THE NEED FOR MARRIAGE THERAPY IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER

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ABSTRACT

Most literature that examines MPD focuses on the treatment of individual clients and only occasionally discusses the use of marital therapy as a supplemental form of treatment. We propose that marital therapy is a critical part of working with MPD patients in that it increases the speed and effectiveness of individual therapy and solidifies gains made with integration. The following specific marital issues are examined: (1) educating the spouse, (2) understanding seepage (affective pervasion), (3) handling conflicting demands of alters, (4) responding to child alters, (5) supporting the sexual relationship, (6) adjusting to integrations, and (7) having patience with the therapeutic process. In addition, both marital therapy techniques and goals are examined in detail.

INTRODUCTION

A review of the multiple personality disorder (MPD) literature shows that the vast majority of publications focus on the treatment of individual clients. However, the recognition by therapists of the importance of working with the social support systems, in particular marriage and family relationships, in the global treatment of MPD has been growing in recent years (Allison, 1974; Beal, 1978; Davis & Osherson, 1977; Horton & Miller, 1972; Levenson & Berry, 1983). In 1985, Kluft, Braun & Sachs briefly examined some issues that led to the use of "family and conjoint sessions to achieve discrete and limited objectives" (p.294). In a following article, Sachs (1986) expanded on the need to work with support systems, and briefly discussed how marital therapy could be "an important adjunct to the primary treatment approach" (p.166). She stated that marital therapy should deal with here-and-now issues. She also warned that the therapist must be sure the patient is not in an abusive marital relationship, and to avoid the sabotaging of therapy by the spouse. In 1988, Sachs, Frischholz, and Woods continued to expand on the need for family therapy in the treatment of MPD, and examined the role of marriage therapy in far greater depth. Along with a presentation of a case example, the authors stated that marital therapy needed to focus on: "(a) educating the spouse about the nature of MPD, (b) dealing with disruptions in the homeostasis of the marital system, (c) sharing thoughts and feelings, and (d) preventing sabotage of the primary treatment" (p. 256). Although the above mentioned marital issues were discussed, the context in which the authors viewed the role of marriage and family therapy was to "foster the development of a healthy social milieu so that the beneficial effects of the primary therapy can be maximized" (p.257).

In 1987, Benjamin, Benjamin, & Gaffga suggested the need for an important shift in the treatment of MPD. Through group and parallel therapy work with spouses and children, they have attempted to change the focus of therapy from working exclusively with the MPD to looking at and facilitating the functioning of the family system. General marital issues that they have discussed have included anger, trust, sexuality, and being balanced in marital support. Unfortunately the authors have yet to publish their works in a forum that can disseminate their results widely.

Despite the efforts of such authors as Benjamin, Benjamin & Gaffga, and the growing recognition of the importance of marriage and family therapy, most therapists see working with support systems as secondary to individual therapy. As Sachs, Frischholz, and Woods (1988) state, marital and family therapy "can be extremely useful in solidifying gains *made in primary treatment*" (italics added, p. 250). We believe that the importance of marital therapy (which may include working with nontraditional relationships) is far more critical than previously recognized and should be a basic and necessary *part* of therapy, and not simply a supplement. Used skillfully and correctly, marriage therapy helps the therapist resolve certain issues (e.g., the patient's sexuality) which may have tremendous impact on an individual's treatment, but are difficult and complex to treat in individual psychotherapy. This paper presents marital issues common to MPD patients and discusses how marriage therapy helps in their resolution and thereby enhances the therapeutic process. We hope therapists will recognize the need for marriage therapy as an ongoing part of an MPD patient's treatment.

SUBJECTS

Before making marital therapy part of the primary treatment of MPD, we took into consideration various spousal factors such as mental health, sensitivity, and willingness

to care enough to be actively involved. This preliminary study is based on analysis of work with five married couples in which one spouse had a diagnosis of multiple personality disorder. Because all symptomatic spouses were female, we will use the pronoun "she" for MPD patients and the pronoun "he" for their spouses. We saw patients in both inpatient and outpatient settings and worked independently of one another in most of cases. In consultation with one another, we noticed similarities among our cases, which suggested possible general themes among MPD couples. It is important to note that at the time of treatment, all couples had reported stress in their relationships and had requested help with their marriages. No known physical abuses were present in the relationships at the time of therapy.

MARITAL ISSUES

Educating the Spouse

We found that one of the most important issues for the couples during the initial phase of therapy was a need for education about MPD. In joint sessions during which MPD was discussed, the wives (the MPD patients) had difficulty talking about their "problem" with their spouse, expressing feelings of shame and guilt, as well as the fear that their husbands would reject them. The husbands typically expressed combinations of shock and relief. They shifted back and forth from finding it unbelievable that their wife suffered MPD to stating how MPD explained many previously confusing behaviors. The objective at this point in marriage therapy is to encourage the open discussion of feelings, which may be extremely difficult for the MPD patient. The spouse may also have difficulties in identifying and expressing feelings, and the therapist must be prepared to encourage the couple and teach them how to communicate effectively. We believe that this process helps both partners develop new ways to deal with emotions. This leads to both a stronger marriage and better individual functioning. The process continues throughout therapy.

A necessary part of educating the couple is to provide accurate information on MPD and how it develops. In particular, the therapist should stress to the spouse that despite having many personalities (alters), it is important to view the MPD patient as a whole person and accept that the spouse is married to this whole person, not to any one alter. At this point in therapy, it may prove helpful to refer to the different personalities as parts to reinforce this idea (e.g., "Sharon is the part of your wife that handles anger").

A framework can be established for the husband and wife, so that therapy is a team effort, where the couple support one another as they look at painful areas of their lives and learn to deal with them. Although MPD is one of the stresses faced in the marriage, it is not "the problem" of the marriage. The spouse would be wrong to assume that all martial problems result from his wife's MPD condition. The couple still has relationship issues to resolve, and both partners will need to look at their own "emotional baggage" as they work on developing a closer, more supportive relationship.

An unexpected issue raised by all the spouses in initial treatment was one of concern for their safety. The husbands typically referred to a movie in which someone had a "Jekyll and Hyde personality" – one part of the person was a psychopathic killer, which often attempted to kill the lover of another personality. We reassured the husbands by having them look at their past relationships to see if such movies actually reflected any part of their lives. Although the degree of concern varied from husband to husband, this fear typifies the need to provide accurate information to the couple. We have noted that MPD patients seem to have developed great sensitivity to the emotional climate of their situations. These wives readily sense feelings, such as confusion, fear, or shock. Their acute emotional perception, coupled with shame or guilt, often cause them to misinterpret the husbands' feelings as rejection. By openly processing feelings with the couple and providing accurate information, the therapist can normalize the situation while strengthening both communication and the relationship.

Understanding Seepage (Affective Pervasion)

It is not unusual for an MPD patient to feel intense emotions, such as anger, anxiety, or fear, while not knowing why they are occurring (although she may confabulate a reason). This certainly can be explained in part by the fact that as an MPD patient progresses toward integration, the ability of different alters to communicate and share information and emotions can increase. Sometimes the emotions of one alter pervade another; in other words, the feelings of one alter are experienced by another, who may not fully comprehend why these emotions exist. For example, one alter may experience the suicidal feelings another alter is having, but she may not even be aware that her feelings are coming from another alter. This affective pervasion can have a profound effect on a relationship. On his part, the husband can respond diversely to these unexplained emotions; he may, for example, respond with anger, hurt, or fear, depending on his personality and ego-strength. We have found that by our helping to improve the couple's communication skills, the partners can both give and elicit new responses that help in the integration process. The effects of improved communications on the relationship are illustrated by the following example.

Mike and Debbie had had a pleasant evening together, talking and eating dinner. After dinner, Mike began reading a news magazine, whose cover described an article about a kidnapping and rape. Suddenly Debbie said to him angrily, "You're too fat. I never want to make love to you again." Typically, Mike would have become angry or hurt. Instead he used communication skills learned in therapy, saying in a supportive voice, "I can tell you're upset. Can you share with me what's going on?" At that point, Debbie realized she was feeling intense anger, but didn't know why. However, searching within herself through internal conversations, she realized that another alter had memories and feelings, triggered by the news magazine cover, regarding a sexual assault by a fat man, and she was feeling some of the rage caused by that event. At this point she was able to realize she was not angry at her husband and was able to process some of her emotions regarding the rape. This event was important not only

because a relationship conflict was avoided, but in the immediacy of this situation, the wife processed emotions that typically would have been dissociated by the next therapy session. Rather than dissociating, Debbie dealt with feelings in a different way. Mike supported his wife instead of acting defensively. Both were able to build on their relationship.

Handling Conflicting Demands

It is not unusual for two alters to have conflicting needs and to place the husband in a double-bind situation in which he is unable to fulfill both wishes. For example, one of the couples had difficulty at Christmas time when a child alter wanted the husband to put up a Christmas tree as soon as possible. Meanwhile, an adult alter wanted him to clean the house before getting the tree. In this case, the couple was new in therapy. The husband did not recognize that he was talking to two different alters; rather he saw his wife as being unreasonable with her demands. In this situation, the husband became angry and began yelling at his wife, resulting in her dissociating into another very young child alter, who began to cry. At this point, the husband realized what had occurred and felt guilt, but he did not know what to do.

Marriage therapy has several goals in such a situation. Foremost is to teach the couple how to express anger and frustration appropriately and how to resolve conflicts. Specifically the husband must first learn to recognize when he is placed in a bind, and second, learn to express his dilemma clearly. In the Christmas tree incident, for example, the husband could have said, "Honey, I feel like I am caught in a bind. I can't put up the Christmas tree and clean at the same time, yet I can tell both of these actions are important to you. How do you want me to handle these requests?"

The goal for the wife is more difficult. When her husband expresses he is in a bind because of two alters' needs, she has to effect a compromise between the two alters, which the husband can carry out. We have found this to be difficult for the MPD patient, especially at the beginning of therapy. The MPD patient may need several individual therapy sessions to resolve conflicts between alters. The goal is to help the MPD patient become proficient at negotiating conflicts between alters on her own. It is important, however, that the spouse respond to all, not just part, of the conflicting needs of the MPD's alters.

Responding to Children Alters

In our study, husbands were commonly confused about how to respond to child alters. Many felt foolish in dealing with them. The MPD wife often interpreted this uneasiness as rejection of a part of herself, an alter she too might have trouble accepting. A focus of therapy may be teaching the couple how to give each other nurturance in ways that feel comfortable to them and meet their needs. For example, one man felt foolish about taking his wife's child alter to the zoo, fearing how she would act in public. In marriage therapy, however, the couple decided he could spend time coloring with crayons with her child alter in the privacy of their own home.

It is not unusual to find that spouses have difficulties responding to child alters, particularly if the spouse had been shamed or punished for having childlike needs in his youth. The husband may benefit from learning to identify and accept his own childlike needs in therapy. The husband's acceptance of puerile needs not only helps him respond emotionally, but also may serve as a model for the wife as she integrates her child alters.

Supporting the Sexual Relationship

According to several researches (Coons, Bowman, & Milstein, 1988; Putnam, Guroff, Silberman, Barban, & Post, 1986), sexual abuse is the most common form of trauma suffered by MPD patients in their childhoods. As a result, MPD patients typically have difficulty in their sexual relationships, particularly once they begin psychotherapy. As one can imagine, this sexual difficulty is a major source of stress on the relationship. Often the incest victim suffers from fear, guilt, anxiety, and anger during attempted sexual activities. Flashbacks are also common, affecting the woman's sexual responses. On their part, partners may experience anger, frustration, rejection, and a sense of helplessness.

The purpose of marital therapy during these times is to validate each partner's feelings, identify the source of the problem, and help the partners communicate their emotional needs, so the couple can work together to resolve their sexual difficulties. We believe that an important part of this process is to help the couple find a type of nonthreatening, gentle, nurturing touch that they can experience together. It is important, however, that this touch be nonpressuring and not become an attempt to engage in sex later. Touch in the subject couples has included back scratching, calf rubbing, and foot massage. In the MPD patient's therapy, this type of touching can be contrasted with the abusive touch of the past. The most important attitude the spouse can hold during this time is one in which he is supportive and emotionally available, while allowing the MPD spouse a feeling of control.

The spouse's sexual needs must also be taken into consideration. We support and use the following position of Maltz and Holman (1987):

> Ignoring or negatively judging the partner's sexual interest will only create distance in the relationship. While honoring her own limits, the survivor must seriously address her partner's sexual concerns. A partner who has sincerely supported a survivor over a period of time may understandably begin to lose interest if no attempt is made to meet his or her own needs. Initiating touch, sensitively stopping or redirecting touch, and suggesting alternative forms of sexual release that may be comfortable for a survivor are ways she can validate the partner's positive sexuality. A survivor can also support her partner's need and ability to take responsibility for his or her own sexual needs through masturbation. A survivor's communicating her own sexual preferences and needs as well as asking about those of her partner can be very helpful to the partner. (p. 96)

One issue often needing attention in therapy is the spouse' attraction to alters that express sexuality. It is not

unusual to find a husband who expresses preference for such an alter, and who often consciously or unconsciously attempts to trigger her emergence. The husband may also have difficulty letting the integration proceed if he fears losing the love-making opportunities with this type of alter. The therapist must help the spouse to realize that the couple can have greater sexual satisfaction as a result of integration in that his wife can respond at a deeper emotional level. In other words, the therapist can help the spouse understand that the potential for greater intimacy in the relationship, both sexually and emotionally, increases with integration.

Adjusting to Integrations

One of the greatest stresses on the marriage occurs during and after the integration of two alters. Couples are often amazed to discover how much of their communication occurs through subtle mannerisms, such as voice tones or raised eyebrows. These mannerisms cause couples great difficulties during an integration, because the MPD patient may quickly change communication styles that affect both perceptions and responses with her mate. The husband may misinterpret the behaviors and needs of his wife and be confused by new expectations of him. For example, one husband who was trying to do something special and reach out to his recently integrated wife brought home her old favorite, a chocolate doughnut. She looked at her husband and said, "You know I don't like chocolate." Feeling hurt and confused the husband replied, "You did yesterday!" We have noticed that after an integration it take couples approximately four to six weeks or longer to learn new communication styles and renegotiate the relationship. The therapist helps this process by reviewing healthy communication methods with the couple. For example, therapists should encourage couples to seek more information, to express and reflect emotions and needs clearly, and to make straightforward requests. In addition, conflict-resolution techniques can be reviewed to encourage a healthier relationship. The therapist should also encourage the couple to spend more time together simply talking and getting to know each other again.

We once again assume that all integrations allow the couple to develop a deeper relationship, since the MPD patient's wider range of emotions and life experiences allows deeper communication. The purpose of marriage therapy at this stage is to make this deeper relationship possible and to deal with the stresses caused by change. Helping the couple recognize positive changes that integration brings is an important step in supporting and helping the couple's relationship. The therapist should project to the couple the attitude that over time, integration strengthens their marriage and ultimately their personal happiness.

Impatience with Therapy

A common complaint we have heard from MPD patients and spouses is how long therapy takes. Coupled with this impatience is the tremendous stress the families face while the MPD patients are working on their traumatic pasts. Therapy causes a great disruption in family life, particularly if the MPD patient becomes suicidal or self-destructive. Because most of the patient's adaptive energy goes toward healing, the MPD wife can not always provide the emotional support that her husband and children may expect and need. In addition, the issues with which the MPD patient struggles, such as past abuse, can be traumatizing to family members. Therefore, the therapist needs to see the family members and provide the emotional support that is needed. Children in particular can be expected to act out or regress when a parent has difficulties. In addition, the husband and family may wonder why they are making financial and emotional sacrifices when, with their limited view, it appears the patient is getting worse. Unless the therapist addresses the situation, the MPD patient may see herself in the bind of either sacrificing herself or her family. As one MPD woman put it, "I don't want to resolve my past if it means I have to destroy my present."

To avoid the frustrations mentioned, the therapist must help each MPD couple to maintain a balance and to invest in familial relationships, not to let therapy and the healing process always be the focus. If possible, the therapist should avoid moving into traumatic issues immediately before major family events or holidays. In addition, the therapist should encourage the MPD patient to support other family members emotionally. By doing so, we have found the family and husband offer the MPD patient more support during the difficult times in therapy.

CONCLUSION

In this paper, we reviewed major treatment issues of MPD patients and their spouses. The therapeutic framework we proposed assumes a supportive marriage is an important part of the healing process. We explored particular issues, such as dealing with sexual problems, child alters, adjustment to integrations, and impatience with therapy, and discussed how marriage therapy needs to deal with these. In particular, we propose that marital therapy is a critical part of working with MPD patients; that is, it increases the speed and effectiveness of individual therapy and solidifies gains made with integrations. Thus we recommend that therapists train themselves in marital therapy by reading literature, learning marriage and family therapy techniques, and becoming acquainted with such organizations as The American Association of Marriage and Family Therapy (AAMFT). By doing so, therapists will not only help heal the pain and suffering of the past, but also assist MPD patients to live happier and more fulfilling lives in the present. ■

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