

# APPLICATION OF CONTEXTUAL THERAPY TO THE TREATMENT OF MULTIPLE PERSONALITY DISORDER

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## ABSTRACT

*Contextual Therapy, as developed by Ivan Boszormenyi-Nagy, M.D., is a system of family therapy which describes an ethical and relational way of appreciating interactions in families and of conducting therapy among members in families. In addition to its conventional use in the interpersonal domain in MPD families, the authors propose that contextual principles may also be useful in an analogous application of its ideas to the internal, intrapsychic system of alters within an MPD client. Included are a synopsis of contextual concepts, a description of seven problem areas in the treatment of MPD and a contextual perspective on each one, two case examples supplying these principles, and a summary of recent interviews with Drs. Ivan and Catherine Nagy about the application of their concepts to this specialized field. Contextual therapy principles add a crucial ethical dimension to MPD work which provides important benefits for both clients and therapists.*

## INTRODUCTION

In a previous paper (Benjamin & Benjamin, 1992a), we attempted to give a broad overview of our family-centered approach to the treatment of multiple personality disorder (MPD). In that article, we asserted that MPD is a family-based illness in which boundaries between individuals are crossed or exploited. Consequently, a family-based approach is an appropriate and effective adjunct, as well as a powerful extension of the essential psychodynamically-based and hypnotically-facilitated individual treatment (Kluft, 1982, 1984a, 1984b, 1985; Braun, 1984a; Putnam, 1989). Our model draws on many sources of input including the literature in psychodynamic approaches to MPD (Kluft, 1984a, 1984b; Putnam, 1989), hypnosis (Kluft, 1982, 1991; Braun, 1984a; Spiegel, 1990), trauma (Figley, 1985; Putnam, 1985; Van der Kolk, 1987; Terr, 1990; Ochberg, 1988; Herman, 1992), approach-

es to traumatized children (Eth & Pynoos, 1985; Gil, 1991; Goodwin, 1989; Hornstein & Tyson, 1991; James, 1989; Kluft, 1984b, 1985, 1986, 1991; Peterson, 1991; Putnam, 1991; Terr, 1984, 1985, 1990), the biology of trauma and MPD (Braun, 1984b; Barkin, Braun, & Kluft, 1986; Van der Kolk, 1987; Loewenstein, 1991), and family treatment of MPD (Davis & Ocherson, 1977; Beal, 1978; Levenson & Berry, 1983; Fagan & McMahon, 1984; Sachs, 1986; Kluft, 1985; Putnam, 1989; Sachs, Frischholz & Woods, 1988; Panos, Panos, & Allred, 1990; Williams, 1991).

However, in addition to these approaches, we propose that another critical aspect of treatment is the ethical dimension as taught by Ivan Boszormenyi-Nagy, M.D. These ideas are expounded in his articles and books (Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Spark, 1984; Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy, 1987; Boszormenyi-Nagy, Grunebaum & Ulrich, 1991). For beginning students of the contextual model of family therapy who may find Dr. Nagy's works difficult to read in the original, summary texts and commentaries are available (Cotroneo, 1986; van Heusden & van den Eerenbeemt, 1987; Roberto, 1992). The first author studied extensively with Dr. Nagy and his ideas about relational ethics have subtly but pervasively influenced both authors' work with MPD. Through his writings, seminars (which were conducted by Dr. Nagy [Boszormenyi-Nagy, 1987-1988] and later joined by his wife and collaborator, child psychiatrist Catherine Ducommun-Nagy [Boszormenyi-Nagy & Ducommun-Nagy, 1989-1990]), individual and group supervision, and conversations with Dr. Nagy, his ideas began to underpin and guide our philosophical stance toward the treatment of MPD. We believe that contextual therapy offers an underestimated and overlooked ethical dimension which has the potential to steer the therapist as he undertakes the difficult task of working with MPD families. Indeed, we would assert that successful MPD therapies are probably ones in which these usually unarticulated and unrecognized ethical guidelines are unknowingly followed and that a variety of common mistakes in MPD treatment can be understood and avoided by a conscious application of these principles. We would like to briefly summarize the key concepts of contextual therapy that have application to MPD treatment, and then go on to describe in more detail how they address some of the problems that complicate the treatment of the MPD client and her family. For purposes of this discussion, we have used the pronouns "he" and "she" interchangeably to refer to either the client or the therapist. It should be noted that the choice of pronouns is arbitrary and can occur in

any combination. We are, in fact, a husband-wife co-therapy team, and we see dissociative clients of both genders.

### CONTEXTUAL PRINCIPLES

Dr. Nagy postulates that four dimensions of relational reality are omnipresent and work in an interrelated way. (See Table 1) Each cluster explains human behavior from a particular point of view, and at the same time, operates with the other three. These four dimensions are: facts, psychology, systems, and ethics. When working with a client-family, the facts of the case constitute the histories of the individuals including time lines and important milestones, the medication that any individual might need, and any other factual reality that exists. The psychology of each person may include needs, motivations, drives, wishes, etc. that might be explained in a traditional psychodynamic fashion. The systems dimension has to do with how the family operates and includes the concepts of boundaries, organization, communication, and permeability as are well described in standard family therapy models. Finally, the ethical dimension has to do with balance in relationships and the consequences to posterity when relationships are not fair. It is anchored in accountability to the future. Dr. Nagy sees the ethical dimension as the pre-eminent umbrella that covers and subsumes the other three and that provides the necessary treatment frame.

Contextual therapy is a relationally-based approach that underscores that fairness in relationships derives from the balance of giving and receiving in a committed, ethically responsible relationship. In such a symmetrical or even relationship, the person who gives benefits the receiver and also derives self-benefit: receiving through giving. The mutuality of give and take serves both parties and leaves no unpaid debts or obligations. In the parent-child relationship, parents obviously give more to their children than the children can ever repay to their parents. However, in the transgenerational chain, children who have been appropriately given to and recognized for their contributions to the family can, as adults, both give appropriately to their own children and carry on balanced relationships with their own partners and peers.

### CONTEXTUAL CONCEPTS ESPECIALLY RELEVANT TO MPD

There are a number of contextual concepts that are especially relevant to the treatment of MPD. (See Table 2) Some of these concepts describe how the client views himself and his situation, others prescribe the stance and approach of the therapist, and some overlap into both areas. These include: entitlement, trustworthiness, loyalty, accountability, exoneration, multi-directed partiality with its concomitant due crediting, a transgenerational stance, and resources.

#### *Entitlement*

A person has the potential to earn entitlement in two

TABLE 1  
Contextual Principles:  
Four Dimensions of Relational Reality

Dimension 1: FACTS

Dimension 2: PSYCHOLOGY

Dimension 3: SYSTEMS

Dimension 4: ETHICS

- A. MUTUALITY OF GIVING AND RECEIVING IN A SYMMETRICAL RELATIONSHIP
- B. TRANSGENERATIONAL CHAIN OF GIVING AND RECEIVING IN THE ASYMMETRICAL RELATIONSHIP BETWEEN PARENTS AND CHILDREN  
(ADDITIONALLY BETWEEN THERAPIST AND CLIENT)

TABLE 2  
Contextual Concepts Especially Relevant to MPD

- 1) ENTITLEMENT
- 2) TRUSTWORTHINESS
- 3) EXONERATION
- 4) LOYALTY
- 5) ACCOUNTABILITY
- 6) MULTI-DIRECTED PARTIALITY AND CREDITING
- 7) TRANSGENERATIONAL STANCE
- 8) RELATIONAL RESOURCES WITHIN THE FOUR DIMENSIONS

directions: a positive and constructive way or a damaging and destructive way. A person who is able to give fairly (neither too little nor too much) into a relationship or who contributes appropriately into his family earns merit or constructive entitlement. Because that person benefits from giving, that person continues to care about giving and functions with greater security and freedom in other relationships. His

ability to risk giving allows him to dynamically spiral upward in a positive reinforcing chain of giving and receiving self-validation. An additional benefit to the ability to give and receive in a relational dialogue is the idea of self-delineation. Through the relationship with another, each person defines the content and boundaries of his own self and, therefore, gains a better definition of who he is.

On the contrary, a person who is blocked from giving in relationships plummets downward in a reinforcing cycle of not giving and not accumulating self-worth. The person who is blocked from giving has as a child usually suffered neglect, physical or sexual abuse, confusion through parental deceit or mystification, or blame for parental failures (Boszormenyi-Nagy & Krasner, 1986, p. 415). That child has to deal with the world as his debtor, but he is unable to satisfactorily collect the debts. In an effort to balance old relationships, he not only does not contribute to relationships, he looks for substitutes to collect his due. He has the potential to hurt people in his adult relationships (like partner, peer, child) by claiming unduly. His earned entitlement becomes destructive to others because he has not been cared for as a child. In addition, his inability to accumulate constructive entitlement leaves him in a state of disentanglement. At that point, the lack of worthiness may lead to desperate attempts to rebalance his own inability to contribute to relationships in healthy ways by instead hurting the self either through self-mutilation or suicide.

## Trustworthiness

When the balance of giving and receiving in a symmetrical relationship over the long term is fair, each partner views the other as worthy of the other's trust. In an asymmetrical relationship such as the parent-child relationship, the child learns to trust the parent when the parent cares for the child in developmentally sound and appropriate ways. Over the long term, the child experiences the relationship as trustworthy.

The therapist-client relationship is asymmetrical. The therapist can engender trust in the relationship by acknowledging the injustices that the client suffered. Although acknowledgement does not remove destructive entitlement from the client, it builds reservoirs of trust which allow the client to rely less on destructive entitlement to rebalance old relationships. As the client experiences the therapeutic relationship as trustworthy, the client may become more open to the therapist's facilitation of contribution in family and peer relationships. The therapist must be aware that he derives benefit from helping the client: he earns the trust of the client. The therapist, therefore, is in an accountable position of trust and has the potential to effect positive change in the client family which ultimately has consequences for posterity.

## Loyalty

Loyalty has to do with an obligation to significant others who merit that loyalty. The person may or may not realize that this loyalty is operative. A child is loyal to a parent at the very least by virtue of the fact that the parent has given

the child life. Loyalty conflicts are an inevitable part of life. They are usually triadic. One person may be loyal to two people but may prefer one over the other. A wife may be loyal to both her husband and her father. She may, however, be more loyal as an adult to her husband than to her father. The situation may induce some conflict in her.

Direct loyalty to people in the family of origin and their beliefs, traditions, habits, and values may cause damage in the current relationship. In a scenario in which a person has been victimized in the family of origin, the person may victimize his partner or child as both a loyalty to his parents and to the way he was treated and also as an attempt to balance the unjust relationship from the past by treating the partner or child as though the partner or child were the original debtor. A transgenerational relational consequence of past injury may result in substitutive revenge for the injured party in a dynamically moving "revolving slate" (Boszormenyi-Nagy & Spark, 1984, pp. 65-67).

An indirect loyalty (a term which Drs. Nagy & Nagy have now substituted for their previous term "invisible loyalty"), on the other hand, is one in which the person's loyalty to the family of origin blocks commitment to a current relationship. For example, while a woman may express direct loyalty to her parents by following their instructions not to marry a man whom she loves because he is not of the religion that her parents fervently follow, she may alternatively manifest indirect loyalty to her parents by first marrying him and then sabotaging the relationship. In this latter instance, she has been directly disloyal but indirectly loyal to her family of origin by refusing to allow herself to have a successful relationship (C. Ducommun-Nagy, personal communication, December 27, 1992).

A split loyalty occurs when a person is forced to choose between two people who are mistrustful or hostile to each other. A child who is caught in the situation of divorce between parents may be caught in a split loyalty situation. Of course, the extent of damage to the child is proportional to the extent of injustice and mistrust between the parents. A child who learns he is adopted falls automatically into a split loyalty situation between the adoptive parents and the natural parents. Being caught in a split loyalty situation is an automatic state of being ethically exploited.

From a therapeutic standpoint, it is important for the therapist to realize that even the client's family members who the client perceives of as "bad," may have acted out of indirect loyalties to their own families of origin. Although a therapist can accept and acknowledge a client's rage over "bad" parents, the therapist must not collude with the client against the "bad" ones. Such a stance automatically puts the client into a loyalty conflict between the "bad" parent and the "good" therapist.

## Accountability

In an ethical sense, a person assumes responsibility for the consequences of actions or inactions. When the person takes on that responsibility, he earns constructive entitlement. The aim of accountability is definitely not to evoke guilt feelings in the client. Rather, awareness of ethical choic-



es and consequences empowers individuals to take charge of their lives. This is a key element in making the shift from the victim stance to one of survivorship.

In a more psychological sense, accountability refers to a person's willingness to accept responsibility for mutuality or commitment in relationships. This concept has implications for the interactions between the client and the client's partner, children, and family of origin.

Accountability is also deeply rooted in the therapist-client relationship. The therapist-client dyad is accountable both to the client and to other family members who may be affected by the repercussions of the therapy.

A principal goal of the therapy is to help the client to assume accountability for actions in relationships with partners, children, and members of the family of origin. For example, if an adult client chooses to cut off a relationship with abusive parents, the therapist must help the client, at an ethical level, to understand the far-reaching consequences of that choice, and at a psychological level, to mourn the loss.

### *Exoneration*

Exoneration has to do with appreciation of the circumstances that lead to a person's actions or behavior. It is not the same as forgiveness, which implies a blanket disregard for culpability.

Because behaviors of people in families often happen both out of indirect loyalties to past generations and in an effort to balance past unfairness in relationships, it would be unfair to assign intentionality to behaviors. However, it is fair to appreciate the circumstances that surround anyone's behaviors.

In the case of individuals who have been exploited through abuse or neglect, exoneration through appreciation of transgenerational relational consequences can be healing. That is, when individuals can appreciate that injustices that were suffered by past generations have consequences for future generations, they begin to see the ethical repercussions. Exoneration of one's parents also opens up the possibility of self-acceptance if a client has hurt others or the self as the client can then see his own actions as a result of an effort to balance past injustices. Additionally, the client begins to understand that his commitment to therapy and to stopping the transgenerational chain of damaging consequences is worthy of credit. The client earns constructive entitlement for his contribution to posterity.

### *Multi-directed Partiality and Crediting*

Multi-directed partiality is the therapeutic stance that mandates that the therapist be accountable to everyone who is potentially affected by therapeutic interventions. That includes family members who are not present in the therapy room. It is not a neutral stance and it is not uni-directed. Multi-directed partiality has two components: empathy (psychological) and crediting (ethical). While empathy is an idea that is well understood by therapists, crediting as an ethical concept needs further explanation.

Crediting allows the therapist to recognize or acknowledge the ethical situation of the client. Through crediting

the therapist can acknowledge the injustices that were perpetrated against the "monster" members of the family (that is, the same family members who mistreated the client was themselves previously victimized in some way), and thus help the client to ultimately see the humanness of all family members. Crediting the experiential injustices of a client who has harmed others or self can help the client to become empathic to his own victims and also self-empathic.

Crediting is a form of giving ethical acknowledgement to another person as it is due. When a therapist credits a client, the therapist begins to rebuild trust reservoirs that have been depleted. Crediting the client models for the client how to give and thus provides a behavioral option for the client. As the client learns how to credit others, the client begins to earn constructive entitlement and may enter the spiral of earning self-worth. In therapeutic work with families, the therapist can facilitate crediting between partners and from parent to child.

### *Transgenerational Stance*

Contextual therapy is always aware of the consequences for posterity due to the circumstances in any given relationship. Children are vulnerable members of a family and they have an inherent right to be cared for. In addition to being cared for in appropriate developmental ways, children need to be encouraged to contribute in equally appropriate ways to the family and to be credited for their contributions. Acknowledgement of a child's contributions encourages the child to enter the self-validating cycle of constructive entitlement which frees the child to enter healthy relationships in adulthood and to parent in healthy ways.

When children are exploited and blocked from contributing, the consequences for posterity are harmful. With the larger picture of posterity in mind, the therapist can look for interventions that break the downward cycle into destructive entitlement and help to build trust in relationships.

### *Resources*

Contextual therapy is not about removing pathology or symptoms. Rather, it seeks opportunities to help people realize their own relational resources. Resources for giving or contributing can be found in all four dimensions: facts, psychology, systems, and ethics. A person who has chronically refused to take needed medication can earn entitlement and credit for consistently taking it. A person who stops a repetitive cycle of promiscuous behavior can earn entitlement and credit for the struggle to stop. A person who is willing to acknowledge a partner's perspective earns entitlement and credit for appreciating another's point of view. A person who is willing to explore and understand the circumstances of her own father's abuse of her earns entitlement and credit for using an ethical resource and "giving" appreciation.

One role of the therapist is to help the client and client-family find and utilize the available relational resources. When a client can use her own resources, she begins to become accountable to herself and to others now and in future generations.

TABLE 3  
Particular Problems of Working with MPD Clients  
and Their Families

- 1) VICTIM STANCE
- 2) DEALING WITH CURRENT RELATIONSHIPS
- 3) TRUST ISSUES WITH THERAPIST
- 4) SENSE OF BEING SOCIAL OUTCASTS
- 5) AMNESIA AND FUGUE STATES
- 6) INTERNAL DIVISIVENESS & WORKING TOWARDS INTEGRATION
- 7) ISSUES FOR THE THERAPIST

## PARTICULAR PROBLEMS OF WORKING WITH MPD CLIENTS AND THEIR FAMILIES

MPD clients and their families present particular problems to therapists because of the nature of the disorder. We will look at seven issues and then discuss how a contextual approach can be utilized to address each (See Table 3).

### *Victim Stance*

Generally, MPD clients are victims of abuse who have been wronged and are in a victim stance. The world has been an unfair place, it feels unsafe, and they feel powerless to change their condition.

### *Current Relationships*

MPD clients often have difficulties carrying on relationships with peers, partners, and their own children. Because of early violations of trust and boundaries, it is hard to trust others and it is hard to know how close or distant to be with others.

### *Trust with Therapist*

It often takes a long time for an MPD client to establish trust with a therapist. Multiple abuses and breaches of trust make the establishment of a working therapeutic team painstaking and difficult. The client often perceives the therapist to be exploitative and "monstrous" like previous perpetrators in the client's life. The client can also feel loyalty conflicts between the therapist and the spouse which slow down the process of trust-building. Reciprocally, the therapist and the client's spouse may become locked in a triangular relationship of mistrust, blaming, and rivalry to be the client's true confidant. This situation may have disastrous results for the individual's therapy as well as for the functioning of the family.

### *Social Outcasts*

MPD clients often feel that they have done things that make them social outcasts. They believe that society in general would not believe the exploitation that they experienced as children or approve of what they may have done to others or to themselves. As outcasts, they feel disconnected and isolated.

### *Amnesia and Fugue States*

The MPD client's initial inability to know about memories, about feelings, and about past events due to amnesic barriers makes individual work as well as marriage and parent-child work complicated and difficult.

### *Dealing With Internal Divisiveness and Working Toward Integration*

MPD clients have numerous alters which are often in conflict with each other. Having alters that they are either not aware of or who take executive control and behave in ways that conflict with the wishes of other alters often results in the MPD client disavowing responsibility for certain behaviors.

The presumed optimal result according to most authors (Kluft, 1984a, 1984b; Braun, 1986; Putnam, 1989) in MPD therapy is the eventual integration of all the alter personalities into a single consciousness. However, as Kluft himself noted, Caul said that a well-functioning individual would suffice regardless of whether internal splits still existed (cited in Kluft, 1984a). In order to achieve either outcome, one must set the stage from early on in therapy for the alters to work out their difficulties in order to either unify or, at least, work together successfully.

### *Specific Issues for the Therapist*

Working with MPD clients presents special issues for the therapist. A neophyte therapist often becomes fascinated by the process of switching from one personality to another and loses sight of the overall process of therapy. The seductiveness of sexual alters or the neediness of child alters can push a therapist to compromise appropriate boundaries. More controversially, therapists can easily get mired in a client's memories of alleged sadistic ritual abuse and perhaps even contribute to leading the client on to come up with memory after memory in a sort of intrapsychic maze that goes nowhere. Alternately, therapists can become so disgusted and upset by the memories that they listen to that they can dissociate themselves during the therapy session or suffer from secondary post-traumatic stress disorder.

Very concrete issues of time and money come up in MPD therapy. Often, MPD therapy goes on for many years and sessions occur more than once a week. When insurance runs out or other financial resources are exhausted, a therapist may continue to see a client at a very low fee. A low fee, difficult case, especially when therapy seems to be endless and stuck in unproductive patterns, can tap many strong and unpleasant feelings in a therapist. These often include, among others, resentment, anger, boredom, desperation leading to experimental use of questionable procedures, and/or an urgency to help the client find other financial resources to

pay for therapy. The last point may lead the therapist to advocate maintaining or changing occupational or marital situations which may not truly be in the client's best interests. A therapist may find himself arriving to sessions late, canceling sessions, shortening sessions, or paying little attention to the client.

## A CONTEXTUAL APPROACH TO THE SEVEN PROBLEMS

### *Victim Stance*

The contextual therapist views the abuse victim as bearing the consequences of the imbalance in the fairness of relationships in a transgenerational chain. Boundaries have been violated and the individual has either over-given to significant adults through parentification or has been blocked from giving. Through the relational unfairness, the person has earned destructive entitlement which may have given way to disentanglement. The job of the therapist is to credit the victim for her struggles. With an MPD client, individual alters have suffered their own unique relational imbalances often with a multitude of violators. The therapist, therefore, must credit each alter for suffering its own injustices. Through the process of crediting, the therapist begins to rebuild trust and to model a healthier behavioral option for relational giving. At the same time, the therapist must guard against over-giving in the therapeutic relationship lest he perpetuate the sense of imbalance. Such over-giving has the potential to discredit and disempower the client from taking responsibility for achieving the client's own recovery.

The therapist can facilitate the process of the "victim" becoming a "survivor" by helping the person to grow to become accountable to herself, to her partner, and to her children. By recognizing the consequences of her actions and implementing changes to promote the well-being of self and the well-being of others, the client earns constructive entitlement, builds trust in relationships, and accrues self-worth. In particular, her accountability to her children, both in an ethical and a psychological sense, can be turned from an onerous liability into a source of strength. A common scenario with suicidal MPD clients with children occurs when a therapist vainly appeals to the client to stay alive "for the sake of the children." Despairing, the MPD parent concludes that her children would be better off without someone as defective as she. By invoking the concept of accountability for the future, a far more useful interaction can be engineered. The MPD parent can be helped to see that her accountability is an opportunity to earn constructive entitlement. She can choose to free the children from a transgenerational burden of unfair treatment. In the psychological sense, the MPD parent is empowered by the attempt to effect positive change in the future. In the ethical and existential sense, the client adds new meaning to her life.

### *Dealing With Current Relationships*

Because of past exploitation, it is hard for the MPD client to trust peers, partners, or children. That lack of trust inhibits the client from taking risks to give into relationships. In fact,

in order to reclaim justice for past hurts, the MPD client may expect the peer, partner, or child to over-give to her. She may exploit the relationship with others through indirect loyalty to her own past or through earned destructive entitlement. Conversely, she may avoid relationships with others because she believes she is incapable of giving or unworthy of receiving. Eventually, she may sink to a state of disentanglement in which she hurts herself in a desperate attempt to balance relationships. If she cannot give to another person or if she believes that she is hurting another person, then hurting herself to relieve the tension or destroying herself may be the only ways she believes she can right the situation.

The contextual therapist looks for ways to facilitate contributions in relationships. In marriage work, the therapist helps the partners to credit each other. In parent-child work, the therapist helps the client to credit the contributions of the child and to appreciate the normal developmental progress of the child. Such an intervention helps the client not to misinterpret awkward or difficult stages in the child as signs of parental failure as the poorly parented client will almost inevitably do. The therapist sensitizes the client to the issues of giving, over-giving, and under-giving in peer relationships in an ethico-educational way.

### *Trust Issues With Therapist*

The MPD client has a history of being exploited by others, and consequently, expects exploitation from the therapist. Different alters have different levels of trust, and some may perceive exploitation when it is not intended. Protector alters may have the least amount of trust. In order to engender trust over time, the therapist would offer his partiality to all alters as well as credit all alters for their struggles. In addition, the therapist would be partial to any family members (present or absent from the therapy room) who might potentially be affected by an intervention. The therapist sees himself as accountable to the client's partner, children, and family of origin. Such a stance of accountability keeps the therapist from colluding with a client against a partner or a parent.

At the same time that the therapist empathizes with a client's anger and pain, the therapist is aware that perpetrators themselves suffer anger and pain. To actively join with a client against a perpetrator would ultimately block the client from self-exoneration. If the therapist openly declares the perpetrator to be "bad," then the client can only see herself as "bad" as well since the client may well have hurt others or self. Pronouncements of "badness" block reconciliation with alters who have perpetrated hurt against others, thereby impeding the goal of eventual integration of the thoughts and feelings that these alters personify into a unified whole consciousness. Additionally, if the therapist sides with a client against an abusive parent, loyalty to the parent is activated in the client and may well undermine the process of therapy. The stance of multi-directed partiality engenders trust because the client ultimately experiences the fairness of the therapist in appreciating every family member's and every alter's plight.



## *Sense of Being Social Outcasts*

MPD clients often suffer a sense of isolation and loneliness. They feel disapproved of by society both for their psychiatric disorder which is frequently bizarre in its manifestations or shameful in its secretness. Alienation from society ensues because of the exploitation that they have suffered and may have, in turn, perpetrated on others. The therapist seeks to intervene at both an intrapsychic and a familial level to help heal the disconnectiveness. Intrapsychically, the therapist credits the loneliness of the many alters, and through the crediting forges a therapeutic connection. The therapist can also facilitate the crediting among alters themselves. When alters can empathize with and acknowledge each other, a sense of internal connection is promoted which eventually leads toward integrative unity.

On the social level, the therapist can do familial interventions that facilitate connection to partner and children. Marriage work, parenting work, and parent-child work help the client to bridge connections to family. As the client learns to contribute both to the marriage and to the parenting, the client earns constructive entitlement and self-worth. Giving credit to partners and children and receiving credit back rebalances relationships which then leads to feeling connected to the family as a whole.

Therapists may also intervene with ethico-educational counseling about fair giving and receiving in peer relationships. Often clients find themselves exploited in their friendships with others. Learning to recognize that their own over-giving may be an indirect loyalty to their past parentification or a compensation for their blockage from giving can help them feel freer to put their peer relationships into fair balance. Fairness in relationships leads to a sense of connection and belonging.

## *Amnesia and Fugue States*

Amnesic barriers among alters keep MPD clients from successfully dealing with the past. These barriers exist, of course, because the client is unable to face unacceptable memories, behaviors, and feelings. They have psychologically distanced themselves by dissociating them into alters with whom they do not share continuous memory. Even though they may not completely remember their past histories, the clients may repeat them due to direct and indirect loyalties. (This is a restatement in contextual terms of the psychodynamic concept of the repetition compulsion, or more specifically for MPD clients, Kluft's "Sitting Duck Syndrome" [Kluft, 1990].)

Moreover, contextual therapy adds another dimension to this problem: namely, the transgenerational view. Without understanding the past, it is hard for the client to make the changes necessary to preserve future generations. The client is ultimately accountable also to the future. Likewise, the therapist is aware of his position of accountability to the future through his interventions with the client. Therefore, the therapist has the responsibility of helping the client to appreciate her own accountability to the future. Such an awareness on the client's part can motivate her to do the work necessary to better understand her own past. For all clients, the

therapist seeks to instill a vision of the future in which the clients will be free to create a new reality for themselves which is no longer crippled by the injustices of the past. Additionally, for clients with children, the therapist can gently credit the client's caring for the children and teach the client how patterns get repeated through direct and indirect loyalties. As the client begins to retrieve memories either spontaneously or with the facilitation of hypnosis, the therapist needs to continuously credit the client for how difficult the work is. It is profoundly unpleasant to face the very memories and issues which the client previously needed to dissociate away, and the client deserves empathy and acknowledgement for this courageous exploration.

## *Internal Divisiveness and Working Toward Integration*

Internal divisiveness among alters is an obstacle to integration. Such divisiveness also interferes with the client's ability to take responsibility for her actions. The therapist can reduce internal divisiveness by slowly building trust among alters through crediting each one for past struggles, current struggles, and relational positives. The therapist takes the time to consider and appreciate with each alter how he/she contributes to the system as a whole and serves a functional purpose. As alters themselves begin to realize the contributions of other alters especially toward the survival of all, they begin to feel less rivalrous. The ability to appreciate other perspectives eventually leads to exoneration among alters. Mutual exoneration sets the stage for integration of alters as they realize that they no longer have to carry the burden of blame. Rather, alters can work as a team that can credit and validate each other.

Translated into a non-dissociative perspective, it can be stated that as the person as a whole becomes less intolerant of the conflicting attitudes, feelings, and modes of relating which had been walled off as alters because of their mutual incompatibility, the rationale for the dividedness of the self becomes superfluous and increasingly obsolete.

## *Issues for the Therapist*

The contextual therapist must be mindful of the asymmetrical relationship between himself and the client. In spite of the fact that it is not an equal relationship, fairness and balance need to be maintained. Both parties derive benefit from the relationship. The client benefits through the formation of a trustworthy relationship which promotes healing and the therapist benefits by earning the trust of the client. Although asymmetrical, the relationship is fair: the therapist gives expertise to the client in exchange for an agreed upon fee for services rendered. The therapist must be careful not to unbalance the relationship either through over-giving, under-giving, or losing track of his own therapeutic accountability to the client and the client's family. Specifically, the therapist cannot undertake a long term therapy under conditions which are unrealistic and which he may eventually come to resent. Examples of this situation include excessively low fees or over-promising commitment of time to the client which becomes impossible to sustain. These are prime demonstrations of over-giving, and they

usually are a prelude to a therapeutic failure.

The therapist can get caught up in fascination with the phenomenology of switching or in stories of alleged sadistic ritual abuses. Either of these conditions can lead to loss of the stance of multi-directed partiality and accountability to the client. Without multi-directed partiality, the therapist may begin to favor alters that appeal to him and reject others whom he finds threatening or unpleasant. This process may begin to subtly shape the therapy and impede its progress. The client may learn to present the favored alters, act out through the vehicle of the unfavored alters, and tell stories of purported memories which seem to please the therapist by holding his interest, neglecting more prosaic issues which, in fact, may be more fundamental to her recovery. Similarly, the client can be led by present or previous therapists' wishes to be fascinated, dazzled, or horrified by sadistic ritual abuse stories to elaborate and expand on these themes and to generalize them to current life situations.

A contextual approach would prescribe that the therapist listen to the client without judging and impartially credit the client for sharing her hurts. This stance emphasizes that the client's telling is her own perspective. At the same time, the therapist is quietly aware that other participants in the events of the client's life have their own particular perspectives of the same stories. This view tends to minimize the client's need to impress the therapist and aids the client in the eventual sorting out of distortions or screen memories from historically accurate and externally consensually validated recollections.

The therapist remains accountable to the client when he keeps the therapy on track and refuses to be diverted by therapeutic traps. Kluft (1989) has elaborated four common errors in this regard. The therapist may assume the role of a skeptical detective, the client's advocate, or the surrogate parent who "breastfeeds" the client and attempts to "love her into health." Alternatively, the therapist may lose ego boundaries and become "burned out." In all of these situations, the therapist abandons the therapeutic stance and, in the process, either turns away from the work or else colludes with the client's unrealistic expectations to sabotage the therapy. These pitfalls may be avoided by observing the principles of multi-directed partiality and remaining vigilant to not stray across boundaries into a position of over-giving.

## CASE EXAMPLES ILLUSTRATING THE USE OF CONTEXTUAL PRINCIPLES

### *Case No. 1*

This case looks at the contextual concepts of loyalty, exoneration, crediting, self-delineation, and self-validation and applies them interpersonally in the classical contextual sense and, then, also intrapsychically in an adaptation of the model to the specialized treatment of the internal alters in MPD.

An MPD client, who from infancy into adulthood, was involved in a sexual relationship with both parents decided to marry outside of the family clan against the wishes of her parents. Although seemingly disloyal to her parents, she found

during the course of therapy that certain alters were engaged in an incestuous relationship with her children which compromised her marriage. Her indirect and unknowing loyalty to her own family of origin played itself out through the behaviors of those alters. The young woman courageously took responsibility for hurting the children, involved them in therapy, and worked hard to appreciate and exonerate the alters who had hurt them. Through the process of crediting the incestuous alters for their own past hurts, the alters agreed to learn to parent the children in healthy ways. Over time, the incestuous alters moved closer together until they all functioned as a unit to care for the outside children. The process of exoneration of those alters moved the client to attempt exoneration of other sets of alters that spontaneously began to integrate.

The intrapsychic integration into a whole self has allowed the client to now work on contextual self-delineation in therapy both with her husband and with her children. When her children do or say something that triggers an old traumatic memory, the client is able to clearly see that the memory belongs to her and to her past and that the child is not the monstrous perpetrator of her childhood. The ability to delineate those boundaries allows her the freedom to contribute to the growth of her children. Additionally, her ability to delineate her own boundaries and to achieve self-validation through her earned constructive entitlement allows her to now take another look at her past as she works toward exoneration of her own parents from an increasingly integrated position.

### *Case No. 2*

This case looks at the relationship between the therapist and client. The therapist's partiality to the client and to the client's perpetrating father and her husband (traditional contextual therapy) set the stage for coalescence among alters.

A middle-aged MPD client was angry at the therapist, fearing the therapist disapproved of her interactions with the therapist over issues of defining treatment boundaries. She was also angry at her husband, whom she believed behaved in a controlling manner toward her. She was able to relate this upset to her memories of anger at her abusers and cooperating family members when she sought as a child to assert her independence and individuality in the midst of her abuse which consisted of unjust invasions of her body by others.

Over the course of several sessions, the angry alters coalesced into one and this single alter was available to the client to dialogue with between sessions. Ultimately, the discussion was extended to the real life current relationship with her husband and the present struggle with the therapist over independence. When she was able to relate these issues to the memory of the parental role in the abuse, the client quietly reported that this final alter had fused.

The therapist credited the client for being able to express her many conflicting feelings. The therapist also maintained a partial stance to the client's perpetrating father and to her controlling husband. The session was not derailed by discussions of the "bad" perpetrator or the "bad" husband which would have aroused loyalty issues. The client found



that she could trust the therapist to be fair in his partiality to insiders and outsiders, that she did not have to worry about being disloyal to the therapist with her anger at him, and that she could delineate herself in dialogue with the therapist by claiming her own story and her own feelings.

The client's working-out of her relationship with the therapist can be viewed psychologically as a classic resolution of the transference neurosis. However, this process was effected through the application of interventions that are derived from the ethical dimension. In an alternative way, it could be viewed in contextual terms as helping the client delineate boundaries for herself through the dialogue with the therapist.

## DISCUSSION WITH DRs. NAGY AND NAGY

Dr. Ivan Boszormenyi-Nagy and his wife Dr. Catherine Ducommun-Nagy reviewed a draft of this paper. They kindly evaluated and corrected our synopsis of the principles of contextual therapy. In an interview with us, they added some important comments which we will summarize (I. Boszormenyi-Nagy & C. Ducommun-Nagy, personal interview, December 27, 1992 & January 3, 1993).

They conceptualize contextual therapy as an interpersonal approach designed to be used in work with families. Therefore, they expressed some reservations about its application to essentially intrapsychic phenomena such as the system of alters within an MPD client. This is not merely quibbling with the metaphor of work with alters being a form of "internal family therapy" but rather a more fundamental issue; namely, the distinction between the psychological dimension (dimension 2) and the ethical dimension (dimension 4) of the contextual principles. They wish to emphasize the distinction between these dimensions because of their insistence that the ethical dimension is not psychological but rather existential and relational. For this reason, while they are pleased that we find the use of their principles pragmatically effective in the clinical setting with this population, they stress that in the intrapsychic work with alters we are making a symbolic analogy between contextual therapy as it is used interpersonally in family therapy rather than directly applying it. We are, therefore, more properly extrapolating contextual principles for use with intrapsychic constructs, that is with the alters within the client as though they were behaving interpersonally. Thus, our use of their ideas in this way is a departure from classic contextual family therapy as they have formulated it.

Their overriding comment was one of agreement and support for the use of family therapy (of any type but particularly contextual!) in this population of clients. They expressed concern that individually-based therapies for victims of trauma and abuse neglected the ethical, relational, and interpersonal aspects of therapy which they deem to be paramount. The Nagys called for more systematic application of the ethical notion of interpersonal dialogue within families in which abuse is alleged to have occurred, both in the family of origin as well as the presently existing nuclear family of the client. While aware that family of origin work has been generally proscribed with dissociative clients, they,

nonetheless, advocated at least making an effort in this regard.

They were critical of solely individually-based therapies for any client and expressed their approval of our attempts to introduce a family-centered intervention model to the MPD literature. In contrast to their reservations about the intrapsychic application of their principles to systems of alters, they were unstinting in their praise of efforts to use contextual therapy with family members of MPD clients. They also acknowledged the appropriateness of using contextually-based concepts to guide the behavior of therapists in working with MPD clients. Most importantly, they asserted that the greatest possible contribution of contextual therapy to this field was in its emphasis on ethically-based principles to all aspects of the work rather than an exclusive focus on the psychological approach.

## COMMENTARY

It is noteworthy that the Drs. Nagy advocate doing family of origin work with adult survivors of severe childhood abuse. Indeed, this is wholly consistent with their philosophy of multi-directed partiality and the concept of exoneration. They believe that every family deserves a chance for treatment. Consequently, they will try to work with anyone, including perpetrators of incest and child abuse.

Although we are open to the idea of working with extended families, and do, in fact, do so on occasion, we are quite circumspect about the tone and timing of such interventions. We will consider work with the extended family at the client's request, at the stage of therapy when we deem that the client is ready, and when we judge that the client is sufficiently strong that revictimization is unlikely to occur. In contrast to Trepper and Barrett (1989) and to Kirschner, Kirschner, and Rappaport (1993), we do not make confrontation sessions between a dissociative client and an allegedly abusive parent a therapeutic goal. Rather, we work to empower the client to resolve feelings about the family of origin through the fabric of the therapy by:

- 1) talking about abuse issues clinically and providing a corrective emotional experience;
- 2) helping the client to establish safe boundaries;
- 3) role-playing and modeling how to be appropriately assertive;
- 4) working transferentially by pointing out the client's reactions to the therapist;
- 5) facilitating the client's capability to be authentic with the therapist as a model for relating to others;
- 6) encouraging participation in one of our two groups (the group for mothers with MPD or the partners'/parents' group) as a social laboratory for rehearsal of how to be assertive, set limits, connect with others, and interact interpersonally in healthy ways.

From a family therapy point of view, our therapeutic emphases are on the marital and child-rearing subsystems. We usually deal with the family of origin *in absentia*. Our orientation is to move the client to focus on the present and the future rather than to stay stuck in the past.

## CONCLUSION

The enhancement of the treatment of MPD with an appreciation of ethical concepts is the most original and helpful aspect of applying contextual therapy to MPD work. It has been our observation that therapists and clients working within an exclusively psychological dimension frequently fall victim to existential despair as they struggle with the arduous task of therapy. While in no way denigrating the essential importance of the psychological approach, we find that adding an ethical overview such as is advocated by contextual therapy principles provides valuable guidelines for both therapist and client. It aids in the preservation and improvement of clients' current family life as well as the resolution of their feelings about their family of origin and the injustices that occurred in their pasts. With its transgenerational stance, it provides hope and meaning for clients who previously felt hopeless and without meaning in their lives. Lastly, the application of contextual therapy to the treatment of MPD helps the therapist to avoid common pitfalls and errors in dealing with the client and gives the therapist a sound framework and ethical therapeutic stance with which to traverse the course of this challenging treatment endeavor. ■

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