

## ISSUES IN THE TREATMENT OF DISSOCIATIVE COUPLES

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### ABSTRACT

*Marital work is an important adjunct to the individual treatment of the dissociative client. In this paper, we examine Kaslow's (1982) standard of the "healthy" couple and the specific problems inherent in marital work with dissociative clients and their partners. We believe that the course of marital treatment needs to be keyed to the stages of the individual treatment, although marital treatment can facilitate the progress of individual treatment as well. We describe our approach including contextual principles, marital dynamics, contributions from affect theory, and utilization of hidden resources. Finally, we review some controversies in the field and express our opinions based on our experiences. Marital work with dissociative clients is still developing as an approach, and there is much yet to be learned.*

### INTRODUCTION

Numerous authors in the literature on dissociative disorders have addressed the marital issues of the dissociative client (Levenson & Berry, 1983; Kluft, Braun, & Sachs, 1984; Sachs, 1986; Sachs, Frischholz, & Wood, 1988; Putnam, 1989; Panos, Panos, & Allred, 1990; Williams, 1991; Benjamin & Benjamin, 1992, 1994c; Chiappa, 1993). Without exception, every author agrees that the diagnosis of a dissociative disorder disrupts the marital homeostasis. Some authors view marital work as strictly supportive to the individual therapy of the dissociative client, but others see it as a more integral part of the overall treatment plan.

Levenson and Berry (1983) directed their therapeutic interventions toward the couple rather than toward the individual with the Multiple Personality Disorder (MPD) (now renamed Dissociative Identity Disorder [DID]). They saw the marital and parent-child systems as maintaining the dissociative symptoms of the MPD partner. Consequently, they believed that by addressing the homeostatic patterns and interpersonal conflicts in the family, and particularly in the

coupleship (a lesbian relationship), the dissociative symptoms would abate. Ultimately, the couple terminated therapy prematurely and the dissociative symptoms persisted. The authors acknowledged: "The return to homeostasis and premature termination can also be seen as a consequence of the incomplete therapeutic work on Mary's [the partner with MPD] family of origin" (p. 80).

Kluft et al. (1984) recognized the predicament of the partner of the dissociative client. They acknowledged the benefits to the therapy of the individual client with multiple personality disorder when the significant other is supported and provided with information. They asserted that the best therapeutic outcome for the relationship occurred when the partner showed concern for all personalities, did not press sexual matters, restrained curiosity about past traumas, and focused on "here and now" issues. They concluded that conventional marital therapy was best utilized in the post-integration phase of therapy.

Other writers (Sachs, 1986; Sachs et al., 1988; Putnam, 1989) saw marital therapy as supportive of the individual therapy of the MPD client. Goals of the marital treatment included educating the spouse, dealing with homeostatic disruptions, sharing thoughts and feelings, and preventing the sabotage of the individual treatment.

Although Panos et al. (1990) saw the individual therapy with the dissociative client as essential, they took a strong stand that marital therapy "should be a basic and necessary part of therapy, and not simply a supplement" (p. 10). They reviewed what they considered to be the major treatment issues of marital interventions: educating the spouse, understanding the pervasion of strong affects across increasing numbers of alters as therapy progresses, handling conflicting demands, responding to child alters, supporting the sexual relationship, adjusting to integrations, and dealing with impatience with the therapeutic process.

While Williams (1991) addressed broader family issues in the treatment of MPD, she focused extensively on the marital relationship. Work with families and partners has the potential to provide a sense of safety for the MPD client as the client proceeds through the therapeutic process. In addition to considering the emotional impact of MPD on the marital partner and the family, she categorized themes of treatment: education, limit-setting, contracts, mapping the system, knowledge of the trauma history, play and intimacy, and needs. She also acknowledged that partners have their own family histories which contribute to the equilibrium or disequilibrium of the family.

Chiappa (1993) examined a likely homeostatic family pattern after a diagnosis of a dissociative disorder is made in a marital partner: a sick-well imbalance between the partners, a preoccupation with the symptomatic member, an increasing narcissism in the identified patient, and an increasing co-dependency in the "well" partner with an accompanying avoidance of his own issues. In contrast, a successful treatment outcome would include: balance and reciprocity in the coupleship, appropriate generational boundaries between parents and children, deparentification of the children, and maturity of the adults. He viewed reorganization of the family system as occurring with a focus on partners' communication skills, intimacy and sexuality, and the individual issues of the non-dissociative partner.

In our first article in this series on dissociative families (Benjamin & Benjamin, 1992), we also advocated the inclusion of marital therapy in the overall treatment plan of the dissociative client. We stated that it was our belief that marital interventions would facilitate the individual therapy of the dissociative client, promote the growth of the other partner, and enhance the marital relationship. Additionally, we (Benjamin & Benjamin, 1994c) have developed a classification system, based on our experiences in our ongoing (since 1986) group for partners of dissociative clients, of seven types of partners who tend to marry dissociative clients. These types include: new abusers, caretakers, "damaged goods," obsessives, paranoids, schizotypal roommates, and closet dissociatives. In our discussion, we examined the homeostatic patterns of each couple-type that helps to maintain both the symptomatology of the client with the dissociative disorder and the symptomatology of the partner. In other words, we endorse the view that a complementarity of needs exists in marital relationships. Thus, we think that an optimal outcome in therapy is most likely if the issues of both partners are addressed and attention is paid to the marriage. Please note that the use of feminine and masculine pronouns is completely arbitrary because the dissociative client may be female or male.

## THE HEALTHY COUPLE

Kaslow (1982) studied the literature on the healthy family, and formulated a portrait of the healthy couple. It is important to note here that "healthy" is *not* synonymous with "well-functioning." Goldberg (1982) noted that very unhealthy couples can function well as long as their need complementarity is compatible. We have summarized Kaslow's findings because we believe that it is important to establish goals before endeavoring to do marital work. While Chiappa (1993), in the dissociative literature, made an effort to provide an outline of a healthy couple, Kaslow (1982), in the family therapy literature, elaborated on a model in considerable detail. Her eight observations are:

- 1) *A Systems Orientation.* The individuals in the couple see themselves as special to each other. There is an equitable balance of sharing and giving. As a unit, they are responsive to outside input but stable enough to provide safety and stabil-

ity for each other. There is mutual trust, respect, and interest, but privacy is honored. They view the relationship as ever-changing with a need for periodic renegotiation of expectations.

- 2) *Boundaries.* Each adult in the couple is comfortable with his/her own identity. They do not need their children to parent them or hold them together by developing symptoms or by becoming the scapegoats. They do not require that their children meet their sexual needs. They encourage their children to engage in age-appropriate activities. They care for their own aging parents but do not allow them to intrude on the couples' commitment to each other. Each partner participates in a sexual relationship which expresses affection, sensuality, love, and playfulness. Sex is not used to hurt the other partner or to avoid resolving problems.
- 3) *Communication.* Communication between partners is clear, direct, and consistent. The content and intent of verbal and nonverbal messages are in agreement. Partner feedback and clarification are welcome. There is an acknowledgement that each partner can have a different perspective or opinion. The partners recognize that problems arise from circular causation (behavior occurs in repetitive feedback loops), not from linear causation (a single cause leads to the effect). Problems get resolved rather than being allowed to build up over time.
- 4) *Power.* Each partner has a sense of potency and competency. Each takes responsibility for thoughts, feelings, and actions and does not project onto the other, try to read the other's mind, or think that the other ought to read his/her mind because of the love between them. Being right and maintaining control are less important than equality and mutual support. Although the couple is intimate, each can manage on his own and can find new meaning in life if the situation arises. The partners nurture the relationship at every stage in the lifecycle.
- 5) *Affective Issues.* A wide range of emotions are accepted and expressed. Fun is encouraged and losses can be dealt with.
- 6) *Effective Models for Coping.* When faced with life stresses, healthy couples are not afraid to reach out to extrafamilial people and resources.
- 7) *Negotiation and Task Performance.* This skill calls for listening to each other's perspective and resolving impasses.

- 8) *A Transcendental Value System.* The partners share a value system that infuses meaning and purpose in their lives.

## PROBLEMATIC AREAS

### *The Dissociative Client*

The therapist who does marital work with a dissociative client is in a peculiar predicament: he attempts to do *interpersonal* therapy with a client who subjectively does not feel *whole*. A refrain that we often hear from dissociative clients is: "I feel like I am in pieces."

We would like to examine some of the possible reasons why it is often so trying to work with a coupleship in which one partner (or both) is dissociative. There are many symptoms (Steinberg, 1993) and issues that interfere with such a couple's attaining the profile that Kaslow (1982) depicted. These include:

- 1) *Amnesia.* Forgetting interferes with relationships. A person who loses periods of time cannot be fully present in a relationship.
- 2) *Depersonalization.* An individual with a dissociative disorder often feels as though she is outside of her body or as though body parts are changing in size (American Psychiatric Association, 1994; Steinberg, 1993). She may feel as though her behavior or her emotions are outside of her control. She may act inappropriately at times, which interferes with her relationships.
- 3) *Derealization.* Sometimes the person with a dissociative disorder does not recognize significant people like partners or children (American Psychiatric Association, 1994; Steinberg, 1993). "Not knowing" interferes with genuine relatedness.
- 4) *Identity Disturbance.* The person with a dissociative disorder does not have a secure sense of self (American Psychiatric Association, 1994; Steinberg, 1993). Often, there are struggles going on inside the person's head. Intrapsychic arguments and chaos stop a person from attending to the needs of another.
- 5) *Alter Personalities and Switching.* Individuals with Dissociative Identity Disorder (DID), (previously Multiple Personality Disorder [MPD]) have numerous intrapsychic alters or "personality states" (American Psychiatric Association, 1994) that represent a multitude of psychodynamic issues. Alters have varying relationships with a partner including erotic ones, disdainful ones, dismissing ones, and complete renunciation (Putnam, 1989). Switching from alter to alter results in rapid mood fluctuation and inability to function (Putnam, 1988, 1989). Such inconsistency is not consonant with sustaining a stable relationship.
- 6) *Cognitive Distortions.* Distortions in thinking affect relationships (Fish-Murray, Koby, & van der Kolk, 1987; Fine, 1988, 1990; Briere, 1992). They do not allow for multiple perspectives or a belief in circular causality (the recognition that behavior occurs in repetitive feedback loops).
- 7) *Multiple Transferences.* Because of the many alters, dissociative clients have many complicated transferences (Wilbur, 1984, 1988; Loewenstein, 1993; Putnam, 1989). Transference phenomena are intense toward family members and toward the therapist. Conversely, this situation increases the intensity of the countertransference issues (Comstock, 1991; Davis & Osherson, 1977; Kluft, 1984b, 1989; Putnam, 1989; Watkins & Watkins, 1984).
- 8) *Unresolved Trauma.* The development of dissociative disorders has to do with the lack of resolution of chronic traumas in childhood (Kluft, 1984a, 1984b, 1984c; Putnam, 1989). It has been found that unresolved chronic childhood trauma has deleterious effects on social functioning (Cole & Putnam, 1992; Briere, 1992; Putnam & Trickett, 1993).
- 9) *Attachment.* The attachment literature indicates that without intervention, early attachment styles persist throughout the lifespan (Ainsworth, 1985; Collins & Read, 1990; Feeney & Noller, 1990), and attachment patterns are transgenerational (Bowlby, 1973; Main & Goldwyn, 1984; Ricks, 1985; Sroufe & Fleeson, 1986; Zeanah & Zeanah, 1989). Barach (1991) viewed a detached attachment as a first step toward the development of a dissociative disorder, and Liotti (1992) saw the disorganized/disoriented attachment as having a role in the etiology of a dissociative disorder. In either case, the insecure attachment styles of dissociative clients contribute to unhealthy relationships.
- 10) *Affect Problems.* Individuals with dissociative disorders have difficulty with affect. Braun (1988a; 1988b) conceptualized MPD as a disruption of the normally integrative functions of behavior, affect, sensation, and knowledge (the BASK model of dissociation). Particular affect states often tend to be walled off and manifested by alter states. Separation of affect states interferes with affect control and modulation. Numbing



is often used as a defense against affect (Stone, 1993). At the opposite end of the pole is affect overload. Associations to past traumas can be experienced as flashbacks or intrusive memories. These reliving experiences may lead to exaggerated startle responses or irritability (Stone, 1993). Such behaviors remove the person from the present and contribute to a sense of overwhelming distress. The inability to regulate affect results in inconsistency of mood which undermines relatedness.

- 11) *Shame*. Individuals with dissociative disorders often operate from a base of shame. A sense of self-defectiveness leads them to defend themselves from others in one of four unhealthy ways: by withdrawing, attacking others, attacking the self, or avoiding dealing with relevant interpersonal situations with others (Nathanson, 1992, 1993). All four defenses serve to separate them from their partners.
- 12) *Trust Issues*. Individuals who have been severely traumatized have had their trust reservoirs eroded (Cotroneo, 1986). Early chronic betrayal by significant others impedes trust in other relationships such as marriage. Sometimes previously exploited individuals try to rebalance old relational injustices by exacting an unfair debt from the marital partner rather than from the original abusers. Such a stance of "destructive entitlement" (Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991) makes marital relating difficult.

## The Dissociative Client's Partner

Putnam (1989) noted that "MPD patients often marry spouses with a significant amount of psychopathology" (p. 268). Based on our clinical observation, we have described seven types of partners that are attracted to dissociative mates. Each of these types interacts in some way with the MPD spouse to maintain the marital homeostasis (Benjamin & Benjamin, 1994c). Moreover, each type of partner brings his own personal unresolved issues from childhood into the marriage. The mate may be depressed, alcoholic, abusive, paranoid, or co-dependent in some way. Other mates may be hidden dissociatives who suffer from many of the same symptoms as the identified client.

## COURSE OF TREATMENT

Many authors (Sachs, 1986; Sachs et al., 1988; Panos et al., 1990; Williams, 1991; Benjamin & Benjamin, 1992, 1994b) have elaborated on the goals or themes of marital treatment. Rather than discussing those themes, we will comment on the course of marital treatment. It is our observation that marital treatment proceeds in stages. These stages

follow the sequence of the individual treatment (Braun, 1986; Putnam, 1989; Kluft, 1993). The time of diagnosis and the initial stages (preliminary interventions and history-gathering) of therapy are best served by marital sessions in which support and education are provided. In this part of therapy, the "here and now" aspects of the marriage need to be dealt with (Sachs et al., 1988). As the individual therapy proceeds to the processing and metabolizing of traumas, the non-dissociative spouse may experience a considerable amount of affect contagion (Figley & McCubbin, 1983; Figley, 1985, 1988; Donaldson & Gardner, 1985; Maltz & Holman, 1987; Courtois, 1988; McCann & Pearlman, 1990; Carroll, Foy, Cannon & Zweir, 1991; Harris, 1991; Dyregrov & Mitchell, 1992). Marital treatment should continue to be supportive and educational. If indicated, the spouse may be referred for individual treatment. Only when both partners near the recovery stage of therapy can traditional marital therapy be effective. It is very difficult to work interpersonally until intrapsychic wholeness is achieved or nearly achieved. It may be that Levenson and Berry's (1983) attempt to do conventional marital therapy without individual work overwhelmed the marital partnership as well as each individual's intrapsychic structures.

## PERSPECTIVES ON TREATMENT

We have a number of goals in the marital treatment of dissociative clients. Our overall goal is to build trust in the relationship. With the establishment of trust, we work to approximate Kaslow's (1982) profile of the healthy couple. In that way, we seek to enhance the couple relationship, the growth of each individual partner, and, in the case of children, the parent-child relationship.

### A Contextual Approach

As we have previously written (Benjamin & Benjamin, 1994d), we believe that the contextual approach of Boszormenyi-Nagy and colleagues (Boszormenyi-Nagy & Spark, 1973/1984; Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991) is particularly well-suited to marital therapy with dissociative couples. In all stages of marital work, we try to build trust. We believe that it is especially important to avoid any interventions that could be construed as tricky, paradoxical, or manipulative. These types of interventions threaten the basic trust which is already extremely fragile in the dissociative client and in the marital relationship. Even though such interventions are rather standard in many schools of family treatment, we think they are fraught with danger and best avoided in work with dissociative couples. Consequently, we adhere to a relationally ethical therapeutic stance:

*Multidirected Partiality*. We are partial to each individual in the room and to those people outside of the therapy room who might be affected by our intervention. We side with each member of the coupleship, and we also require that each be accountable to self, other, and children. We are

both empathic (non-judgmental and accepting), and we credit the struggles and injustices suffered by each partner and the couple.

*Transgenerational Stance.* We acknowledge the transgenerational relational injustices for both partners. If the couple has children, we explore expectations and developmental issues. Encouraging children to give to the family in developmentally sound and appropriate ways builds trust in the parent-child relationship. Stopping patterns of exploitation and parentification of children helps parents to feel responsible and caring.

*Relational Resources.* Helping marital partners become aware of their own relational resources for contributing to the couple relationship builds trust. For example, when a partner can acknowledge the other's perspective (without necessarily agreeing with it), he earns credit. When an individual earns credit, it increases his sense of self-worth. When the other partner's perspective is acknowledged by a mate, she begins to be able to trust the mate more, and the overall relationship seems more trustworthy.

In our previous paper (Benjamin & Benjamin, 1994d), we detailed the application of contextual principles to dissociative disorders from the point of view of the individual treatment. Consequently, we will not examine those principles in depth here. However, we will comment briefly from a couples' perspective on a few of the guidelines that we follow:

*Giving and Receiving.* We work to sensitize couples to how fair giving and receiving between them builds an ethically responsible relationship. Where one partner overgives and the other undergives, we try to help the individuals bring more balance into the relationship. When one partner is too incapacitated to give (perhaps because of hospitalization), we may frame the hospital stay as "giving" because the dissociative individual is committing herself to getting well. Likewise, the non-dissociative partner is giving the gift of support to help his mate heal by carrying a disproportionate share of family care. This contribution of committing extra time to the family and of providing financial resources over an extended term also needs to be acknowledged and appreciated. Moreover, this kind of support (in contrast to trying to be a "therapist-spouse" who demands a detailed account of the dissociative mate's trauma exploration) is a constructive way for the partner to assist the therapy. The partner may see himself as the eventual beneficiary of a whole, healed spouse who will credit him for his loving support while she underwent an extended, painful, and difficult therapeutic operation, which might be best described as a psychic reconstructive plastic surgery. Ultimately, both partners learn that they receive through their giving.

*Entitlement.* Each member of the coupleship has a position with regard to healthy entitlement. Cotroneo (1986) has defined entitlement as "the freedom to give and ask in trust" (p. 418). When a person cares about another person in a

relationship, the person earns constructive entitlement and is free to claim reciprocal care. Often when a person has been hurt in previous relationships (e.g., in childhood), the person feels entitled to hurt others in a substitutive way. Acting on that entitlement is called "destructive entitlement" (Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991), and it erodes trust in relationships. In our experience, it is common for an individual who has been exploited in childhood to seek revenge in the marital relationship. The therapist has the job of helping the partners appreciate the origin of destructive entitlement and of balancing self-protection and self-growth with care for the other (Cotroneo, 1986). Entitlement that is earned through giving and caring for others is a motivator of positive action (Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991).

*Loyalty.* Individuals feel an obligation to significant others in their lives, especially to their parents. These loyalties may be in or out of a person's awareness, and they may be direct or indirect. Often these loyalties block commitment to a current relationship. For example, sometimes we work with a marital pair in which one partner reports that her family disapproved intensely of her choice of a mate. Seemingly disloyal to her parents, she married her partner anyway. However, she demonstrated indirect loyalty by sabotaging her relationship with her partner (e.g., by having an extra-marital affair, by engaging in incest with a child, by constantly criticizing her partner and making him miserable, etc.).

When a couple has children, they need to be aware of their own children's loyalty bonds to them as parents. Children are so loyal to their parents that they can easily be exploited through parentification (Cotroneo, 1986; Benjamin & Benjamin, 1994d). When parents are in constant conflict with each other, children get caught in a "split loyalty" trap (Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Krasner, 1986; Cotroneo, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991; Benjamin & Benjamin, 1994d). When they feel they must choose between father or mother, their trust is damaged.

*Exoneration.* Appreciation of the circumstances that lead to a person's actions allows for relational healing to take place. Although such appreciation is not blanket forgiveness, it can ultimately lead to forgiveness between partners. For example, when a partner feels shut out of an intimate relationship with his wife as she metabolizes the past traumas in her own life, he may become resentful and bitter. If he can appreciate, however, how she was brutally and chronically sexually victimized and robbed of trust, he may be able to appreciate her circumstances. His acceptance of her needs for privacy and space to heal, even though it bars him from an exclusive role as her trusted confidant (as in large measure this role is ceded to the therapist), earns him constructive entitlement. However, he can maintain the hope that by presently conceding the role of confidant to the therapist to expedite healing, he himself will eventually occupy that



role. This exoneration of his partner renders him a trustworthy person. As the wife resolves her own past issues, she is more likely to trust her husband and allow intimacy with him.

**Accountability.** Clients with dissociative disorders have been severely victimized. They may in many ways act on their past exploitations through loyalties to their abusers or with destructive entitlement. Accountability offers the client (and her partner) an ethical option to change behavior. Becoming accountable for one's actions earns a person constructive entitlement. For example, when each partner can acknowledge the hurts they have perpetrated on each other (step one) and make a commitment to change their behavior (step two), they are choosing to take responsibility for their actions. This attitude and commitment empower clients and help them move from a victim stance to a survivor stance (Benjamin & Benjamin, 1994d).

In the third phase of marital work, which dovetails with the integration-resolution phase (Kluft, 1993) and beyond, the therapist can help the couple work in a more transactional dimension (Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991). The process of "self-delineation" of each partner has to do with the boundaries between the partners. It is not possible to delineate between "me" and "not me" in the earlier stages of therapy when a dissociative person's identity is not yet whole. Helping the clients understand how to be part of a unit as well as be separate is a major step in marital work. The paradox is that being *in* relationship fosters the process of self-delineation (Boszormenyi-Nagy & Krasner, 1986). Other transactional dynamics include communication skills, power transactions, role assignments, and family organization. While some of these issues may have come up earlier in marital treatment, they can be examined in a new and more meaningful way once the dissociative client has achieved (or nearly achieved) integration and the other partner has felt the relationship is more stable.

## Marital Dynamics: Power/Control

Goldberg (1982) has elaborated on six dynamics of marital interaction that surface repeatedly in work with couples: Power or Control, Nurture, Intimacy, Trust, Fidelity, and Life-Style and Sense of Order. We have briefly touched on some of these themes in a previous paper (Benjamin & Benjamin, 1994c). A full discussion of these six marital dynamics in dissociative couples is beyond the scope of this article. We will, however, comment here on how these dynamics fit into the timing of marital treatment through a more detailed exploration of one of these issues: power/control. This dynamic has important implications for the course of treatment.

While couples that contain a dissociative partner have the extraordinary task of dealing with the dissociative symptoms and the past traumas, they also have the ordinary dilemmas that face all couples. When dealing with any of these issues, we follow the overall contextual approach that we outlined previously: multidirected partiality, a transgenerational stance, and attention to all potential relational resources.

As the individual(s) and the couple proceed through the various stages of therapy, each of Goldberg's (1982) six dynamics changes, takes on different meaning, and needs to be reworked or reconsidered. To demonstrate this process, we can examine the dimension of power/control. Early in therapy, a hostile alter may be especially angry and resentful. She may believe that she was exploited previously by powerful people, that inside alters threaten her control, and that the partner (who she feels *she is not* married to) is controlling and too powerful. Thus, the fear of losing power is amplified, and the hostile alter acts out in ways to grab power. At this early stage, the therapist in the marital session may have to work with the hostile alter in the presence of the partner. Typically, this alter actually represents a scared child who felt powerless in the face of childhood abuse and who countered this terror by adapting an "identification with the aggressor" stance. Demonstrating partiality to that alter (as well as to all other alters) models for the partner how to credit and be empathic. It also alerts the partner to the dissociative mate's submerged sensitivity to the issue of power. It helps him to avoid discounting his mate and stumbling into a hidden minefield. Of course, the therapist also demonstrates partiality to the non-dissociative partner and to his struggles. In time, with collaboration between individual and conjoint therapy, there may be a mitigation of the fear of loss of power of the particular alter. The alter may become more amicable in the relationship even if at that time she subjectively believes that she is not married! As integration approaches, the dissociative mate resolves these issues, and both the alter and the issue represented become more acceptable to the emerging wholeness of the self and, hopefully, to the non-dissociative partner. The increasingly healthy individual and well-functioning couple can then deal with the power balance in a more optimal way as in Kaslow's (1983) description.

Power and control issues continue to surface in all phases of the therapy in different ways. The different marital types (Benjamin & Benjamin, 1994c) may demonstrate different problems with power. The dissociative client may feel that she is rendered too powerful because her partner cannot make decisions or deal with social relations (schizotypal and paranoid partners), affect (obsessive partner), his deficiencies ("damaged goods"), or his dissociative defenses (closet dissociative). Using the same approaches (multidirected partiality, a transgenerational stance, and attention to relational resources), these power issues need to be openly explored in the marital therapy. Only when both clients have a sufficiently intact sense of self can the therapist begin to examine power issues in a conventional way. As Goldberg (1982) indicated, power struggles occur not because each partner wants control over the other, but because each partner fears being controlled by the other. Ultimately, both partners need to experience a sense of personal control as well as feel that they can share control. Often the individual therapeutic process builds a sense of self-power through self-growth. Learning how to be mutually respectful, supportive, and inclusive may require practice as well as awareness.

### Dealing With Affect

Affective dyscontrol is a major issue in the treatment of dissociative disorders. The fluctuation between being affectively numb and overwhelmed by affect can throw a relationship into a tailspin. Additionally, the distressed affect that accompanies many of the stages of therapy may be infectious to the partner and to other members of the household. Clients with DID often exhibit all of the innate negative affects that Tomkins (1963, 1991) described: fear/terror, distress/anguish, anger/rage, shame/humiliation, dismissal, and disgust.

Kelly (1993) pointed out that the interplay between innate affects supports intimacy. In many dyads in which one of the partners is dissociative, intimacy is a problem. Kelly (1993) went on to note that failures of intimacy result from a lack of interpersonal skills to:

- 1) maximize positive interpersonal affect;
- 2) minimize negative interpersonal affect;
- 3) minimize the inhibition of interpersonal affect.

Early in treatment, before interpersonal skills are well-established, these same rules apply to the intra-alter system. The twin processes of empathy and crediting by a therapist or by a partner can help in this regard. Both partners need to find ways of self-caring and caring for the other that maximize positive affect. Sometimes finding extrafamilial supports decrease negative affect. Successes in parenting can also aid in maximizing positive affect (Benjamin & Benjamin, 1994e, 1994f).

Dissociative partners have affects that have been walled off. Marital sessions can offer a safe place for those affects to emerge. Early in treatment, it may be helpful for a partner to interact with alters who hold encapsulated affect states. But it needs to be clear to both partners that over the course of therapy, more regulation, modulation, and blending of affect will occur. The partner, too, is encouraged to be less inhibited about interpersonal affect as the dissociative client is better equipped to handle emotions in a non-dissociative and constructive fashion.

In the later stages of marital work, the issues around affect can be revisited. With a strengthened intrapsychic stability and an ability to interact interpersonally, the couple can come up with their own ways of increasing positive affect, decreasing negative affect, and minimizing the inhibition of negative affect.

### Hidden Couple Resources

In work with couples, it behooves the therapist to locate any hidden resources (Karpel, 1986) that can propel the therapy toward an optimal outcome. In our own work with couples in which one member is dissociative, we have found several resources within the family:

- 1) *Willingness to Explore the Relationship.* The relationship between a dissociative client and his

partner can be extremely stressful. Willingness on the part of both partners to remain in the relationship and explore it is a major resource (Beavers, 1982). It bespeaks a commitment to the current bond as well as an openness to face and make major transformations.

- 2) *Need Complementarity.* The typology of marital dynamics (Benjamin & Benjamin, 1994c) can either be seen as a list of deficiencies in the couple or as a resource to understand the couple's need complementarity and why the relationship functions the way it does. The homeostasis is upset at many junctures during the course of therapy. Understanding needs at the outset can help the clients fulfill them in healthy ways.
- 3) *Survivorship/Resiliency.* The adaptational patterns of the trauma survivor indicate a sense of internal strength. That strength and resiliency in the face of overwhelming stress can be credited and drawn upon as the dissociative client proceeds through marital therapy.
- 4) *Children.* Most couples want their children to grow up in developmentally sound ways. Children in a family, therefore, can operate as a motivating force to optimize the couples' work. The knowledge that a healthy marital relationship contributes to a child's well-being provides therapeutic leverage (Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991).

### OUR VIEWS ON CURRENT CONTROVERSIAL ISSUES IN MARITAL AND FAMILY TREATMENT

#### *The Number of Therapists*

Chiappa (1993) has taken a strong stand against one therapist being both the individual therapist and the family therapist for the DID client. We prefer to be less absolute. The number of therapists that ought to be involved in any family depends on the style and orientation of the therapists, the complexity of the case, and practical matters (such as the availability of another experienced therapist with whom to closely collaborate). In some cases, one of us works with the individual DID client, as well as with other groupings of the same family. In other cases, one of us sees the individual DID client and the other does the family/marital work.

We believe that it can be a profound disservice to the family to have too many therapists involved in the care of a family. We know of cases in which there is one therapist for the DID individual, a different therapist for the partner, one for each child, and one for the family/couple to do the family or marital therapy! We think that such a situation may preclude adequate collaboration among therapists and frag-



ments the family.

## How to Involve Alters in the Marriage

In our opinion, it is up to the individual client whether or not to involve alters in the marital work. Some dissociative clients want their alters listened to/talked to by their partners while others regard their alters as internal phenomena and view being called by separate names as intrusive. Regardless of the individual dissociative client's preference, we have clear expectations that as therapy proceeds these alters will progress and change. We are careful not to reify alters, heightening the possibility of regression in the dissociative client and of exploitation by the partner. We are careful to set a tone that indicates that dissociation happened because of *past* trauma. We recognize it for what it is *now*: an outmoded coping mechanism. We move toward a *future* of blending, joining, and healing so the dissociative client can become one healthy person.

## How Alters Relate to Children

Similar to Chiappa (1993) and contrary to Williams (1991), we do not involve children in relating differently to alters. We try to sensitize the couple to the dangers of parentification and strongly recommend that alters appropriate to the task of parenting remain in control when relating to children. The couple is encouraged to work as a team in parenting (Benjamin & Benjamin, 1994e, 1994f). We believe that it is important to keep generational boundaries clear. At home, the parent is a parent, not a patient.

## How the Couple Relates to the Dissociative Partner's Family of Origin

In our opinion, the decision about whether or not to have a relationship with the dissociative client's family of origin must be individualized in each case. We cannot presume that trauma necessarily originated in the home (Kluft, 1984a). Often, in our experience, parental culpability was confined to neglect or inattention to the needs of the child, and not necessarily to volitional mistreatment. While some families may well have been abusive in the past, the situation in the present may be quite different. In many cases, renewing a relationship on different terms can be healing to the dissociative client, and extended family members can become important resources in the recovery process. Sometimes exoneration of a parent's past hurts can help a dissociative client exonerate herself for hurts that she has inflicted on others (Benjamin & Benjamin, 1994d).

In some cases, members of a dissociative client's family of origin continue to be frankly dangerous and, if given the opportunity, will readily resume exploitation of the client or the client's children. In those cases, the only safe courses are to have a distant and guarded relationship or to have no relationship at all. This latter step, however, is not to be taken lightly. Except in cases of clear and present danger or threat to the client or the grandchildren, we recommend a more measured, "wait and see" approach. In some cases, we are willing to have sessions which include members of the dissociative client's family of origin to help clarify the situation.

In the terminology of contextual therapy, exoneration, as we explained previously in the context of the coupleship, means an ethical appreciation of the circumstances that lead to a person's actions (Boszormenyi-Nagy & Ulrich, 1981; Boszormenyi-Nagy & Krasner, 1986; Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991). In all cases, we believe that it is important for the dissociative client to exonerate (in *this* specific sense) members of the client's family of origin. It is not healthy for the dissociative client and her partner to collude in blaming the family of origin for the client's dissociative disorder without focusing on changing their own circumstances and changing the client's symptoms. That kind of myopic united stand against the "bad guys" can become a pathological glue that holds the marriage together. But this union comes at the cost of maintaining a paranoid stance that blocks the couple from maturing into a more functional entity that can relate appropriately to the outside world.

## CONCLUSION

Marital treatment with a dissociative client and her partner is a challenging task. It needs to be keyed to the course of the individual therapy of the dissociative partner. A healthy marriage serves to provide a secure base for both partners so they can each grow separately and as a couple. Marital therapy and individual therapy operate as a synergistic process, each propelling the other forward.

We have touched on a number of significant issues in our work with dissociative marriages. This area is one which calls for additional clinical observations and empirical research. ■

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