THE REHABILITATION OFTHERAPISTS OVERWHELMED BY THEIR WORK WITH MPD PATIENTS

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ABSTRACT

It is generally recognized that the treatment of multiple personality disorder (MPD) may prove an arduous undertaking for patient and therapist alike. The literature is replete with descriptions of the impact of treatment upon MPD patients, but has been understandably circumspect about the effects of this process upon therapists. This discrete silence belies the intense concentration upon this aspect of work with MPD patients in workshop and consultation settings. Although the number of new therapists in the field continues to expand, it is well known that there is a much smaller, but not inconsiderable stream of clinicians who exit the field, and discontinue working with MPD patients. Furthermore, a larger group continues to work with MPD patients, but at a diminished level of effectiveness. This presentation will review some of the stressors inherent in work with MPD patients, and describe characteristic sequences in the reactions of those who work with MPD (e.g., from fascination with MPD and MPD patients to various expressions of withdrawal, the breakdown of empathy and rapport, the loss of an optimal therapeutic stance, and acting out in the countertransference). Several patterns of therapist distress will be noted. A model for diagnosing the problem areas of overwhelmed therapists will be described, and types of interventions targeted at the alleviation of the problem areas will be noted. Corrective measures will be outlined, in the framework of educational domains. Observations on the effect of rehabilitating the therapist upon the therapist's patients will be offered.

In the late 1970s and early1980s, when workshops on the treatment of multiple personality disorder (MPD) were both novel and uncommon, Bennett G. Braun, M.D., invariably would end his presentations with the injunction that "once you have treated a patient with MPD, you will never be the same." Few have challenged the wisdom of Braun's remarks. For some psychotherapists, the experience of working with MPD has been a growth experience, in which new skills are mastered, and difficult circumstances are overcome. They emerge having found within themselves resources and strengths that enhance their clinical work in general and enrich their personal sense of competence and self-esteem. For others, however, the encounter proves demoralizing, even devastating. They find themselves feeling deskilled, ashamed, guilty, and traumatized, questioning their personal worth and professional expertise. Many therapists have had both types of experiences, either in a simple sequence or in a series of frequently oscillating states of mind. Although the examples cited are polar and extreme, they illustrate the far borders of a range of responses that are painfully familiar.

It is generally recognized that the treatment of MPD is an arduous undertaking for patient and therapist alike (Kluft, 1984). Although the literature is replete with descriptions of the impact of treatment upon MPD patients, it has been notably circumspect about the effect of this process upon psychotherapists. This discrete silence belies the intense concentration upon and preoccupation with this aspect of work with MPD patients in workshop and consultation stettings. Although the number of new clinicians and scientific investigators entering the MPD field continues to expand, it is well known that there is a smaller but not inconsiderable number of therapists who exit the field, and discontinue working with MPD patients. Furthermore, a larger group continues to work with MPD patients, but at a diminished level of effectiveness. This paper will address the problems of the therapist whose effectiveness and equanimity has been compromised in connection with his or her work with MPD patients. It is based on my giving advice to a sizeable number of psychotherapists who have asked for assistance and identified themselves as overwhelmed by their work with MPD patients. In the interest of confidentiality, no elaborate vignettes will be used unless they are artificial composites of many situations.

Review of the Literature

The size of the literature in this area is inversely proportional to degree of concern that surrounds it. Although observations upon the stresses experienced by therapists in their work with MPD are commonplace in both articles and conference presentations, most of these are made tersely, cryptically, and in passing, often laced with humor. The full picture of the therapist's dilemma is rarely articulated.

Kluft (1984) offered a general discussion. He described "Initial excitement, fascination, overinvestment, and interest in documenting differences among alters yield to feelings of bewilderment, exasperation, and a sense of being drained by the patient" (p. 52). He observed that therapists were distressed by their colleagues' skepticism and criticism. He found that most therapists had not appreciated the variety of clinical skills that they would have to employ, nor had they anticipated the vicissitudes of the treatment, nor had they foreseen how many new areas of knowledge they might have to master.

He noted that therapists found MPD patients extraordinarily demanding, and that their attentions to them consumed substantial amounts of their personal as well as their professional time. Both familial and collegial relationships could become compromised. He observed that many therapists found themselves "carrying" the treatment as the patients abdicated or never formed a reasonable therapeutic alliance, persisted in manipulative and controlling behaviors, and in many ways undercut the therapists' best efforts.

Furthermore, he indicated that the therapist's empathic capacities could be taxed, leading to frustration, confusion, and the retreat into a more remote and intellectualized therapy. It is grueling to remain in empathic rapport with a patient who maintains he or she has been severely traumatized, and many a therapist consciously or unconsciously "beats a retreat" from the intensity of the treatment process.

Watkins and Watkins (1984) discussed the hazards to the therapist that stem from the MPD patient's overt behaviors, especially those of an aggressive or seductive variety, and from more covert ones as well: "There are the more subtle possibilities by which an intelligent patient can frustrate the treatment and psychologically destroy the treating one" (p. 116). Coons (1986) researched the resistances of MPD patients and the reactions of 20 therapists to their work with MPD. The patients showed excessive use of repression (85%), conscious withholding of clinical data (69%), stubbornness (54%), sexual acting out (46%), secretiveness (46%), manipulativeness (46%), continuous crises (46%), "special patient" behaviors (38%), threats to stop therapy (38%), excessive dependency on the therapist (31%), suicidal threats (31%), prominent secondary gain (31%), numerous missed appointments (23%), refusal of hypnosis (23%), creation of new ego states (15%), sexual seductiveness (15%), denial of their illness (15%), refusal to accept coconsciousness (15%), lateness (15%), and failure to pay (15%). The countertransferences experienced by their therapists included exasperation (75%), anger (58%), emotional exhaustion (50%), desires to rescue (33%), vicarious enjoyment (17%), fear of acting out (17%), socialization outside of therapy (8%), depression, lateness for appointments (8%), and inability to set limits (8%). Most experienced therapists who study these figures suspect that they may be rather conservative.

In a series of articles Kluft (1984, 1988aa, 1988b, 1989; also see Wilbur & Kluft, 1989) attempted to describe the natural history of the therapist's attitude toward work with MPD. As noted above, it begins with fascination and overinvestment. As the patient demonstrates difficult resistances, acts out, and presents material that is difficult to hear, let alone to have endured, therapists tend to withdraw from an optimal therapeutic stance toward one or a combination of four types of countertransferential positions. The first is that of skeptically derealizing the patient's account, and becoming more a detective than a healer. Empathy, which has proven too overwhelming to sustain, is abandoned. The patient is implicitly or explicitly requested to prove his or her allegations or recollections, or to doubt them or discount them. The second involves the assumption that the patient has been so badly injured that his or her needs must be met in special and tangible ways; in effect, the patient must be "loved into health." From this flow violations of the boundaries of therapy and a host of misadventures. The third is that the patient's situation needs tangible redress rather than therapy; i.e., the therapist must become an advocate rather than a healer. Together patient and therapist abandon usual conceptions of treatment, and embark on a series of what are assumed to be reality-oriented interventions (often without any external validation for the pursuit of this type of effort). Fourth and finally, the therapist may lose distance from the patient, experience counteridentification, and become engulfed in the patient's misery, ultimately experiencing posttraumatic stress. All of these reactions are normal if they are brief and not acted upon to any problematic degree, but when they become a fixed pattern of adaptation, they are extremely counter-productive.

These forms of countertransference reactions often prove to be valuable indicators that the therapy has moved from the beginning to the middle phase (C.G. Fine, personal communication, January, 1989). If they are surmounted, the therapist moves on to a sense of mastery. If they remain unresolved, misadventure and/or stalemate is likely, and the therapist becomes demoralized and/or overwhelmed, or maintains an adaptation that, in defending the therapist, induces such feelings in the patient. The therapist who survives the vicissitudes of the trying middle phase is likely to arrive at a sense of cautious and tempered optimism that makes both the typical early and middle phase countertransferences much less intense in work with subsequent MPD patients (Kluft, 1989). Coons came to similar conclusions: "Although the psychotherapy of patients with multiple personality disorder is tedious and time consuming, it can be eminently successful if the patient and therapist persevere" (1986, p. 715).

Greaves (1988) and Chu (1988a, 1988b) have offered a number of useful observations about particular instances of the general phenomena described above, and provided invaluable illustrative vignettes.

The Injured Healer

As noted above, it is the rule rather than the exception for the countertransference patterns noted above to influence the treatment of MPD, at least briefly. However, the actual compromise of the therapist's capacities on a sustained basis is a sign of more serious difficulties. No published work addresses the prevalence of more fixed and major problems in those who work with MPD patients. Nor is my consultation experience nor that of any other author

an indication of their prevalence. On the one hand some such troubled therapists may seek consultation differentially, but on the other, many compromised therapists may keep their plight to themselves, especially when they experience severe guilt or shame over some action or failure on their own part.

In my experience, the therapists overwhelmed by their work with MPD who present for consultation or treatment may be classified into seven groups, which are not mutually exclusive. It is useful to know which type of therapist one is confronting in order to plan rehabilitation, but often sufficient information is not available, because it is withheld, or the circumstances do not allow for its being elicited in a manner that does not inflict a narcissistic injury.

The first type or category is that of the basically sound therapist who simply lacks experience or knowledge, and has gotten into difficulty with an MPD patient. Such a situation is exemplified by the first year psychiatry resident who, before he or she has had crucial basic training in the fundamentals of psychotherapy, is precipitously given charge of an MPD patient without adequate supervision. Often the supervisor is quite competent, but lacks knowledge about MPD, and cannot offer assistance that enables the resident to move forward. Another common example is that of the experienced therapist who has done his or her best to learn about MPD in connection with his or her first case of MPD, but that case turns out to be an extraordinarily demanding patient that would tax the abilities of the most specialized ad experienced expert. Elsewhere (Kluft, 1989) I have commented on the irony that the most conflicted poorly defended, and decompensated MPD patients are often among the easiest to diagnose. Consequently, they often are found by the neophyte or the veteran clinician newly sensitized to MPD, who will have no way of knowing that such patients are usually among the most difficult to treat, and will find little guidance about their management in the literature. The impact of watching one's best efforts expended to no avail can be far from salubrious. Such individuals are usually relatively easy to remobilize with a combination of guided didactic experiences and consultation.

The second type of compromised therapist is the type of individual who is normally high-functioning and has good relationships and minimal fixed psychopathology, but who is working with an MPD patient at a time of great personal stress, most often in the context of the loss of an important relationship. The demands of the patient, the treatment, and the therapist's compromised state interact such that the therapist begins to invest the patient with an inappropriate significance, to bring his or her personal issues into the treatment, and/or to suffer a general decline in professional objectivity and competence. This may take myriad forms. One is a projection of the therapist's own issues onto the patient, followed by a form of projective identification in which the therapist attempts to heal herself or himself in the patient. Boundaries fall, and efforts are made to love the patient/self into health. In another pattern, the patient may be invested with the significance of the lost relationship, and reacted to in a manner more appropriate to the relationship than to the therapy. Three psychiatrists, all in the throes of painful divorces, developed sexualized relationships with MPD patients. A motherly social worker, newly estranged from her own daughter, virtually adopted and actually attempted to breast-feed an MPD patient, whom she "suddenly" realized "needed" reparenting.

A third category is the therapist who has had a history of difficulties in relationships, appears dependent and needy, and has significant character psychopathology. Such a therapist may bring to the treatment conflicts and difficulties that augment the patient's psychopathology, leading to problematic patient behaviors that augment the therapist's psychopathology, creating a self-perpetuating and exhausting atmosphere of crisis. Such therapists often have profound difficulties maintaining both therapy boundaries and ego boundaries. Cycles of mutual projective identification and escalating dysphoria are not uncommon. A common situation for this category is the plight of the very needy therapist who needs to be needed, identifying him- or herself with the patient and attempting to heal him- or herself in the patient. Not infrequently such therapists are very effective with patients who need brief or long-term supportive therapy, value their personalities as powerful healing instruments, and determine their own value by their impact on their patients. As their best efforts do not bring about the results they are accustomed to achieve, they may give more and more, exhausting themselves with a patient whose needs are voracious, and who will not give them the sort of feedback upon which they base their self-esteem. They may become burned out, depleted, and depressed.

The fourth category consists of those therapists who have had severe major psychiatric illnesses, been hospitalized, made suicide attempts, and/or have had difficulty with drugs and/or alcohol. The burden of work with MPD may tax their ego strengths by creating intolerably intense affects that they have difficulty in managing. It is not uncommon for them to suffer to the extent that they may resume treatment. For example, a psychologist with a history of recurrent major depressions and alcohol abuse found that work with a depressed and self-destructive MPD patient was too painful to tolerate without her experiencing severe and persistent dysphoria. Feeling tempted to drink once again, she intensified her attendance at Alcoholics Anonymous, and sought virtually session by session supervision for an extended period of time.

Treating MPD is not for everyone. A fifth group of therapists consists of those individuals who cannot tolerate dealing with the type of materials that MPD patients must face in order to recover. This was exemplified by a sensitive social worker with no psychopathology who found that the memories that her MPD patient had to deal with were rendering her (the therapist) symptomatic. She endured out of dedication until the burden was too great for her to bear, and then felt obliged to transfer the patient.

A sixth group of therapists consist of those who are survivors of child abuse and those who themselves suffer MPD. Counteridentification often compromises their therapeutic capacities; they may find themselves triggered by the patient's memories and conflicts. It can be very difficult for such therapists, who may be continuing to heal themselves

in others, to be objective about their difficulties with MPD patients. They often have knowingly or unconsciously gambled heavily upon their ability to achieve vicarious mastery by their treatment of others.

A seventh and final group invariably overlaps with at least one of those noted above but for reasons of exposition is listed separately — those therapists who have behaved unethically. In some cases rehabilitation either is impossible, or is exceptionally complicated because of legal complications.

Diagnosing Rehabilitative Needs

In diagnosing the situation of the overwhelmed therapist, it is essential to assess: 1) the *status of the therapist*, as noted above; 2) the *status of the therapy* the therapist is conducting, with respect to stalemates and even its very viability; 3) the *specific MPD-related aspects of the problem*, and 4) the *learning needs of the therapist.*

1) It is important to appreciate the *status of the therapist* as accurately as possible. The rehabilitation of the compromised therapist is difficult to plan without a solid notion of the capacities of the person for whom the rehabilitation is being designed. I emphasize that it often is difficult to achieve an accurate picture. Unlike a therapy situation, the person who is called upon to help an overwhelmed therapist get back on his or her feet will not have access to the wealth of data that become known in the course of a therapy. The person seeking help may be in therapy elsewhere, and not wish to share too much about him- or herself as opposed to the problem that is being confronted. The focus is on the therapist's needs and priorities, and detailed self-disclosure, as opposed to sharing the details of the patient's situation, may not occur. Furthermore, such a person may not have a legally privileged relationship with the therapist. There may be a preexisting or anticipated collegial or other professional relationship between them. Therefore, often all one can do is come to an impressionistic conclusion. I often will ask, "Is there anything about you that bears on what we are trying to achieve that I should be aware of?"

2) It is important to assess the *status of the therapy* that is the ostensible source of the difficulty. On occasion the treatment is going well, but the therapist is overwhelmed nonetheless. However, this is rarely the case. More commonly, the treatment is stalemated. It should not be assumed that what has transpired, however problematic, is more related to MPD than to problems in the basics of psychotherapy. I spend time going over possible reasons for the stalemate, using an eight category outline (Kluft, 1989, in press). A similar outline can be derived from an excellent chapter in Weiner's (1986) *Practical Psychotherapy.* I ask about 1) general concerns, such as whether the patient's problems are resolvable by therapy, and whether there is a coexisting medical or psychobiological problem that requires attention. In a recent case a despairing therapist had not noted that the patient had a coexisting major depression and hypothyroidism, neither of which was being addressed adequately.

I ask about 2) external pressures on the patient and the therapist. Sometimes too much is going on for therapy to affect any change, and both parties are "spinning their wheels," perhaps even worsening the situation by their efforts. Especially important in MPD are 3) treatment frame issues. If safety, confidentiality, consistency, and boundaries cannot be maintained, it is likely that the therapy will exhaust both therapist and patient to no avail. In one instance, the therapist planned to write a book about the treatment. Although the therapist denied my observations vociferously, I had the impression that the treatment was being influenced unduly by this design, and that the needs of the book were being treated rather than those of the patient. The patient had responded by massive acting out, which made the therapist feel a failure in front of his or her anticipated audience. Finally an ironic slip of the tongue convinced the therapist that my observation was correct. To that person's credit, the book project was put aside, and the patient treated successfully.

It is important to ascertain the 4) constraints and logistic considerations that pertain, and determine whether the vehicle of the therapy is adequate or counterproductive. It is also crucial to be sure that the patient 5) is correctly diagnosed, both phenomenologically, dynamically, and culturally. No two patients are the same. One MPD patient may be, in the main, quite different from another. Often treatments falter over the failure to acknowledge this. There may be 6) therapist factors that impede the treatment, or 7) patient factors. Therapist factors include the presence of the necessary knowledge and expertise, the therapist's areas of difficulty and ability to manage them, the therapist's empathy, honesty, and flexibility/rigidity, and the ability to utilize rather than act upon countertransference feelings. Patient factors include ego strength, supports, motivation, the flexibility of resistances, honesty, masochism, and willingness to forego the gains of the illness and the gratification of the patient role. Finally, 8) the interaction pattern of therapist and patient must be assessed.

3) The *MPD -related aspects of the problem* must be evaluated. It is essential that the person who is to assist the encumbered therapist is able to identify, comprehend, and render comprehensible to the troubled therapist the nature of the difficulties that the therapist is encountering with MPD, and the problems that are intrinsic to the particular patient. I will only indicate a few examples. The therapist's knowledge may be deficient; he or she may hold attitudes toward MPD or the circumstances that give rise to it that are problematic. The therapist may lack essential skills. Often there are problems with the therapist's countertransference to certain personalities and/or in response to certain issues; the failure to recognize layering and/or the presence of additional alters may be difficult. It is uncommon in my experience to find that an overwhelmed therapist has been able to be even-handed to all sorts of personalities or has identified the full extent of the patient's complexity. Almost invariably the therapist's difficulties have interfered in these areas.

Also, it is necessary to outline the patient-centered problems that are fairly specific to MPD. It is useful to determine the patient's prognosis, using Caul's (1988) criteria as a guide. It is not uncommon to find that the therapist has no information about what factors make one MPD patient more treatable than another. Complexity, secondary

gain, enmeshment with abusers, and a history of alleged ritualistic abuse all auger for a more demanding and prolonged treatment. In a recent consultation with a demoralized type 1) therapist who was about to transfer her patient and decline another MPD referral because she was sure she was incompetent, I was able to demonstrate that her patient had every single poor prognostic feature and that her work (until she lost confidence) had been exemplary rather than execrable.

4) The *learning needs of the therapist* must be identified and classified. The format of this process is simple. I sit down with the overwhelmed therapist and together we develop a list of all of the therapist's learning needs. Simply stated, a learning need is the gap between where a person is and where a person wants to be with respect to a particular set of competencies. I am not content until we have listed all of the learning needs that interfere with the therapist's achieving optimal function. Clearly, much of what appears on such a list is derived from the assessment of the three factors described above.

In my own mind, I classify each learning need according to the domain of competencies to which it belongs, because learning needs in the different domains often are best achieved by different interventions. The following discussion is derived largely from observations brought together by Knowles (1984, pp. 9-10). The cognitive domain has to do with the recall and recognition of knowledge and the development of intellectual skills. These are best acquired by the presentation of knowledge in an organized and meaningful context, the acquisition of intellectual skills, and the mastery of cognitive strategies by presenting challenges to thinking. In short, the learner has to do the reading and/or attend lecture and workshops, and then practice the necessary modes of thinking in an active manner, as would occur in supervision and/or in a study group or peer supervisory setting.

The affective/attitudinal domain pertains to changes in interests, attitudes, and values, and the development of appreciation and adequate adjustment. Assuming that there are no blocks to learning, this is best achieved by modelling and by vicarious reinforcement. If there are blocks, therapy may be necessary to facilitate their removal. In short, if the learner is not in his or her own way, exposure to others who demonstrate the desirable affective/attitudinal learning achievement and seeing others praised for its attainment is likely to be effective. If the learner is in his or her own way, this must be corrected, probably in another setting. In any case, interaction with others appears to be a prerequisite. The instrumental of psychomotor domain involves skill mastery and a "how to do it" perspective. Such achievements involve practice, and often an initial demonstration of what is to be practiced. The learner may know what is to be done, and his or her heart may be in the right place, but that will not necessarily facilitate this type of competence.

What is the relevance of these domains to rehabilitation? The proposed approach to respond to the learning need should be matched to the nature of the domain that it encompasses. For example, if a therapist is unaware of an area of knowledge, reading may be a useful first step. If the therapist is aware of the area, but cannot apply the ideas therein, the therapist must be helped to think them through repeatedly, and this must be in the company of others who can give corrective feedback. If the therapist is simply unable to connect to important feeling issues, the therapist should be exposed to and have to interact with people who demonstrate the mastery of these issues. If the therapist needs to learn techniques, demonstrations, practice under supervision, and role-playing may be of greater value. I often ask such therapists to bring their patient along, so I can demonstrate the technique and have the therapist practice it while I observe and can give feedback.

Making Rehabilitative Interventions

In essence, the role of the consultant to the troubled therapist is to perform a consultee-centered more than a case-centered consultation that takes the form of a crisis intervention. However, aside from the engendering of general support and the giving of encouragement, and excluding the impact of any ongoing or ad hoc psychotherapy (which may prove necessary), in my work rehabilitative interventions have the general form of a learning contract (Knowles, 1986).

A learning contract specifies how a body of knowledge will be acquired by the learner; it has eight steps. Step 1 involves the diagnosis of learning needs; Step 2 is to specify the learning objectives. Step 3 is specifying learning resources and strategies. Step 4 is to specify evidence of accomplishment; Step 5 specifies how the evidence will be validated. Step 6, reviewing the contract with a consultant, is an ongoing aspect of the rehabilitative intervention. Step 7 is to carry out the contract, and Step 8 is to evaluate the learning that has occurred.

I have become accustomed to overwhelmed therapists' attempting to take an initial regressively dependent position vis á vis what they must achieve, and rapidly coming to see that this model enables and empowers them so rapidly that they become more self-directed quite rapidly. I do not hesitate to recommend therapy if that seems to be the best way to achieve what needs to be achieved, but I am aware that relatively few accept this advice with enthusiasm, if at all.

The use of the learning contract model prevents the rehabilitative intervention from becoming a supportive psychotherapy, and keeps efforts well-focused. Usually it both achieves those goals that it can, and makes the need for therapy, if it is present, glaringly obvious. It does so not by hectoring the therapist, but by demonstrating that every type of intervention has things that it can address, and things that it cannot.

The therapist, as he or she achieves the competencies deemed necessary, engages in an ongoing rediagnosis and redefinition of his or her learning needs. Often a few experiences of mastery and competence open the way for the rapid acquisition of others — the therapist seems to "get the knack" of the MPD field. However, some feel the need to assure themselves step by step; they need to have experienced the carryover of competencies into their own clinical work time and time again before they feel comfortable.

I have found it is generally unwise to mix these sorts of

rehabilitative interventions with doing psychotherapy, and to respect the integrity of any ongoing psychotherapy process in which such therapists are involved. When a psychotherapist who is overwhelmed applies to me for psychotherapy, I insist that he or she see a colleague with respect to the other aspects of rehabilitation.

Brief Remarks on Special Therapist Populations

Several groups of psychotherapists deserve special note. Therapists who are in therapy must be treated with extreme tact. It cannot be assumed that their ongoing treatment will address their problems in their work with MPD. Often, after such consultees discuss their situation with their therapists, an appropriate arrangement to explore the relevant problem areas can be made. In other cases this is not feasible.

Pastoral counselors often become involved in extremely complex relationships with MPD patients that are syntonic to their value systems, but undermine the possibility of a therapy with appropriate boundaries. It is not uncommon for a patient to be patient, parishioner, a member of several groups at the church, and the object of volunteer efforts by fellow congregants. While many pastoral counselors point to advantages in such a situation, there certainly is the potential for a most difficult and confusing set of circumstances.

Therapists who themselves are survivors of childhood mistreatment often find that this type of patient reopens old wounds. It is not uncommon for such individuals to mistake their own unacknowledged masochism in this connection for an opportunity to demonstrate and/or acquire vicarious mastery over their own private demons. Among this group are those therapists who themselves suffer MPD, or have recovered from it. Some such persons are superior psychotherapists, and some are not. One of the problems that afflicts some therapists who have MPD is a difficulty in assessing their work accurately. They are analogous to MPD mothers (Kluft, 1987), who often, without committing any inappropriate act, are compromised by their dissociation in ways they do not perceive. I consulted to one MPD therapist who did not realize that she was incapable of taking an adequate history because so many types of issues triggered her that she could not stay on a subject. Another grandiosely assured me that she was a superior and special therapist, but in fact switched chaotically in front of her patients and made many grossly inappropriate interventions.

A final group that requires special attention consists of those therapists who have hung their personal and professional identities on their treatment of an MPD patient, and the treatment has gone sour. Such individuals often suffer profound guilt and shame, and may become severely depressed.

Effectiveness of the Measures Recommended

To date, all of the therapists who have participated in this type of rehabilitation program have been able to reach decisions with which they were comfortable as to whether they wished to continue to work with MPD patients, and all of those who have wanted to do so have been able to do so, although in some instances a hiatus in their involvement with clinical MPD has been necessary. I regard this as possibly as much due to the nature of the sample as the interventions, because of all the therapists who sought me out in this connection were highly motivated and readily agreed to the model of intervention described above. Therefore, the success or the interventions with this group leaves unresolved the question as to whether this model is applicable in general.

The Effects of Such Interventions on the Therapists' Patients

In the vast majority of cases in which the therapists were involved in treatment situations that have neither deteriorated irretrievably nor had violated ethical constraints, their patients did well. The exceptions were those few patients who had become so regressively dependent that the correction of the treatment frame constituted (in their minds) an intolerable deprivation. These patients felt abandoned and betrayed; some have spent years mourning the boundaryless and chaotic therapies in which they had felt loved and accepted, even if they had made no progress and their therapists had been hurt or compromised in consequence.

For the patients whose treatments could not be salvaged or which had to be interrupted in the interests of the therapist's rehabilitation, those who could understand the need for such a step on an affective as well as an intellectual level did well; those who could not have had severe difficulties.

Effects of Rehabilitative Interventions on the Intervenor

I have not succeeded in identifying any particular countertransference pattern or strain in the course of doing this type of work. What has impressed me most is the exhausting impact of the constant effort to be attentive to the boundaries that must be maintained in order for me to render appropriate respect to all aspects of the situation. It is hard for me to discipline myself to neither do treatment nor supervision, but instead to remain a facilitator helping the therapist to find his or her own way. I have not yet become relaxed and comfortable with this type of work, which remains less familiar to me than doing therapy or conventional supervision.

CONCLUSION

Treating MPD is not for everyone. Nonetheless, the majority of therapists overwhelmed by their work with MPD can be rehabilitated. In this presentation I have described a model for rehabilitation that focuses heavily on the making of a detailed diagnosis of the overall situation. This may be puzzling to many who may have anticipated that this entire exploration would focus on the treatment of secondary posttraumatic stress, which I have only mentioned briefly, and in passing. It must be emphasized that such rehabilitation is not a substitute for psychotherapy, which may be necessary in addition for many individuals.

It is increasingly recognized that the treatment of the person who is overwhelmed by traumatic stress is not complete if it focuses exclusively upon the trauma experience. As central as it may be, the mobilization of the patient and the restoration of competence is essential. In my early work with

overwhelmed therapists, we focused on their experience of being overwhelmed, and a virtual therapy situation ensued. Often the same therapist would return with similar or closely related difficulties. I concluded that although I had indeed helped the therapists feel better, I had not helped them to become better equipped. The proverb "give a man a fish and he will eat for a day, teach a man to fish and he will eat forever" seemed relevant.

The current model appears to me to be more respectful of the overwhelmed therapist, and speaks more directly to his or her needs for the future. Since, unfortunately, overwhelmed therapists are not in short supply, I look forward to learning how this model will fare in the hands of colleagues. I anticipate that there are alternative models that have been developed by other colleagues, and hope that this publication will encourage them to share their ideas. There is ample need for increased efforts in this area of endeavor. ■

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