AN OVERVIEW OF FAMILY TREATMENT IN DISSOCIATIVE DISORDERS

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ABSTRACT:

Family treatment interventions, in contradistinction to family therapy, are an important concomitant to individual therapy in the treatment of multiple personality disorder (MPD). Such interventions have the potential to restore trustworthy relationships in the family and, thus, to promote the healing of the individual patient and other family members. This article discusses some of the possible modalities of treatment, including parallel therapy with a partner, marriage therapy, child therapy, parenting counseling, group therapy with MPD mothers, and group therapy with partners or parents of individuals with MPD. It also explores some of the philosophical underpinnings of these approaches with particular emphasis on ethical concepts derived from Contextual Family Therapy.

INTRODUCTION

Relatively little has been written about the use of family treatment with families in which one or more members has a dissociative disorder (Beal, 1978; Davis & Osherson, 1977; Fagan & McMahon, 1984; Sachs, 1985; Kluft, 1985; Kluft, Braun, & Sachs, 1984; Frischholz, & Woods, 1988; Panos, Panos, & Allred, 1990; Williams, 1991). It seems ironic to us that a family-based approach has been underutilized since this disorder is precisely about the failure of a healthy family process. In dissociative families, either the family is directly the agent of abuse (through incest, alcoholism, brutality in childrearing) which results in the direct traumatization of children, or the family is neglectful, inattentive, or overwhelmed by the effects of external trauma (e.g., war, natural disasters, or physical or sexual abuse by non-family members).

Dissociation is a defense mechanism which is characterized by a splitting off of troubling memories, sensations, feelings, or thoughts with an accompanying disowning of these disavowed mental structures. Braun (1984) has conceptualized dissociation on a continuum which extends from the normal loss of awareness in daydreaming through increasing losses of memory, reality, or identity such as in Multiple Personality Disorder (MPD). According to the Diagnostic and Statistical Manual of Mental Disorders (*DSM-III-R*), MPD is characterized by the existence in a person of two or more distinct personalities, lost periods of time, internal voices, and a mechanism for switching from one personality state to another.

REVIEW OF THE FAMILY LITERATURE ON MPD

Kluft (1984a; 1984b) has formulated a four-factor theory to explain the etiology of the disorder which begins in early childhood. The first factor is the individual's biological capacity for dissociation. The second factor includes traumatic events or life experiences which overwhelm a child's non-dissociative defenses. In addition to sexual abuse, extreme physical abuse, abandonment, neglect and psychological abuse, Kluft (1984a) has catalogued a list of traumas such as the loss or death of significant others, witnessing a murder, an accident or the carnage of war, receiving serious death threats, being dislocated culturally, being caught between embattled parents in a divorce situation, being treated as if the child is the opposite gender, and excessive observation of the primal scene. The third factor has to do with two concurrent processes: the environmental shaping influences on a child (such as the modeling done by a parent who may have MPD or another psychiatric disorder) and the intrapsychic developmental substrates (such as imaginary companions, introjections, and internalizations) that the child experiences at any given time that predispose to the development of alter personalities. The fourth factor has to do with parenting. When a child's caregivers either do not provide barriers that protect a child from traumatic experiences (neglect) or do not provide the child with restorative experiences (nurturing, soothing, processing) after traumatic events, the child adapts to the situation by going inside himself to find comfort and protection.

Kluft, Braun, & Sachs (1984) have elaborated on the characteristics of parents in families in which children develop MPD. They say a sense of sadomasochism may be apparent, and the parents may have low self-esteem. One parent may be grandiose while the other is deflated or there may be a fluctuation of that dynamic. The parents may not be able to empathize, and they may misunderstand the devel-

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opmental needs of children. Other characteristics that they may possess are: impulsivity or aggressiveness, overvalue of control, and an ability to nurture the child that is limited to when the child is serving their needs. While social interactions tend not to be meaningful, some function well in circumscribed roles such as the military or religious settings. One or both may have a diagnosable mental illness often with dissociative or borderline qualities. These parents are often users of drugs or alcohol and engage the children in the use of these substances to make them amnestic to the abuses. The authors go on to describe three types of marital styles: a "pseudo-normal veneer", a conflicted relationship, or a relationship in which one partner is apparently overadequate while the other is apparently underadequate. The family system as a whole can be described as unpredictable, closed with impermeable boundaries, having unconventional roles for family members, and an air of secrecy and obedience.

Braun (1985) has pointed out that MPD is transgenerational in nature, and Kluft (1984b) and Coons (1985) note that the children of MPD mothers are at risk for a variety of psychiatric disorders. Kluft (1987) observes that the majority of identified patients with MPD are women in the childbearing and childrearing age range. Kluft goes on to categorize mothers who have MPD as abusive (mothers who inflicted harm), compromised/impaired (mothers whose symptoms got in the way of parenting, who did not behave in the best interests of the child), competent (mothers who acted in the best interest of the child), and exceptional (mothers who performed the mothering function in one personality or in a co-conscious fashion or who avoided switching in front of the child). The results of his study suggested that 61.3% of the mothers fell in the range of abusive or compromised/impaired.

PHILOSOPHY AND METHODS OF FAMILY TREATMENT

Exonerating the Extended Family

The traditional treatment of MPD has been individual therapy although a number of clinicians have begun to see other family members as an adjunct to individual therapy (Beal, 1978: Davis & Osherson, 1977; Fagan & McMahon, 1984; Sachs, 1985; Kluft, 1985; Sachs, Frishholz, & Woods, 1988; Putnam, 1989; James, 1989; Panos, Panos, & Allred, 1990; Williams, 1991). The authors of this article see the family as a resource for rebuilding trustworthiness in relationships (Boszormenyi-Nagy & Ulrich, 1981). The individuals who enter treatment for MPD have been systematically and consistently robbed of their ability to trust themselves and others. Although some practitioners have included the extended family of MPD patients in treatment (Beal, 1978; Kluft, Braun, & Sachs, 1984; Putnam, 1989), our experience has been that the extended family has been so excessively abusive to the MPD client that contact has often had to be terminated to insure the safety of the client.

Nevertheless, the issues around relationships to extended family members are main themes in the treatment of MPD clients. Boszormenyi-Nagy & Krasner (1986) believe that clinical improvement often coincides with a parent-client's ability to "exonerate" or appreciate in a mature fashion the limitations of her own parents. (Although the pronoun "she" is used for simplicity, our explanation is equally applicable to males and females.) It should be noted that in the Contextual Approach to family therapy, there is a strong distinction made between "forgiveness" and "exoneration": "...exoneration typically results from an adult reassessment of the failing parent's own past childhood victimization. It replaces a framework of blame with mature appreciation of a given person's (or situation's) past options, efforts and limits" (Boszormenyi-Nagy & Krasner, p. 416).

Consequently, in utilizing this concept, it should be clearly understood that we are not advocating that a client who is a victim of abuse unconditionally pardon or excuse abusive or neglectful parents, but rather that the client come to a mature understanding of the parents' actions as a product of the parents' own traumatizations in a transgenerational chain of disturbed parenting. This idea becomes particularly key because as therapy unfolds, a client who presents as a victim may ultimately come to reveal that she herself was a perpetrator of abuse of her own children. Indeed, this is a rather common scenario. Only when the client can view her parents as victims of transgenerational abuse does she have the resources to see herself in a fair light: as a victim/perpetrator of an intergenerational legacy of child abuse. At that point, the client is much freer to begin to learn to parent in healthier ways without being paralyzed by the emotional baggage from the relationship between the client and her parents.

The Distinction Between Family Therapy and Family Treatment

Because the development of MPD happens within the context of an abusive and/or neglectful family, we believe that family interventions are an integral part of the treatment of the disorder. Like Sgroi (1982) and Friedrich (1990), we differentiate family therapy from family-centered treatment strategies. While family-centered treatment is an umbrella that covers many family interventions, family therapy is one of the possible interventions under that umbrella. Our main treatment goal is to stop the cycle of transgenerational abuse and/or dysfunctional parenting and to encourage healthier alternatives. Our emphasis is on the family as a whole entity and particularly on the parenting within the family. Boszormenyi-Nagi & Ulrich (1981) point out that the potential for trust in future generations is deeply rooted in parental accountability. Because of the transgenerational nature of the illness, we see the responsibility to posterity to be as important as the responsibility to the individual MPD client. Kluft (1985) and others (Sachs, 1985; Goodwin, 1989) recommend routine assessment of children who have a parent with MPD. Our treatment philosophy is aimed at dual goals: both the traditional one of providing treatment to the individual family member with MPD in an effort to move the person in the direction of integration of personalities and also the additional goal of facilitating healthy relationships within the family. We provide a variety of inter-

ventions: supportive individual treatment for the partner (either with another therapist or with us), assessment and treatment (if necessary) of individual children (either with another therapist or with us), marriage work, parent-child dyad work, sibling observation, group support for the MPD mother and group support for the MPD partner or parent of an MPD child. Family therapy in which parents and child(ren) work together is another important modality.

Occasionally the client who is referred to our practice is the child of an MPD parent. Usually the MPD parent is in individual therapy with another clinician. In that event, one of us may work with the child and one with the MPD parent's partner. We will do parenting counseling for one or both parents, and we will invite the MPD mother to the mother's group and the partner to the partner's group. Additionally, we will use part or all of each child's session to work on the relationship between parent and child.

Parenting Issues in MPD

Our experience in working with MPD parents suggests that the MPD parent has many specific issues that affect parenting:

- Inconsistencies in relating to the child because of switching from personality to personality with accompanying loss of memory

- Modeling switching behaviors such as eyeroll or covering the eyes

- Confusion in the head from a multitude of voices that makes it hard to focus on the needs of the child

- Competitive feelings toward the child who has much more familial support that the MPD parent did as a child

- Child alters who want to play in their alter states with a child

- Their own inadequate parental role models

- Problems in the marital relationship that interfere with team parenting

- Personal social problems that make it hard to deal with teachers, neighbors, or parents of the child's friends

- Feelings of guilt for their inadequacies and worry about the effects of the inadequacies on the child

- The adjustments on recovery when the parenting cannot be delegated to one or several designated parenting alters

- Emotional separations (due to dissociation) and physical separations (due to hospitalizations) from the child

- Other complications as a result of additional psychiatric disorders or consequences of the underlying MPD (alcoholism, depression, anorexia/bulimia, phobias, suicidal tendencies, etc.)

As a result of the MPD parent's specific issues, the children of MPD parents are at a risk for emotional/physical abuse or neglect. There is often confusion in the communication from the MPD parent. The child may be parentified and overly protective of the MPD parent. The child may feel responsible for the parent's illness particularly because often the child's behaviors trigger memories for the parent which may result in switching and either hurting or withdrawing from the child. The child may feel abandoned because of frequent hospitalizations of the parent or emotional distancing. The child may be afraid to (because of the unpredictability of the parent) or told not to bring friends home because the parent cannot handle the extra stress.

Types of Therapeutic Interventions

Because we view parenting as a critical issue in therapy, we have a number of ways of intervening. We do individual or couples' parenting counseling. We talk about parenting in the mothers' group and the partners' group. We send individuals to outside parenting education groups. Also, we provide child therapy which focuses both on the individual child and healing traumas as well as on relationships between the child and both parents and the child and siblings. In both the mothers' group and the partners' group, we credit parents for everything they are doing including attending the group. Specifically, we encourage parents to set limits and care for themselves so they are not giving more than they can handle either emotionally or in physical ways to other family members. Such overgiving may result in emotional exhaustion, guilt for failing to adequately meet the needs of others, or anger that the needs of others seem like insatiable demands. We try to build hope and trust in the family through giving the MPD parent encouragement about his/her power to change and break the cycle of abuse.

For young children, we provide play therapy to help them work through their feelings. (Fagan & McMahon, 1984; Guerney, 1983; Griff, 1983; Terr, 1984; James, 1989; Gil, 1991) We conduct some sessions or parts of sessions with one or both parents present in order to model how to listen, accept feelings, and set limits. In situations in which the parent fits Kluft's (1987) "competent " or "exceptional" description, the parent may function as a "co-therapist" with occasional cues from the therapist. Children are helped to feel safe in a stable therapeutic situation in order to build trust in the outside world and ultimately to build self-trust. Strategies are aimed at teaching appropriate boundaries, the idea of fairness, and what constitutes appropriate touch (in cases in which there has been sexual molestation).

Many play therapists and clinicians who work with MPD children concur that unless the traumatized child can re-enact and process the traumatic event(s), healing cannot occur (Fagan & McMahon, 1984; James, 1989; Terr, 1983; Kluft, 1991; Gil, 1991). Consequently, we use a trauma-based

model (Gil, 1991) in which, after an appropriate sequence of exploratory and non-directive sessions have been provided (with opportunities to allow the child to test limits), play materials are set out that provide a context for a child to re-enact the trauma. Materials that are particularly useful are art media, sandtray, puppets, dolls and figures, bopbags, and rubber animals and insects. Hypnosis has been used by some clinicians in the treatment of traumatized children (Friedrich, 1990; Kluft, 1991; Rhue & Lynn, 1991). Where appropriate, we use hypnosis with the parents' permission to enhance mastery, promote relaxation, and assess for MPD. The majority of hypnotic interventions tend to be naturalistic inductions through the use of metaphorical stories. Finally, where needed, we call in outside agencies such as child protective services or we maintain a relationship with the child's teacher, guidance counselor, or pediatrician.

Marital Issues and Couples' Treatment

A number of clinicians have felt that marital interventions enhance the treatment of MPD clients (Sachs, Frischholz & Woods, 1988; Putnam, 1989; Panos, Panos, & Allred, 1990; Williams, 1991). Two specifically caution that such work needs to focus on "here and now" issues (Sachs, Frishholz & Woods, 1988; Putnam, 1989). Sachs, Frischholz and Woods (1988) see marriage work as focusing on the education of the partner about MPD, dealing with the disruptions of the home-ostasis of the marital system, sharing thoughts and feelings, and preventing the sabotage of the primary treatment of the MPD client. Panos, Panos, and Allred (1990) expand the issues of marriage work to include education, understanding "seepage" or what they see as the pervasion of the feelings of one alter into another alter, handling conflicting demands, responding to child alters, the sexual relationship, adjusting to integration, and having patience with the therapeutic process. Williams (1991) also focuses on the themes of marital treatment: education, limit setting, contracts, mapping of the MPD client's internal system, knowledge of the trauma history, play and intimacy, the needs of the partners and children, partner's issues, and the emotional impact on the marriage.

In our experience, marriage work has the potential to be very helpful in the overall treatment plan. The timing of marriage work is different for individual couples. Sometimes the marriage work needs to pave the way for the individual work in order for the MPD client to feel that he/she has a safe haven to go back to during the process of therapy. Other times, the individual work preceeds the marriage work and shores up each of the partners before they feel confident enough to work on the relationship. Sometimes we do the marriage work as a co-therapy team and other times one of us sees the couple as an individual therapist. The focus of the work is on the marital relationship and promoting a sense of appreciation and empathy of each partner for the other.

While the MPD partner has usually been severely traumatized, the non-MPD partner has his/her own story (which is regarded as equally legitimate) to tell. Family of origin issues and their effects on the relationship, current marital issues such as the impact of the MPD on the family, sexuality, trust, feelings, and co-parenting all come up in marital sessions. The therapy hour provides a safe place where the MPD client can feel comfortable "switching" in a controlled way and in the reassuring presence of the therapist. This process allows an introduction of the spouse to the alters in a constructive manner rather than in the usual chance interaction during the throes of an emotional storm or a marital misunderstanding. They may meet alters who do not view themselves as married, child alters, and angry alters. This setting provides an opportunity for education about useful communication skills such as how to listen and how to disagree respectfully, i.e., "fair fighting". Appreciating family loyalties and how each individual can give to and receive from the other in fair ways helps to build a sense of trustworthiness in the relationship. (Boszormenyi-Nagy & Spark, 1984) Assessing what the strengths of the family are and what resources are available to the family (e.g., help from extended family of the non-abused partner, daycare help, etc.) and dealing with the practical issues of everyday living find their place in marital sessions.

Groups for MPD Mothers and Partners/Parents

Adjunctive modalities are the two types of groups that we run: one for mothers who have MPD and one for parents of or partners of a person with MPD. Both groups meet once each month. It has long been known that groups have the potential to provide healing experiences for individuals (Yalom, 1975). Homogeneous groups for individuals with MPD have been discussed in the literature (Coons & Bradley, 1985; Caul, Sachs, & Braun, 1985; Putnam, 1989). An MPD mothers' group, however, is somewhat distinctive from those described. The group is composed of mothers from our own practice as well as referred mothers who we have screened and accepted from other practices. This group therapy is for MPD clients who are responsible for the rearing of children ranging in age from newborns to young adults. It provides for them a safe context in which they can share with other women the difficulties of parenting with a dissociative disorder. Additionally, as Yalom (1975) notes, it gives them corrective emotional experiences via a group interaction which provides a constructive contrast to the family of origin group settings from which they came. The group is structured with a number of ground rules including a request that mothering alters stay present for the group. The group provides an arena for both education about parenting and support for difficult issues that MPD mothers face. Some of those issues include:

- Guilt for not being "normal"

- How to care for themselves

- Lack of trust in the outside world

- Children as triggers for memories

- How to focus on individual therapy while having to manage the practicalities of parenting

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- Feeling like they are living a "lie" or the illusion of a "normal" life

- Social struggles

- How to handle their feelings around their own past abuse or neglect of their children

- How to explain MPD to their children

- How to deal with the relationship with their partners

- How to set boundaries in their lives

- How to deal with recovery

The group format for partners and/or parents of MPD clients is also a unique model. A group setting for these individuals gives them a social milieu to talk about issues that they feel they cannot bring up in ordinary social encounters. Hearing other people talk about their problems with an MPD partner or child gives them opportunities to both give and receive around issues that are very central to their lives. While the goals are education and support, the emphasis in the group is on what is going on for the group member at any given time rather than on the MPD client. The group is made up of clients from our own practices as well as screened clients from other practices. Themes that commonly come up are:

- How to care for themselves

- Guilt over not noticing that a child was being abused or neglected

- Feeling like they are not doing enough for the MPD partner

- Upset over false starts for the MPD client in therapy

- Grief and confusion over the diagnosis

- Coming to terms with the disability of their partner or child

- How to deal with anger toward the perpetrators of the partner/child, toward the partner, toward themselves

- How to relate to others

- How to set boundaries for themselves in the relationship

- How to deal with the practicalities of everyday living

- How much to trust the partner or the child

- Marital issues

- Sexual issues

- Parenting issues

- Competition with the MPD mate's therapist

- How to balance work with home life

- Loss of expectations of what life was supposed to be like

- A sense of unfairness

A Case Example of the Uses of Family Treatment Modalities

Mrs. O was a woman in her thirties who came initially for treatment of postpartum depression. After nine months of therapy, it became apparent that she suffered from MPD. She realized that her son had been involved in intrafamilial incest with her parents and herself. He was assessed in play therapy for MPD. She attended his sessions and occasionally alternated with her husband. On several occasions the whole family, including the year old baby, attended a family session. Mr. O and Mrs. O came for marital work. Mr. O joined the parents'/partners' group and realized that he needed individual work around his own neglectful family of origin. He continued in both group and individual therapy. Mrs. O joined the mothers' group as well as attending individual sessions twice weekly. Mrs. O also attended an ancillary parenting education group. Their child continued in play therapy.

CONCLUSION

We believe that the therapist who treats individuals with a dissociative disorder needs to be well grounded in individual treatment so that the use of family-centered interventions can be appropriately directed and effective. However, in our view, often the individual intervention is not sufficient. Unless there is a family treatment approach as well, the MPD client may not derive maximal benefit from the therapeutic process, or even if the individual makes an adequate recovery, the family may still be grossly impaired or not survive as a unit. We see the family approach as critical for utilizing the resources that already exist within the family to rebuild the trustworthy relationships and to provide a safe context for healing. ■

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