

INTERVENTIONS WITH CHILDREN IN DISSOCIATIVE FAMILIES: A FAMILY TREATMENT MODEL

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ABSTRACT

Interventions with children are surveyed from the literature of the diverse fields of MPD, play therapy, family therapy, and sexual abuse and trauma. Within a family treatment model, play therapy and hypnotic interventions can be useful in helping a child master the physical, cognitive, emotional, and spiritual dimensions of trauma. When parents are able to participate in the child's therapy, they can become a very important ally in the therapeutic process. We emphasize rebuilding of trust in the relationship between the parents and the child. It is our belief that treatment of the child-parent subsystem of a dissociative family has the most potential to interrupt a transgenerational chain of dysfunctional family patterns.

INTRODUCTION

Because the development of Multiple Personality Disorder (MPD) occurs within the context of a family, it is our experience that a family-centered treatment model along with individual therapy for the person in the family who has MPD has the maximum potential to restore trustworthiness in the family (Benjamin and Benjamin, 1992). For the purpose of our discussion, a dissociative family is a family unit in which one or more members has a dissociative disorder. It follows, then, that when the dissociative client is a parent, family-centered treatment must necessarily address the issue of how to involve the children.

Kluft (1984; 1985) and many others (Braun, 1985; Sachs, 1986; Putnam, 1989) have long advocated for the assessment of the children in a family where a parent has MPD. It has been our experience in working with our own MPD client-parents that most are quite concerned about the welfare and well-being of their children. Some explicitly request clinical

evaluations for their children for the presence of dissociation. Others worry about the effects on their children of the consequences of their own problems, often including numerous hospitalizations, custody battles, or loss of their children to the primary care by the other parent or a grandparent. Many are concerned about the general effects on the child of having a parent with MPD. While we frequently focus specifically on parenting concerns and skills in individual, couples, and group settings, we also see children themselves in the context of our overall treatment of the family.

LITERATURE REVIEW ON THE TREATMENT OF CHILDREN

The MPD Literature on Approaches to Children

Following Ellenberger (1970), Kluft (1984) and Fine (1988) have written about the earliest documented case of the treatment of a child with MPD. From 1836 to 1837, Despine Pere treated an eleven-year-old Swiss girl, Estelle, for a conversion disorder that paralyzed her legs. While Despine utilized both individual psychotherapy and hypnotherapy, he also recognized the role of her family in her situation.

Davis and Ocherson (1977) have written about the concurrent treatment of an MPD mother and her nine-year-old adopted son who was referred for adjustment problems. The authors focus on the effects of the mother's MPD on the child's ego development: his adaptation to the separate personalities and his need to maintain sameness in a constantly changing world, and his distorted perceptions and maladaptive responses toward peers. They also allude to the issue of how to explain the mother's MPD to the child.

Brown (1983) has reported the frustrating case of a toddler who was violently abused by her MPD step-father and the inability of the Alaskan public mental health services to secure treatment for the step-father or support for the entire family. Levenson and Berry (1983) have pointed out the case of a woman with MPD who thought that her teenaged daughters would not notice their mother's shifts in personality. The therapists observe that the daughters' manipulation of the mother's amnesic periods, either to get permission from a lenient personality to do something that the host personality would have refused or to lie after doing something and tell their mother that she had given them permission and forgotten, demonstrated their awareness of their mother's changes. Additionally, each daughter assumed a half-adozen names for herself.

Fagan and McMahon have written a landmark article

(1984) on incipient MPD in children. They offer a checklist to assess for childhood MPD, and they categorize families according to whether or not they are "supportive", "problematic", or "pathological." They offer treatment interventions that would be appropriate for each category, and they describe their play therapy techniques for children with incipient MPD.

Kluft (1984) has proposed a predictor list for childhood MPD along with an elaboration of five cases of childhood MPD. In three of the five cases, he provided family interventions as well as individual therapy with the child. In the following two years, Kluft (1985; 1986) wrote further about successful treatment of children with MPD through the use of individual therapy including hypnosis, and a variety of family interventions including family therapy and work with family subsystems.

Kluft, Braun, and Sachs (1984) have supported family interventions with MPD clients although they feel that often it is impossible to be evenhandedly supportive of all family members while at the same time maintaining a therapeutic alliance with the MPD patient. Consequently, they advocate individual therapy with "advocacy-oriented" family sessions. In cases in which a parent suffers from MPD, a family session might be utilized to explain MPD to a child, to free a child of self-blame for a parent's MPD, and to alleviate inappropriate roles in the family. It might also serve as an arena for the observation of incipient MPD in a child.

Sachs (1986) has presented specific family interventions as an adjunct to individual therapy when the MPD client is either the child or the parent. In both cases, she insists that any abuses to the child stop before a family intervention can even be made. The parents of the MPD child can then be helped with how to effectively nurture and discipline the child. Family therapy in the case of the MPD parent is aimed at validating the child's perceptions of the parent and helping the child to deal with the MPD parent. Additionally, it provides an arena in which to observe the child for possible signs of dissociation.

James (1990) has written a very specific article on the treatment of the child with a dissociative disorder in which she supports the formation of a strong alliance with the child's caregivers. McMahon and Fagan (1993) offer a play therapy approach to the treatment of MPD children based on their work with sixty such children. Although their approach is individually oriented, the case example that they present includes the child's teacher, caseworker, and foster mother in the treatment.

The general trend in the MPD literature indicates that family interventions may serve as an important supportive adjunct to individual therapy. When a child has an MPD parent, the child has a right to understand the disorder and not feel blamed for causing it. The MPD parent can benefit from interventions that teach healthy parenting. Children with MPD need individual therapy to help them resolve their traumas. Their parents may also need help with parenting skills as the child proceeds through the therapeutic process.

Play Therapy Literature with Traumatized Children

Mann and McDermott (1983) have outlined four phases

of treatment for victims of childhood trauma: 1) establishing rapport and learning how to play, 2) regression and abreaction of trauma 3) testing of real relationships and developing impulse control and self-esteem, 4) termination. They also believe that concomitant, but not joint, treatment of the parents is key to their approach.

Terr (1983) has elaborated the characteristics of post-traumatic play which were based on her observations of the child kidnapping victims of Chowchilla. Noteworthy are the compulsive repetition of the play with a failure to relieve anxiety and the contagious effect of the play on non-traumatized children. She advocates using four types of play therapy for traumatized children: release (abreactive) therapy, psychotherapy utilizing spontaneous play, psychotherapy utilizing present or prearranged play, and play therapy utilizing corrective denouement. She (1985) also notes that parents play an important role in the therapy of the traumatized child. They may need separate sessions, participate as observers in the child's sessions, or be involved in family treatment.

James (1989) has advocated a direct, active treatment approach that aims at addressing the physical, cognitive, emotional, and spiritual parts of the traumatized child. She notes that children may engage in secret, dysfunctional behaviors long after a trauma is past. Unless a therapist makes an effort to uncover such behaviors, they are unlikely to be noticed. The involvement of parents or caregivers in a child's therapy is a key and planned intervention that helps to facilitate the therapeutic process.

Donovan and McIntyre (1990) have written extensively about the complexities of play and how children think, communicate, interact, and change. Their developmental-contextual approach appreciates both the development of children and the familial context in which they grow. They have adapted a parallel therapy to address both development and context. The authors work as a team which meets with both child and caregivers at the beginning of the session, splits up in the middle with one therapist with the child and the other with the parent(s), and re-unites as a group at the end. The parallel relationship between the therapies of child and adults forms a critical aspect of their approach.

Gil (1991) has suggested that hurt children need a safe therapeutic environment with an early non-directive approach. As therapy progresses, the clinician may become more directive in helping the child to face and process traumatic events. It is important for the therapist to interrupt repetitive post-traumatic play in order to help the child achieve mastery over the trauma and to orient the child toward the future. In many of Gil's case examples, she includes family contacts and interventions to support the therapy.

O'Connor (1991) has recognized that collateral work with parents has a place in play therapy. He conceptualizes a variety of positions for parents: as the child's therapist, as the parent in a conjoint parent-child session, or in parallel individual or couples treatment.

In general, play therapy approaches to traumatized children tend to focus on the individual treatment of the child. However, they usually acknowledge that some level of parental or guardian involvement is necessary. At the most

minimal level, parents provide the history of the child and observational data for the therapist. In contrast, Donovan and McIntyre (1990) rest their approach on a parallel therapeutic process for child and parent. As previously, stated, Terr (1985) sees parents as playing a significant supportive role in a child's recovery.

Child Sexual Abuse and Trauma Literature

Most authors who write about the sexual abuse of children agree that some form of family intervention is necessary either because the family is the agent of the sexual abuse or because the family is overwhelmed by sexual abuse to the child that has occurred outside of the immediate family (Burgess, Holmstrom and McCausland, 1978; Sgroi, 1982; Porter, Blick, and Sgroi, 1982; James and Nasjleti, 1983; Long, 1986; Damon and Waterman, 1986; Kempe, 1987; Jones and Alexander, 1987; Gelinas, 1988; Friedrich, 1990). Without changing family dynamics, the child is neither safe to stay in the family nor able to process productively and effectively sexual violations. Although Marvasti (1989) has offered an essentially child-focused model of play therapy for the sexually abused child, he does advise individual therapy for each parent and group therapy for the offender.

Mowbray (1988) believes that posttraumatic therapy for children who are victims of violence should consider family or parental therapy as well as individual therapy. In the case of a chronically ill child, Patterson and McCubbin (1983) have argued that the therapeutic focus should be on the current functioning and problem-solving abilities of the whole family.

Without exception, the child sexual abuse authors acknowledge the vital role that the family plays in a child's recovery. They include the parents in a number of family interventions. Mowbray (1988), Patterson and McCubbin (1983), specifically see family therapy as valuable in the treatment plan.

Family Therapy Literature

Beezley, Martin and Alexander (1976) have focused extensively on therapy for parents in an abusive family. They see parents as needing individual, marital, and group therapies. Figley (1988) also sees the family as key in its support for victims of trauma.

Boszormenyi-Nagy and Ulrich (1981) have specifically addressed the inclusion of children in their contextual approach to family therapy. Having children present graphically demonstrates to the family the transgenerational nature of family problems. The presence of children functions as a therapeutic leverage. Contextual therapy postulates that children are entitled to have a trustworthy relationship with their parents. Consequently, parents are accountable for making sure that children are treated in a fair and trustworthy way. Family therapy with children occurs in such a way that a trust-building between parents and child is fostered rather than the therapist engaging in "child therapy." For example, the therapist may ask the child to describe the problem that he sees the family as having and how the child has tried to make the family situation better. The therapist then may acknowledge the child's act of giving to the

family and facilitate the parents' acknowledgement of the child's contribution. The parents' crediting of the child begins to build trust between parents and child by noticing the child's efforts at giving. The parents can then be encouraged to take parental responsibility for working out problems and not leave the child to silently believe that he has responsibility for making family problems better.

Zilbach (1986) has written specifically on the integration of children into family therapy. Although she chronicles how many of the early family therapists including Ackerman, Satir, Minuchin, and Whitaker worked with young children in their treatment approaches, she also notes that the amount of documentation of their work with young children is scant. She sees children as serving critical functions in family therapy: providing access to hidden family problems by making them visible through their communications or symptoms, being "allies" to the therapist and "direct explainers" of family mechanisms, bringing developing family problems to the attention of the therapist, and helping the therapist to understand how the whole family operates so the therapist can model behaviors that might be useful to the family. She encourages the specific use of play materials such as a bop bag, paper, crayons, clay, and puppets to facilitate the expression of children's feelings.

In the family therapy literature, Sachs, Frischholz and Wood (1988) have addressed the marriage and family treatment of MPD in two specific circumstances: when the MPD client is a child and when the MPD client is a parent. When the MPD child is the client they offer six guidelines: establish safety for the child, develop a consistent and nurturing environment for the child, develop functional communication in the family, develop appropriate boundaries, prevent the triangulation of the child, and establish family rules, expectations and consequences. Alternatively, when the family therapy focus is around an MPD parent, the therapist needs to identify the effects of the MPD on the children, assess children for dissociation, help the children learn to relate to the MPD parent, identify stressors in the environment which cause the MPD parent to dissociate, establish boundaries, and establish a strong parental subsystem.

Overall, the family therapy literature acknowledges that everyone in a family, including children, are affected by family problems. Zilbach (1986) notes that although family therapists, in general, see the importance of children, many training programs in family therapy omit instruction in how to directly include children in treatment. Zilbach herself fills that void with her contribution on working with young children in family therapy. A number of authors in the family treatment field see parenting counseling as a specialized intervention. Notably, Contextual Therapy views parents as accountable for building trust in relationships with children by caring for them in appropriate ways without the expectation that children take care of the parents. With its emphasis on the ethical dimension in therapy, it focuses on fairness in relationships and on a transgenerational transmission of appropriate giving from parent to child (Boszormenyi-Nagy and Ulrich, 1981).

THE IMPORTANCE OF WORKING WITH CHILDREN IN DISSOCIATIVE FAMILIES

The foregoing discussion of the literature indicates that the MPD literature, the play therapy literature, the sexual abuse and trauma literature, and the family therapy literature all contribute to supporting the notion that family interventions have a place in therapy. In our own work with MPD clients, we believe that a family approach as well as individual treatment enhances the treatment at both a systemic level and an ethical level. Further, we assert that within that family context, treatment of the child-parent subsystem has the most potential to interrupt a transgenerational chain of dysfunctional family patterns. Of course, in cases where the clinician has reason to believe that either physical or sexual abuse of the child is presently occurring, it is necessary to first stop the abuse before any meaningful treatment can proceed. The therapist is obligated to report the abuse to the appropriate authorities according to the legal guidelines which exist in that particular jurisdiction. We attempt to help families deal with the course and consequences of the reporting as a planned intervention incorporated into the fabric of the work with the family.

In dissociative families, children may or may not have MPD themselves. However, they always play an important role in the family treatment. Even if the children are not directly included in the therapy of the MPD client-parent, they, nevertheless, are affected by individual or marital interventions. At the very least, developing children notice that there are problems in the family. They are often perplexed by the switches of the MPD parent. As therapy proceeds, they may be further confused by the shifts in behavior that occur in the identified client, in the client's partner, and in the relationship between the partners. Further, Putnam and Trickett (1993) suggest that dissociation may be transmitted transgenerationally by environmental mechanisms and that parents and children may mutually stimulate dissociative behavior in each other.

When a main caregiver has MPD, a child may come to feel that it is his role to take care of the parent or he may feel that he is to blame for the MPD. In a previous article (Benjamin and Benjamin, 1992), we have enumerated a number of potential risks that face children of MPD parents. First, there is the risk of physical or emotional abuse or neglect. Because alters may switch to do caretaking, children may experience a sense of unpredictability and inconsistency toward them. They may feel confused if the MPD parent suffers from bouts of amnesia or emotionally abandoned if the MPD parent spends large amounts of time focused inward instead of listening to the needs of the child. The child may experience lengthy or periodic physical separations from the parent if the parent needs hospitalization. The sense of unpredictability in the parent may discourage the child from bringing peers home to play, and, thus, inhibit the child's social development. The behaviors themselves of the child may unwittingly evoke overwhelming feelings in the parent that cause him to withdraw from or hurt the child. The child, who observes the parent's instabilities, may feel overly responsible for the parent or for younger siblings if the par-

ent is unavailable. Additionally, a young child may feel to blame for the parent's illness. Often an MPD parent has other complicating problems such as alcoholism, eating disorders, depression, suicidal behaviors, or phobias. The child finds a way to cope with those other obstacles as well.

Kluft has published a striking article (1987) in which he has studied the parental fitness of seventy-five mothers with MPD. Implicit in the results of the study is a concern for whether or not the children of mothers with MPD are receiving an adequate childrearing experience. Of the total number of mothers, he found that 38.7% were "competent or exceptional"; they did what was good for the child and best for the family, avoided switching in front of the child, and achieved co-consciousness across personalities or developed collaborating personalities to do the parenting. Another 45.3% were labeled as "compromised or impaired"; they had MPD symptoms that interfered with their parenting, behaved against the best interests of the child, neglected the needs of the child, parentified the child, and practiced some form of psychological abuse. Finally, 16% of mothers were "grossly abusive"; they inflicted harm on the child, physically damaged the child, failed to protect the child from injury, or sexually exploited the child. Summing up his categories, 61.3% of the mothers were behaving in ways which were likely to harm the children to a lesser or greater extent. The interventions that Kluft proposed for the abusive mothers were: agency or legal interventions, ongoing supervision including parenting skills, intensive psychotherapy for the MPD mother specifically for her MPD, treatment and follow-up for her children, and supportive therapy and education and advice for the caretaking partners. We see in these suggestions a clarion call for efforts to help these mothers and their children.

In Kluft's four-factor theory of causality of MPD, he describes the kinds of traumatic events that can overwhelm a child's non-dissociative defenses and to the part that caregivers play in the evolution of MPD in the child (1984). In addition to sexual abuse, extreme physical abuse, abandonment, neglect, and psychological abuse, other life experiences that are overwhelming are: the loss or death of significant others, witnessing a murder, an accident or carnage of war, receiving serious death threats, cultural dislocation, being caught between embattled parents in a divorce situation, being treated as if the child is the opposite gender, or excessive observation of the primal scene. Most of these situations either involve the family directly in the trauma or else rely on the family to mediate the effects of external trauma. Kluft (1984) labels the family's inability to process the trauma or protect the child as Factor 4: "Inadequate provision of stimulus barriers and restorative experiences by significant others, for example, insufficient 'soothing'" (p. 15). When a traumatized child is neither protected nor helped to process trauma within the family, the child may go inside him/herself to find soothing and comfort.

This notion of a parent neither providing a stimulus barrier nor processing traumatic events with a child can be viewed from two ends of the telescope when working with families. On the child side, a lack of protection or soothing may be a risk factor in the development of MPD in a child.

From the parental lens, an MPD parent who has not had the protection and soothing from her own parent may have difficulty giving it to her non-MPD children because she has not experienced it herself. The inability of a parent to modulate affect states in herself may hinder the parental task of modulating affect states in children (Cole and Putnam, 1992; Nathanson, 1993). Additionally, Frederick (1985) points out that children of a traumatized parent are affected by the parent's traumatization. Children are upset when they perceive their parent as unstable. Other authors have written about this phenomenon of contagion of trauma (McCann and Pearlman, 1990; Dyregrov and Mitchell, 1992; Figley and McCubbin, 1983; Figley, 1985; Donaldson and Gardner, 1985; Terr, 1985; Maltz and Holman, 1987; Courtois, 1988; Figley, 1988; Carroll, Foy, Cannon and Zweir, 1991; Harris, 1991).

In a study of psychic trauma in children who have witnessed the homicide of a parent, Eth and Pynoos (1985) emphasize that trauma affects children differently at different developmental stages. Cognitive, social and emotional development may be altered as traumatized children struggle to manage schoolwork, play, and interpersonal relations. They recommend early treatment interventions to prevent maladaptive trauma resolution. Terr (1985) asserts that childhood trauma leads to cognitive-perceptual difficulties and the collapse of early developmental achievements. Fish-Murray, Koby, and van der Kolk (1987) report that abuse affects the accommodative capacity of the child which may lead to an inability to self-correct. Fine (1990) further observes that abuse may also interfere with assimilative capacity which may result in cognitive distortions. Briere (1992) discusses both the impact of abuse on the survivor's inner experience (e.g., cognitive distortions, altered emotionality, dissociation, and impaired self-reference) and on interpersonal relations (e.g., disturbed relatedness, avoidance, co-dependent relationships and borderline tendencies). Cole and Putnam (1992) offer a developmental model of the effects of incest on children and conclude that incest interferes with the development of self and social skills in children in a way that increases the risk of severe psychopathology. Moreover, Putnam and Trickett (1993) assert that traumatized children suffer serious physical/biological, psychological, and social consequences.

Furthermore, authors in the MPD literature have noted the transgenerational nature of dissociative disorders. Kluft (1984) has found MPD in one or both parents of 40% of his childhood MPD patients. Braun (1985) has studied eighteen cases of MPD in which dissociative phenomena were found in the family histories of all eighteen. In a study of twenty patients with MPD, Coons (1985) has found that children of MPD mothers had a 39% incidence of diagnosable psychiatric disturbances including 9% with MPD. Such evidence adds to the urgency of assessing all children of parents who have MPD. A number of authors (Kluft, 1984, 1985; Braun, 1985; Sachs, 1986; Putnam, 1989) advocate for routine assessment of the children of MPD parents.

Based on the foregoing studies, it seems evident that there is an increased risk of children of MPD parents receiving less than adequate parenting. In addition, the MPD client-parents themselves may have trouble with parenting skills

based on the lack of competent role models from their own families of origin. This conclusion is implied in Kluft's (1984) Factor 4 which states that inadequate provision of stimulus barriers or restorative experiences to children by significant others in the face of overwhelming trauma is an essential element in the etiology of MPD. As traumas in minor, if not in major ways, are ubiquitous in the everyday life of a child, it follows that many parents with MPD may be woefully unprepared to help their children cope if their own coping skills are based solely on their experiences of how they have been parented in their own childhoods. Consequently, our therapeutic interventions take two forms: 1) to work directly with the child to help the child process his or her experiences, both in terms of handling life events and relating to a parent with MPD (if that is the circumstance); 2) to work indirectly with the child by teaching the parent how to help the child process experiences.

Thus by both methods, we are seeking to provide the stimulus barrier and soothing that will protect the child from becoming or remaining dissociative, and/or from continuing in the transgenerational chain of dissociative pathology.

Rationales for Working with Children

To summarize the various rationales for working with children in dissociative families, we feel that they include:

- 1) Children are often affected by the dissociation of a parent.
- 2) Children need to be observed and assessed for dissociation or other signs of maladaptive behavior.
- 3) MPD parents are often concerned about the effects of the MPD on the child.
- 4) MPD parents are often concerned about the effects of the child's current life situation (custody battle, alternative caregiver, abusive situation outside the family) on the child.
- 5) An MPD parent often benefits from watching the therapist interact with the child. The therapist can model both nurturing and limitsetting behaviors. The therapist can demonstrate appropriate boundaries in an interactive rather than a didactic way.
- 6) The therapist can empower the MPD parent to relate well to her children by participating in sessions with them. Confidence in parenting has the potential to become a self-esteem enhancing resource for the MPD client.
- 7) Work with parents and children provides therapeutic leverage for the therapist.
- 8) Strengthening the parental subsystem deparentifies the child. It shifts accountability for parenting to the parent.

- 9) Work with parents and children builds trust in their relationship and restores a fair balance of giving from parent to child.

The last three points draw heavily on contextual principles (Boszormenyi-Nagy and Ulrich, 1981) which we have discussed at length in a previous paper (Benjamin and Benjamin, 1993a).

TREATMENT GOALS IN WORKING WITH CHILDREN

Within the context of our family-centered treatment philosophy for MPD, we have five goals in working with children:

- 1) To restore healthy interactions and enhance relationships between child and parents and child and siblings.
- 2) To increase mastery and control in the child's life through a combination of nurturing and empowering messages, activities, and techniques.
- 3) To help the child resolve trauma(s) with trauma-based play therapy (Terr, 1983, 1985; Gil, 1991; James, 1989), activities such as storytelling (Gardner, 1992), or frank hypnotic interventions (Rhue and Lynn, 1991; Kluft, 1984, 1985a, 1985b, 1991; McMahon and Fagan, 1993).
- 4) To promote a sense of wellness and normalcy for the child.
- 5) To help the child connect to family, peers, and the larger community through participation in relevant experiences based on the child's talents and interests (e.g. sports, art classes, dance, etc.).

TYPES OF INTERVENTIONS

Our work with children always involves the parents to some degree. We agree with James (1989) who notes that the involvement of parents is not a breach of confidentiality. Rather, it is a planned intervention. James justifies parental participation for many reasons: children spend more time with their parents than in therapy, parental involvement lessens secrecy and shame, acceptance by parents promotes self-acceptance in the child, it insures parental cooperation, it allows for the strengthening of attachment of the traumatized child to the parent. Filial play therapy (Guerney, 1983) includes parents in the therapeutic process in order to specifically teach and model parenting skills. Unlike filial therapy, however, which first places a parent behind a one-way mirror to watch the therapist interact with the child and then allows the parent to interact with the child while the therapist observes, we usually prefer to have the parent in the same room with the child and therapist as the child plays. In that way, the parent can participate directly in the process of the play therapy. The therapist is then able to observe

and later process with the parent the parent's reactions to the play of the child. Not only can the therapist be helpful specifically in the parenting area, but such interactions frequently stir up a well of more general psychodynamic and family of origin issues for the MPD client that can be processed in individual sessions.

The type of involvement that we have with children varies from family to family. Often, we have a few sessions with the children of an MPD client-parent to look for signs of dissociative symptoms or other problem behaviors. In those cases, we spend part of the session with parents and child and part with the child alone. If further child work is indicated, we include the MPD parent as much as is possible for him or her in the session with the child. In cases in which the parent is able to remain in a child's session without overtly switching or experiencing flashbacks or numbing, the parent is welcomed to join in the play therapy of the child. In instances in which the parent is unable to participate for the entire session, the parent participates for ten minutes at the beginning of the session and five or ten minutes at the end.

On occasion, therapists from outside our own practice request an evaluation of a child of their MPD client. In that case, we interview the parents together for one or two sessions in order to get a family history and genogram, and a developmental history of the child. Then we meet with the parents and child for several sessions. During those sessions, we spend about half the session alone with the child. Alternately, if two therapists are available, we split the treatment into two rooms so that one therapist meets primarily with the child while the other spends further time separately with the parents gathering additional history and building rapport. Later, all reconvene to review the session together briefly. Usually, further time is then spent with both therapists talking with the parents while the child or children remain in a nearby waiting room. If this feedback to the parents cannot be done immediately, then a separate session is arranged within a few days to accomplish this purpose. Sometimes we then continue the treatment of the child while the MPD parent remains in individual therapy with another therapist. In that event, if it is appropriate and agreeable with the primary therapist, we encourage the MPD mother to join our MPD mothers' group (Benjamin and Benjamin, 1992) and the spouse to join our Partners and Parents' group (1993b). We are also available to meet separately with the parents for parenting counseling if this seems indicated. Again, it is in cooperation with the client's primary therapist.

Another possibility which occurs is that one or both parents continue in parallel therapy with one of us while the other therapist works with the child. This is the method advocated by Donovan and McIntyre (1990). We find this approach to be a powerful and useful method. However, it has some practical drawbacks. It requires extraordinarily close collaboration between the therapists, and it presents a financial problem in that two services are being rendered by two therapists. The latter results in either a double bill for the client-family or else a sharing of a single fee between the two therapists.

Sometimes we are asked to do an evaluation of a child for court. Although one child who we originally evaluated

for child abuse has remained in treatment with us for over five years, we have since modified our own policy toward legal cases subsequent to that experience. Because we strongly believe in the Contextual Approach (Boszormenyi-Nagy and Ulrich, 1981; Gelinas, 1988) that mandates that the therapist show multidirectional partiality to all family members including the ones who are absent but directly affected by our interventions, we see legal advocacy as antithetical to our philosophy of the practice of psychotherapy. It runs the risk of putting the child into a split loyalty situation between the therapist and the adversarial parent in custody disputes. Therefore, we now explain to prospective clients that we will consider either working with them therapeutically or else serving as an expert witness, but we will not agree to be in both roles on a given case.

Our preferred method of working is with the members of an entire family. If after an evaluation of a child, it seems that therapy work with the child is indicated, we will offer to see the child within the context of the family. That means that one of us treats the MPD parent individually, one of us treats the non-MPD parent, each parent is in a group for mothers with MPD or for parents or partners, and the child has play sessions preferably with the MPD parent present.

SPECIFIC MODALITIES WITH CHILDREN

Play Therapy

A discussion of play therapy necessitates a brief digression about the function of play in a child's life. Erikson (1963) views play as a child's effort to master reality: "I propose the theory that the child's play is the infantile form of the human ability to deal with experience by creating model situations and to master reality by experiment and planning" (p. 222). O'Connor (1991) sees particular elements as typifying play behavior: it is intrinsically complete without needing external rewards, it is aimed at making use of objects, it does not proceed with a conscious goal on the part of the child, it absorbs the child's awareness to the point of loss of self-consciousness, it is fun, it is variable and flexible depending on the situation and the child, and it does not occur in new or frightening situations. He regards the goal of play therapy as "the reestablishment of the child's ability to engage in play behavior as it is classically defined" (p. 6). It does not matter that the therapist and child engage in behavior that may not be called "play" along the way to the goal. Treatment is complete when a child has the ability to play in a joyous way.

However, the secretive and compulsive play of traumatized children (Terr, 1983) is not fun. It may, instead, be an attempt to master an experience of trauma. Trauma affects children cognitively, emotionally, physically and spiritually (James, 1989), and, by extension, interferes with the normal processes of self and social development (Cole and Putnam, 1992). Play therapy with traumatized children (Terr, 1983; Mann and McDermott, 1983; Fagan and McMahon, 1984; James, 1989; Gil, 1991) utilizes play to help children master the trauma, and, ultimately, to free children to continue the processes of normal development.

Like James (1989), our style is direct and open. With

the parents present, we explain the purpose of our meeting. We usually begin sessions with the child and parents together reviewing what has happened during the week at home, at school, in the neighborhood. Where possible, we invite a parent to stay to be a part of the child's play therapy session as explained previously.

A number of play therapists (Mills and Crowley, 1986; James, 1989; Gil, 1991) advocate the use of multidimensional strategies with children that address physical, cognitive, emotional, and spiritual aspects. The play materials and activities that we provide in our office address each of these developmental areas as well. To this list, we would add hypnotic interventions which do not fit neatly under any of the other categories.

The Physical Aspect

Materials for physical use include balls of all sizes and textures, various bop bags, a large karate kicking bag, and a velcro ball "dart" game. Children use these props to make up their own physically appealing games. One child methodically and ritually blew up a small bop bag in each session over a period of months, punched it until he was exhausted and the bag either deflated from a hole or the sandbag weight inside burst. He would then take a scissors, cut out the sandbag (which he called the "heart") and drape the bag over his head like a cape. The same child, in a late stage of his treatment, punched and kicked the indestructible karate bag repetitively over many sessions in a trance-like way while the therapist intoned the elements of a hypnotic integration ceremony to help him coalesce his alter personalities.

The Cognitive Aspect

Quite a bit of direct discussion happens in the playroom between therapist and child, therapist and parent, and parent and child. For instance, a child who is going through the separation and divorce of his parents may need reassurance that his upset and loyalty feelings toward both parents are very normal. The parents may also need counseling on how to cooperate about rearing the child as they go through a divorce process. Storytelling and metaphors (Mills and Crowley, 1986; Gardner, 1992) are often used to help a child both understand and master his situation. Puppets (Burgess, Holmstrom, and McCausland, 1978) can be utilized to initiate a non-threatening story. They take the direct focus off of the child and allow the child, therapist, and parent to talk in an indirect way that may be less intimidating or embarrassing than direct conversation. We find the use of puppets to be a very powerful and effective technique that we employ extensively in work with children. We maintain a large collection of colorful and engaging puppets, primarily in the form of interesting and whimsical animals. They are used both formally in a puppet theater stand and informally and spontaneously to interact with the child.

Hypnotic Interventions

Formal hypnosis has been used with traumatized children to help the child master the trauma, to alleviate symptoms, and to retrieve information (Kluft, 1991). Storytelling techniques have been used to create hypnotic inductions

(Olness and Gardner, 1988). Hypnotic techniques have been used to help sexually abused children find a safe context, restore personal power, reduce feelings of self-blame, shame or brokenness, to promote a sense of wellness, and to resolve sexual issues (Rhue and Lynn, 1988). Kluft (1991) cautions that before resorting to formal hypnosis with a child, the therapist take into account the child's ego functions, cognitive and psychodynamic development, coping styles, the family's attitude toward hypnosis, and whether or not a hypnotic intervention might later contaminate forensic testimony. As Green (1985) notes, traumatized children often present as hypervigilant, frozen, and mistrustful, hardly a promising combination for formal hypnosis. Hilgard and LeBaron (1984) explain that very young children (from about three to six years) engage in "protohypnosis", pretend play which is guided by language. They cannot engage in formal hypnosis because their limited cognitive abilities interfere with typical hypnotic suggestions and tasks and they cannot engage in the internal elaboration of fantasy. Usually they keep their eyes open just as they would as they engage in pretend play. Hypnotic ability of the type we are able to recognize, describe, and measure begins to rise at about five years and peaks between nine and twelve years.

Children who dissociate have discovered an autohypnotic way of coping with trauma and reducing their own stress. It makes sense that hypnosis, which has a link to dissociation, might be an intervention of choice with dissociative children (Kluft, 1991). In our own sample of children who appear to have MPD, we have used formal hypnosis sparingly with elementary school-aged children as part of the larger treatment plan, to increase mastery, identify alter personalities, and facilitate integration. More frequently, however, we have used hypnotic or "hypnoidal" (Linden, 1993) techniques to increase a child's sense of safety and mastery. These techniques capitalize on the child's ability to be absorbed in fantasy play. Once involved in the pretend play of the child, the therapist can send messages of safety, strength, control, and mastery.

The Emotional Aspect

This realm includes all of the play therapy materials and activities that encourage exploration and expression of feelings. James (1991) offers a wealth of interactive activities with children to help them label and get in touch with feelings. In our practice, the many art supplies such as paper, paints, markers, crayons, pencils, clay, glue, feathers, imitation gems, pipe cleaners, etc. encourage children to express feelings. Mills and Crowley (1986) have devised the helpful technique of having a child and the child's parents draw what the problem as they see it looks like, drawing what life will be like when the problem is resolved, and then drawing how the child can best solve the problem.

The use of sand tray (Kalff, 1980; De Domenico, 1988; Dundas, 1990) allows the child to project feelings and experiences onto the sand. The tactile use of the sand can help to soothe a child (Gil, 1991). Some children merely finger the sand at first, others play out repetitive simple scenes, and other make elaborate constructions in the sand. Our observation is that over the course of therapy, a child's capacity

to create scenarios in the sand increases. The children choose the figures that they wish to use in the sand and create a scene. They are asked to explain the scene and then two still instant photos are taken. One stays with the therapist and one goes home with the child. One child created a sand tray of a male figure in a boat being attacked on all sides by clawed creatures (crabs, lobsters, and sharks). The child put sand in the figure's mouth. This child was in the middle of a hostile custody battle and was scheduled to appear before a judge to say whether he wanted to live with his mother or his father.

In addition to the sand tray, children create scenes on the rug with figures, vehicles, and props (dolls, furniture, bugs, dinosaurs, fish, snakes, cars, trucks, trains, a futuristic "Star Wars" type ship, etc.) One school-aged child, whose parents were divorcing, repetitively created scenes of car accidents in which all the participants were hurt and broken.

The Spiritual Aspect

Traumatized children have suffered many losses. When they have a parent who has been traumatized as well, the parent may have trouble passing on a sense of life's meaning to the child. James (1991) believes that children can be given the message that they have something of value inside of them that no one can take away. The therapist can utilize the specific religious affiliation of the family to encourage spirituality and connection to universal values. The spiritual dimension can also be appreciated in the power and beauty of nature. Mills (1991) encourages keeping natural wonders such as stones, gems, and shells in the office.

FAMILY INTERVENTIONS

Parent-Child Sessions

In our model, parents are vitally involved in the child's therapy. A major goal of our approach is to empower the parent to relate successfully to the child: to nurture, soothe, set limits, and be aware of boundaries. In cases in which the parent has been the perpetrator of abuse, we work with the parent individually to help the parent reach a comfort level of addressing the abuse directly with the child. Over several sessions, the parent explains that he/she was wrong, that the child was hurt, and that the parent deeply regrets having hurt the child. In cases where the parent has MPD, we have worked extensively with the offending alter(s) and invited the alters (with preparation of the child) to the playroom to deal directly with apologizing to the child.

Sibling Interaction

Frequently, siblings attend a child's play therapy session. Such sessions give the therapist valuable data on sibling interactions. The therapist can observe how the parent interacts with the other children in contrast to the index child. Frequently, sibling rivalry is an issue. In a particularly dramatic example of the importance of including the siblings, when a mother with MPD and her eight-year-old child were together, the child presented with florid MPD symptoms which mirrored the mother's. The child's three-year-old brother

attended a number of sessions in which he dominated and distracted her mother's attention by his exuberant behavior. Eventually, the child-client renounced the MPD symptoms as feigned in imitation of her mother. She admitted that her real problem was her anger at her mother for her prolonged hospitalization which left her stuck for extended periods of time with her younger brother. Her imitation of her mother was an effort to win her mother's approval and divert her mother's attention from her brother.

Family Therapy

Often the entire family or subsystems of families attend sessions. Family sessions allow the therapist to invite perspectives from all family members. Problem behaviors at home may be dealt with in family sessions. One family came together after the mother with MPD had sexually fondled her school-aged son. After a session of parallel therapy in which one therapist worked with the parents and one worked with the child, both therapists, the parents, and the child convened. The child showed the parents a puppet show that he had made up which depicted the abuse. At the end, he showed what the boy would do if the fondling occurred again. His mother reassured him that it would not happen again and his father was alerted that his child needed protection.

TRANSFERENCE AND COUNTERTRANSFERENCE

Donovan and McIntyre (1990) note that interpretation of "transference relationships" in psychotherapy with young children can be counterproductive and represent an intrusion by the therapist. However, O'Connor (1991) broadens the context by looking at the emotions, thoughts, and behaviors that the child and therapist bring into therapy. He further examines the emotions, thoughts, and behaviors that the child has, that as a result of therapy, enter the child's ecosystem. In a similar way, the therapist has emotions, thoughts, and feelings with regard to the child's larger ecosystem. Three types of transference that O'Connor sees on the part of the child are: the child treating the therapist as parent, the child seeing the therapist as omniscient and all-powerful, and the child taking behaviors from the therapy session into the larger ecosystem (e.g. the child who becomes dependent in therapy becomes clingy at home). All of these transference problems may be addressed with the parents.

According to O'Connor, types of therapist countertransference include: wanting to "save" the child and the child's ecosystem, anger and frustration if the child does not improve, and an attitude of blaming the parents and seeing them as failing the child.

Gil (1991) adds that abused children, because of their experiences of violation, may experience feelings of distrust, fear, rage, and longing toward the therapist. They may be confused because the therapist does not hurt them. The therapist, in turn, may desire to be nurturing even in the face of attacking behavior by a child. Ultimately, Gil relates, the attacking behavior may elicit other responses in the therapist.

We have found that it very important for us to stay grounded with a particular treatment philosophy in order to avoid

common countertransference responses to traumatized children and their families. In our case, we combine and integrate both psychodynamic and family therapy approaches (Nichols, 1988). More specifically, our family approach is heavily influenced by the contextual ideas of Ivan Boszormenyi-Nagy (Benjamin & Benjamin, 1993a). James (1991) suggests constructing a metaphor to describe the therapeutic process to a child. Similarly, we believe that it is important for the clinician to have a vision of the goals and the purpose of the treatment. Our own metaphor is that we are tour guides to family health and functioning. We know the destination of the journey, but the individuals in the family must decide on the course of the trip and set the pace. By the end of the journey, parents are empowered to care for their children, children do not have responsibility for their parents, individual traumas are resolved, and children can continue the process of development facilitated by their own families or caregivers. Ultimately trust is restored in the family.

CONCLUSION

Within a family treatment model, play therapy and hypnotic interventions can be useful in helping a child master the physical, cognitive, emotional, and spiritual dimensions of trauma. In cases in which a parent is abusive toward a child, the abuse needs to stop and the damage needs to be contained, apologized for, and re-processed. The child needs opportunities to deal with the damage directly and in play. If possible, trust in the relationship between child and parent needs to be rebuilt. When a child has been traumatized outside the home, direct discussion and play therapy that is geared to help the child process and master the trauma is necessary. When parents are able to participate in the child's therapy, they can become a very important ally in the therapeutic process. In child-parent sessions, individual sessions, and couples' sessions, they can learn how to care for their children by learning how to listen, how to encourage play, how to help a child process problems, how to set limits, how to be sensitive to boundaries, and how to go about exploring and solving childrearing problems. The parents' commitment to involvement in the child's therapy is a major step toward ethical accountability on the part of the parents to the child's well-being and to the well-being of future generations. ■

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