

# THE PROCESS OF THE MPD THERAPIST AND THE USE OF THE STUDY GROUP

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## ABSTRACT

*This article presents a developmental model of the therapist's process of skill acquisition delineating Neophyte, Mastery, and Expert Phases. Specific characteristics and pitfalls of each developmental stage are described on a continuum. The discussion also focuses on the use of the local study group as an educational and supportive environment for the therapist treating patients diagnosed with dissociative disorders. A description of how such a study group provides a source for case consultation, peer supervision and support for the otherwise isolated and confused therapist is presented.*

Just as survivors of Post-traumatic Stress Disorder (PTSD) are struggling to cope with the impact of the knowledge of their trauma, so do therapists struggle to integrate the effects upon themselves of the trauma told to them by their clients. Figley (1983) names this kind of experience, "secondary victimization." In our experience the therapist's process parallels many aspects of PTSD. For example, members of our study group report recurrent distressing recollections of clients' experiences of abuse, difficulty sleeping, nightmares, paranoia about people or situations in the environment, and hypervigilance.

Much is written about the negative effect of the client's traumatic material on the therapist. The literature on burnout (e.g., Freudenberg & Robbins, 1979; Bermak, 1977; Farber & Heifetz, 1982) emphasizes that all mental health professionals, to varying degrees, are negatively impacted by their work with populations in need. Carl Jung (1966) terms this "unconscious infection." Chessick (1978) reported that the symptoms of depression, sadness, and despair can be contagious. Farber (1985) said that the clients' psychopathology can be transferred to the therapist. Traumatic material presented by the client threatens the therapist's established beliefs, expectations, and assumptions about her or himself and the world. Piaget (1971) named these established beliefs, "cognitive schema." As McCann and Perlman (1989a) point out, these beliefs relate to issues of trust, belonging, isolation, power, safety, respect for others, independence, and frame of reference. We would like to include an addi-

tional item: the betrayal of our professional training. In treating the profoundly traumatized, what we have been taught may fail us. We are called upon to create non-traditional modalities which diverge from traditional psychological protocols and may evoke critical judgment from professional colleagues. Feeling demoralized, the therapist may experience isolation from the professional community.

## THE DEVELOPMENTAL PHASES OF THE MPD THERAPIST

The intention of this paper is to present a model describing the developmental phases of the therapist who works with dissociative disorders. This model is an outgrowth of observing the reactions and growth in members of the Houston Dissociative Disorders Study Group over a two-year period. The Houston Study Group is one of the largest component groups within the International Society for the Study of Multiple Personality and Dissociation, with a current membership of sixty-three clinicians. As a function of the study group's purpose to provide support to the overwhelmed therapist, members were invited to share their feelings about their work with MPD clients. As the group grew in membership we saw patterns in other clinicians similar to our own experience. In the initial stages we differentiated between what then were clearly two phases of expertise: The Neophyte Phase and The Mastery Phase. Later, to make the model complete we recognized a third phase: The Expert Phase. These three phases define an evolutionary process that moves along a continuum from Neophyte through Mastery to Expert Phases. The boundaries between the phases are permeable, allowing regression to an earlier phase to occur, and its typical feeling states to be re-experienced. In this paper we will use the terms client and patient and the pronouns she, his, and hers interchangeably.

## NEOPHYTE PHASE

### *Characteristics*

1. The therapist feels overwhelmed by the nature of the disorder and its demands. For example, the Neophyte can only tolerate one MPD client at a time.

2. The therapist often feels inadequate because her training did not prepare her for working with highly dissociative patients. It betrays her sense of competency.

3. The therapist often feels an urgency to keep people in treatment.

4. The therapist may feel pressured by the patient to push past conventional and accustomed therapeutic boundaries.

5. The clinician often experiences feeling indispensable when caught up in the client's idealization of her. As the client says: "You're the only person who understands me;" or "No one else could diagnosis this."

6. The new therapist reports feeling overly responsible for the patient's progress.

7. Anger seems to be a more common reaction among new therapists, manifesting itself in control issues.

8. The clinician in this phase reports feeling isolated from her customary professional support systems.

9. The therapist experiences secondary post-traumatic stress symptoms, such as:

- depression
- physical illness or symptoms
- recurrent distressing recollections
- dreams of client or client's abuse incidents
- sleep disturbance
- hypervigilance
- paranoia

### *Common Pitfalls*

1. The collegial nature of the work blurs boundaries, and requires the therapist to define and re-articulate the therapist's role and the patient's role. Nonetheless, there is difficulty in this area.

2. The therapist colludes in fragmentation of alternative personalities by: talking to a favored or single alter; thinking it possible to keep secrets from other parts of the system; and/or accepting specific alters' statements about their powerlessness within the system or powerfulness over the system.

3. The clinician's denial of the diagnosis of MPD is parallel to the client's denial of the diagnosis of MPD, which may impede the progress of the therapy.

4. Therapists in this phase have more difficulty in taking care of their own needs, and run the risk of becoming overly invested in the client.

5. The neophyte may engage in power struggles with the patient.

6. The therapist may have greater difficulty maintaining therapeutic boundaries increasing the likelihood of becoming enmeshed.

## **MASTERY PHASE**

### *Characteristics*

1. How the therapist deals with the counter-transference issues is the critical difference between the Neophyte and the more experienced therapist. Neophytes follow the directions of the experts because they are overwhelmed by the complexity of the treatment of MPD. In the Mastery Phase the therapist appears more capable of exploring his own counter-transference issues that are triggered by the work.

2. The therapist can articulate expectations about the therapeutic relationship, defining the therapist role and the

client system role.

3. The therapist sees the patient as a conglomerate and focuses on the whole system as the sum of its parts.

4. The therapist faces the loss of the client as a possible reality due to the nature of the disorder rather than as a glaring statement about his or her competency.

5. The therapist is able to manage and acknowledge a certain level of internal conflict and ambivalence.

6. Because of No. 5, the therapist is better able to use cognitive skills to look for patterns, develop a framework, and learn new treatment techniques.

7. The therapist is sufficiently desensitized to the traumatic material that she no longer uses denial as a primary defense mechanism.

8. The therapist has a growing respect for the system's internal knowledge about what it needs to heal. Since the therapist now has experience and a developing framework of understanding, the material the client presents is more effectively used.

9. Clinicians seem more self-confidence using their own creativity.

### *Common Pitfalls*

1. The clinician may push work too fast for the client.

2. He may lead the patient instead of following the patient.

3. The therapist in the Mastery Phase may fall into the trap of becoming self-righteous.

4. The clinician may experience secondary post-traumatic stress disorder when he is subjected to new heinous material.

5. At this point the therapist has developed her own style and point of view and can be rewarded for her competence and gain recognition. This, however, may set the stage for competitiveness.

## **EXPERT PHASE**

### *Characteristics:*

1. The therapist shares what he knows through teaching, consultation, supervision, and publishing. He then gains recognition from colleagues.

2. The experts have seen and treated large numbers of cases.

3. They have experience with complex cases as well as having treated a wider variety of cases.

4. This clinician distinguishes more quickly between counter-transference and projective identification.

5. She has a greater understanding of her own patterns of counter-transference and a more established process for dealing with them.

### *Common Pitfalls:*

1. It is possible for anyone to become grandiose in the face of acclaim.

2. The therapist may struggle with feelings of competition with colleagues at this level.

3. With the rigorous demands placed on the therapist, he may experience physical and emotional exhaustion from

overextension of himself.

### THE STUDY GROUP AS A PART OF THE LEARNING PROCESS

One of the problems for those of us working with MPD is that the diagnosis is controversial and many of the treatment modalities are different in many respects from those taught in traditional psychological education. The material these patients present is horrific in nature and difficult to assimilate. Charles Sherrington (1935) suggests the inclusion of the social environment to offset the incredible isolation that envelops the therapist. It is our assertion that a peer study group can provide this environment.

Suzanne Langer (1979), in discussing symbolic transformation, said that the growth of the mind parallels in large measure the observable use of language. Under normative conditions the development of thinking and of human intelligence moves through a predictive sequence. Lev Vygotsky (1986) describes a program of inquiry that, when applied to adult learning, indicates that the adult learner, when face-to-face with sensory data and charged with learning new concepts, repeats the states of symbolic transformation as described by Langer. Unlike the child learner, the adult learner's efforts are facilitated by the enormous amounts of prior learning that is anchored in one of three learning levels: the Cognitive, the Verbal, and the Human Act. For a similar but alternative view of the process of learning therapy, see Kluft (1989, 1990).

First level learning is in the cognitive, occurring solely within the human mind. It includes symbols, concepts, and sentences, as well as facts and information. Recall and recognition of knowledge is an important observable indicator of mastery at this level. It is cognitive-vicarious learning in which symbolic activity is abstract, but geared to picturing reality as it was or as it might be. Case material, movies, videotapes, and verbal descriptions can be used effectively. Kluft (1989) discussed using the consultees' interests, their changes, both personal and work-related, and the importance of providing a model for them.

Third level learning involves cognitive, vicarious, and social presence. At this level, a maximum proportion of the person is involved and it is often called total learning. The task here involves the learner in social processes with one or more persons, literally at the moment when all responses are to some degree new and never experienced before. Clearly, the study group can act as a forum for the developing therapist to learn new skills and theory in a supportive and nurturing community.

Putnam (1989) suggests that the negative effects of the overwhelmed therapist can be ameliorated by developing his or her competence. Kluft (1989) says that in diagnosing the overwhelmed therapist, it is essential to assess the following areas: the status of the therapist; the status of the therapy; specific MPD-related aspects of the problem; and diagnosing the learning needs of the therapist.

Participation in a study group can diminish one's sense of isolation and powerlessness. It may help lessen feelings

of disorientation, and validate the therapist's experience. The study group offers a structure for learning by providing resources, educational activities, and peer case consultation. Colleagues in the group can validate (or disconfirm) the creative use of various therapeutic interventions.

Study groups offer the therapist who works with MPD a group of others with similar experiences in much the same way that the survivor group offers support to survivors. In the context of the group, a safe place is created to discuss the difficult material, counter-transference issues, and non-traditional interventions. In its healthiest form, the group allows for the inclusion of humor and laughter. These are healing, and provide a natural outlet for the buildup of tension caused by this challenging work. Often, the only way out of a therapeutic dilemma is to find the funny bone.

The study group is a community of people brought together because of similar work interests. The work, although fascinating, at first, forces each therapist to look at the core of his being. In this process, the therapist experiences her own multiple realities: home reality, work reality, the reality of misery and evil, and the constant reality of suicidality. The bombardment of complex and difficult material filled with the most cruel and intentional abuses is debilitating to the therapist. The study group acts as a container to hold the therapist together in the face of the client's and her own parallel fragmentation.

The work with these patients also impacts the therapist's spiritual self. Therapists are forced to question their own religious training; their relationship to God, themselves, and others; what they believe about good and evil; and the creation of the human race. The therapist may feel more of a need for spiritual protection and comfort in the context of the realities of pain and misery that their patients present. Clinicians may dialogue about these powerful issues in the safety of the study group.

Study groups provide a vehicle for disseminating information into the community and enhancing the credibility of the diagnosis and its treatment. The study group can act as a liaison to hospitals to provide advocacy for patient care and training for staff.

Some of the issues that arise in the development of a study group include those common to any new organization. As it grows, the study group needs to be mindful of schisms and splits that occur within, and must protect the group from factionalization. The nature of the material that is discussed is controversial. The therapist, who may feel himself or herself on the edge of the therapeutic community, may become swept into a kind of cultism, a sense of we versus they.

It was our experience that as the study group grew in membership, administrative matters and more formal educational programs became a bigger part of each meeting. The time for case consultation, didactic presentation, and support decreased. The need for additional small groups emerged, to refocus on these concerns. The support groups consist of six to eight members, and meet regularly once a month. At the present time we are developing a vehicle for support group formation. Currently three support groups



have developed. Our goal is to have the majority of the study group members active in a support group as well. We now see another issue of rejection is possible. As the smaller support groups formed, some felt excluded by established groups that wished to remain small and intimate, and declined to take new members.

As the therapist learns to trust his colleagues and is able to transform them into comrades, the therapist experiences the same healing as the client. The study group is a place where people come together to provide a safety net woven from the presentation of issues and feelings met with useful and honest communication, which bolsters self-esteem.

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