each person, but at the same time, demands accountability from each person. The therapist also empathizes with and credits each family member as he shares. This process contributes to trust-building among the members of the family.

As the parent-client proceeds in this process and owns her accountability, the issue of how she can forgive herself for hurting her child often surfaces. Helping her to appreciate the situation of her own abusers and the transgenerational relational consequences of abuse may assist her to exonerate her own abusers. When she can appreciate the circumstances of her parents, she can more fully accept her own circumstances and begin to exonerate herself (Benjamin & Benjamin, 1994a). By making a conscious choice to stop the abuse, rebuild relationships in the family, and prevent abuse in the next generation, she makes use of relational resources that she did not know she had. Through crediting from the therapist, her own internal trust reservoirs are filled. Increased self-acceptance, self-validation, and self-trust lay a foundation for the client to build upon as she proceeds in the arduous intrapsychic psychotherapeutic process.

CONCLUSION

A focus on the parenting process of the client with a dissociative disorder can be utilized clinically in a number of ways to further individual treatment and to enhance family relationships. The therapeutic alliance can initially be fostered by attention to the client's parenting. Within the secure base of the therapeutic relationship, the client learns the twin processes of empathy and crediting which she can use with her children and her intrapsychic alter system. As she cognitively and affectively remembers more of her own childhood traumas, often in response to her own children's developmental phases, she becomes more accountable to the well-being of her children. The motivation to be effective with her children may also activate her to work with her parenting partner (usually her spouse) to improve the parenting: reduce conflict between the partners, reduce negative affect, become more sensitive to the developmental needs of the children, etc. Cooperating with the partner to build trust in the family instills a sense of self-efficacy in the client. Thus, working on parenting is important both for its own sake and because it paves the way for progress in the individual therapy. ■

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