

EFFECTIVE MANAGEMENT OF FAMILY AND INDIVIDUAL INTERVENTIONS IN THE TREATMENT OF DISSOCIATIVE DISORDERS

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ABSTRACT

While individual therapy is the primary treatment for multiple personality disorder (MPD) and dissociative disorder (DD) family interventions are necessary in many cases. A review of the relevant literature finds it lacking in three areas: a family systems perspective, an appreciation of the fundamental differences between individual and family therapy, and a clear position on the degree to which family sessions should focus on the MPD/DD symptoms. These shortcomings are discussed, a typical MPD/DD family configuration is described, and suggestions for effective family interventions are offered. While many therapists choose to provide both individual and family interventions in a case, it is argued here that this arrangement creates more problems than it solves. An alternative is the management of the two contrasting modalities by a treatment team.

INTRODUCTION

Multiple personality disorder (MPD) and dissociative disorder (DD) usually require an extended course of treatment that is complex and difficult for both client and therapist. Individual therapy alone is often not enough to resolve all relevant issues, and concurrent family treatment may be necessary. Family treatment could include family and marital therapy as well as group and individual treatments for various family members. In theory, this could include the family of origin. In practice, however, the family of origin rarely possesses the motivation or the capacity to confront its history and reconfigure itself in response to the MPD/DD client's allegations of child maltreatment. If the family of origin is determined to maintain its status quo, an invitation into treatment is inappropriate.

Family treatment can facilitate the MPD/DD client's progress in individual treatment as well as address directly the myriad problems often present in such families. For example, studies have typically found a high incidence of psychological difficulties in children of MPD parents. Braun (1985) has documented the transgenerational nature of MPD. But despite the often deleterious effects of multiple per-

sonality parents on their children, some multiples can be fine parents (Coons, 1985; Kluft, 1987). Kluft (1987) found 38.7% of his MPD mothers to be competent or exceptional.

In contrast, the effects of MPD/DD on spouses are not well documented. It is the author's impression that spousal relationships, as compared to parent-child relationships, are almost always a struggle. These problems are not only the effect of the one partner's dissociative disorder on the other, they are also the function of a relationship between two troubled people.

Conducting a support group for spouses of incest survivors, providing family and marital components in the treatment of 22 MPD/DD clients, and supervising others has sensitized the author to the tribulations of these families. The management of concurrent individual and family interventions in the treatment of a complex disorder that deeply affects the capacity for interpersonal relationships presents particular difficulties. This paper will address effective family interventions (subsuming both marital and family therapy) in MPD/DD and their interface with the primary treatment, that is, long-term individual psychotherapy.

REVIEW OF LITERATURE ON FAMILY INTERVENTIONS

The literature on family interventions in MPD/DD is rather small. Within it, the influence of a family systems perspective is small, the fundamental differences between individual and family therapy are not well appreciated, and the two modalities are typically conducted by one therapist. A review of the literature from a family systems viewpoint will lay the foundation for discussion of these issues and the effective management of individual and family interventions.

The earliest writings on family interventions with MPD, based on single case studies, observed family dynamics indirectly, through individual treatment material (Beal, 1978). Davis and Osherson (1977) reported concurrent individual sessions with an MPD mother and her son, along with conjoint sessions, but treatment was far more concerned with the internal dynamics of MPD than the mother-son relationship. Apparently there was but one therapist for mother and son. While the authors speak of a confidentiality problem between alter personalities, they did not address any confidentiality dilemmas arising from the inclusion of mother and son in each other's therapy. These dilemmas were all the more important because of the high degree of enmeshment in the mother-son relationship. One explanation of the aborted out-

come in this case is that therapy was terminated by the mother when she felt (1) that the therapist was too concerned with the son's welfare, and (2) her statements to her therapist were demonstrably not private. With therapist priorities muddled by the attempt to service both mother's and son's needs, neither person could feel safe. In fact, neither one really had an individual therapist.

Levenson and Berry (1983) provide the only published case report of family therapy from a family systems perspective. They achieved partial success in limiting dissociation and acting out in an MPD mother via the hypothesis that "the family system supports the symptoms of multiple personality, and that the symptoms serve adaptive functions within the couple and family, and are therefore homeostatic, keeping the family together" (p.74). They interpreted personality switching in sessions as changes in the client's feelings about her mate and they suggested the family begin calling the mother by only one name. While these interventions worked for a time, an eventual return to homeostasis and premature termination resulted, perhaps because the MPD mother was not working directly on herself; that is, there was no individual therapy. Here family therapy proved helpful but insufficient on its own to effect lasting change.

More recently, a number of authors have detailed a course of family and/or marital therapy adjunctive to individual therapy (Benjamin & Benjamin, 1992; Panos, Panos, & Allred, 1990; Putnam, 1989; Sachs, 1986; Sachs, Frischholz, & Wood, 1988; Williams, 1991). As a whole, these writings display great sensitivity to the reciprocal influence between the dissociative disorder and the family as well as the need to modify the family environment to facilitate individual treatment. The one ubiquitous theme is the education of the partner and family regarding the diagnosis, the handling of related dissociative phenomena, and the course of treatment. Open discussion of these issues is seen as essential. Children are helped to understand the parent's switching and inconsistent or bizarre behavior. Their perceptions are validated and their feelings about the disorder, including fear and anger, are to be expressed within the family. Discussion of how dissociation is evoked within the family environment or the couple, particularly with regard to sexuality and touch, is frequently recommended. Many clinicians emphasize the spouse's personal development and needs, all the more so because these individuals tend to be in a co-dependent or caretaker role. The family system must be strengthened, as it is assisted with communication, negotiation, conflict resolution, and stress-reduction skills. Any abuse within the present family must, of course, be stopped.

Treatment themes suggested less often in the literature include contracting, to set limits on destructive acting out, screening the children for dissociative disorder, preventing sabotage of individual treatment by the spouse, supporting the need for the family to play (particularly in response to any child alters and the spouse's "inner child"), and helping the MPD/DD client differentiate family members from her childhood abusers.

Despite these common themes there appear to be substantially different emphases in actual clinical work. For exam-

ple, while Panos, Panos, and Allred (1990) suggest to spouses that they "view the MPD patient as a whole person" (p.11), Williams (1991) counsels family members to get to know each individual alter. Some authors seem to encourage the spouse to act as a surrogate therapist. For example, Williams (1991) encourages spouses to assist the therapist in mapping the system of alters. Sachs, Frischholz, and Wood (1988) also recommend this and encourage the family to focus on the disorder, stating "Every personality state needs to be recognized and validated to facilitate communication within the family" (p.252). In apparent contrast, in an earlier paper Sachs (1986) specifically cautioned against spouses acting as lay therapists, a stance that may be approached if such direct interaction with the alter system is recommended. Another point of apparent divergence is the strictness of limits on acting out and openly dissociative behavior.

The field seems of two minds about how much attention should be paid to the client and the disorder in family treatment. At times, even in the same article, (e.g., Williams, 1991), there is vacillation between supporting the family in focusing on the condition and stating that it must not become the centerpiece of family life. A true family systems perspective is absent from this literature, with the partial exceptions of Benjamin and Benjamin (1992) and Panos, Panos, and Allred (1990). Of the various interventions suggested, systemic ones such as strengthening the family or delineating boundaries between parent and child subsystems are infrequently emphasized.

A recent contribution by Benjamin and Benjamin (1994), while focusing more generally on treatment of MPD across all modalities, is noteworthy from a family systems perspective. Their application of the principles of contextual therapy, a line of thought within family therapy, produces the most systemic view of individual and family phenomenology available in the MPD/DD literature.

Lastly, the issue of whether one therapist can provide both the primary individual therapy plus couple and family therapy is usually sidestepped. Where it is addressed, authors such as Williams (1991) and Sachs, Frischholz, and Wood (1988) feel that a single therapist can do this without complication.

Individual vs. Family Therapy: Fundamental Differences

To sharpen the discussion of the different but complementary roles of individual and family therapy and the difficulties in managing the two, the fundamental nature of each modality must be considered. The individual therapy setting is primarily dyadic, even when therapists at times include other participants, typically the client's significant others. The situation exists solely for the benefit of the client. The therapist is present to assist the client in the process of personal change. The subject of this dyadic interchange is the client: his or her experiences, behavior and subjective reality. Relationships may provide a focus, but they are filtered through the client's often cloudy lens. Only the relationship between therapist and client is open to direct observation. Dissociation or regression in the service of connecting with the past may be permitted or even encouraged during the

therapy hour. The client may work with alter personalities freely, with integration as the ultimate goal. All this makes the client, quite appropriately, the center of attention, encouraging a degree of narcissism, hopefully of the healthy variety.

In contrast, family therapy includes the entire family system as the unit of treatment. While there is usually an "identified patient," in family therapy the well-being of the entire family system is the first priority. With the whole family as the client, the focus is on roles, interpersonal dynamics, communication; i.e., social reality. To the extent that one individual, the identified patient, is helped, it is through the social engineering of the family system. Whether family therapy is historical, behavioral, structural, strategic, or systemic in orientation, the focus of intervention remains the family system as a whole (Hoffman, 1981). In a systems view, the family's identification of a patient and its focus on his or her symptoms are essential for the maintenance of system homeostasis. As the status quo prevails, other family dilemmas may be avoided and certain difficult interactions controlled. For example, an MPD/DD client may be over-involved with one of the children and the spouse over-involved in trying to cure the MPD/DD. Meanwhile the issue of intimacy, a painful one for both partners, is avoided.

Family therapists have suggested that certain cases of very serious conditions, such as eating disorders and major depression (Minuchin, 1974), drug addiction (Stanton & Todd, 1982) and psychotic disorders (Selvini Palazzoli, Cecchin, Prata, & Boscolo, 1978) can be treated exclusively through the reorganization of the family system, as the family is moved from an old, maladaptive homeostasis to a new one, in which the symptom is no longer essential for the preservation of the family. While it cannot be argued that reordering the family system alone can treat MPD/DD, it can facilitate treatment in ways that individual therapy cannot.

Treating the Family System in Dissociative Disorders

To better understand the MPD/DD family system and how family therapy can be uniquely helpful, I will attempt to describe the modal dissociative disorder family configuration. Naturally, this is but one of many possible configurations. Benjamins' work with groups for partners and parents of MPD clients (Benjamin & Benjamin, 1994) is also suggestive of both the typical dynamics and the varieties of configurations seen in MPD/DD families.

The identified patient parent's MPD/DD condition is by definition pre-existing, probably rooted in the family of origin, but probably undiagnosed. Prior to diagnosis, marital difficulties are present but are not likely to have become well defined. The relationship is characterized by mistrust, conflict, and efforts by both partners to be in control. The future MPD/DD client is likely the emotional and quixotic one, while the spouse may be cool and distant. In some cases, complementary roles of "sick" and "well" or "dependent" and "co-dependent" develop prior to diagnosis.

Once the diagnosis is made, the sick-well dynamic is likely to jell between the MPD/DD client and the spouse-care-

taker. Children will participate in the system in ways that support the stability of the couple. The family is likely to become preoccupied with the symptomatic member, just as family interaction coalesces around any disorder, whether it is dissociative, depressive, psychotic, alcoholic, or even chronic physical illness. With the MPD/DD parent in individual therapy and with therapy encouraging preoccupation with one's self and narcissism as it does, her life will revolve around the disorder and treatment, strong feelings of entitlement will develop, and the disorder and its cure may become excuses for what other family members sometimes feel is selfish behavior. The spouse will become preoccupied with the client and the disorder, increasing in co-dependency, and all the while avoiding his own issues. Children may become over-involved as caretakers. The healing process as it is reinforced in individual therapy may become a justification for the family's preoccupation with the client and her disorder. Ironically, this will inhibit her progress in individual therapy as well as confirm family roles that are inimical to the children's interests, marital intimacy, and the health of the family system.

In successful family treatment, the couple would become more balanced and reciprocal, while parent-child relationships would be governed by appropriate boundaries between the two generations. As the whole system evolves in therapy, parentified children and child-like adults would be moved to act their age. MPD/DD clients would become responsible parents, despite the intermittent intrusions of symptomatology. We must now ask which approaches or techniques will be helpful and which will be counterproductive in healing the MPD/DD family system?

As noted earlier, the family treatment literature in dissociative disorders is rather weak from a systems viewpoint, and this is one of its major shortcomings. Some of the suggestions in that literature keep the dissociative individual in the sick role, by encouraging the family's preoccupation with that person and their symptoms. For example, using the family to "map the system" of alters, teaching children to look out for and respond differentially to different alters, playing with child alters, and working flashbacks at home are all interventions that skew the system toward preoccupation with the symptomatic member. These may be quite appropriate for individual therapy, but in the family context they place the client at center stage, and by implication ignore everyone else's needs.

The disorder becomes the family's focus, obscuring the roles of spouse, parent, and child, which are the foundation of a well-functioning family. Children in particular should be spared having to cope with a parent's alters and flashbacks, because this dissolves the parent-child boundary and reenacts incest at a psychological level. The family and individual therapists both must make clear to the MPD/DD member that he or she is responsible for controlling symptomatic behavior at home, particularly around the children. Therapists may consciously or unconsciously encourage other family members to become surrogate therapists, and this will only complicate the healing of the family system. This also applies when a parent becomes a surrogate therapist for an MPD/DD child. The enmeshment that results impedes the child's auton-

omy and provides a cover for the parent to avoid his or her own psychological issues. It is crucial that therapists take these positions at the beginning of therapy, because as the family becomes more organized around the disorder it is that much more enmeshed and resistant to change.

Other interventions may skew the system, depending on the therapist's emphasis. It is important to discuss the MPD/DD parent's behavior so the family can make sense of it, but it would be a mistake to be too tolerant of symptomatic behavior at home. It is the parent's responsibility to act like a parent, not a child. Similarly, the disorder should be explained to the family in plain terms but it should not become an excuse for everything, thereby sidestepping painful family issues or interactions. The point is that psychoeducation regarding the disorder must be done with great finesse, so as not to reinforce roles that will obstruct systemic change.

Interventions which support the reorganization of the family system are worth noting. Appropriate generational boundaries must be established and children discouraged from parenting the MPD/DD client. The marital dyad must be balanced and strengthened and complementary roles that serve to maintain the status quo must be questioned. Help with communication skills, including expressive, empathic, discussion, negotiation and conflict resolution skills, will facilitate this. Issues of intimacy, touch, and sexuality must be addressed openly and repeatedly, because these are resolved only with much time and effort. Finally, partner's and children's issues must be addressed, including making referrals for individual therapy or groupwork, if indicated.

It should be apparent that the messages conveyed by individual and family therapy as described here are at times contradictory. The author would suggest that this is quite acceptable, emphasizing the point that behaviors appropriate in one setting are often inappropriate in another. For example, dissociation, regression, and "acting in" in individual therapy may assist in healing but must be controlled at home.

One Therapist or Two?

Individual therapists are uncomfortably aware of the insularity of therapy. They are dependent on the client's reporting of events. Client distortions, cover-ups, or even lies are ubiquitous and it is often impossible to discern what really happened to the client. At the same time it is this insularity which gives individual therapy its special power, because the client has the therapist's undivided attention, something which many clients, especially MPD/DD clients, have never before experienced with anyone. The presence of only two people in the room intensifies the relationship, magnifying transference phenomena, which then become a significant part of the healing process, as the client's relatedness to others can be directly observed and changed.

Many therapists choose to conduct both individual and family therapy with MPD/DD clients. Involving others reduces the insularity of individual therapy, dilutes the therapeutic relationship, and complicates the transference. It is especially tempting to get the family involved in individual therapy of MPD/DD, because the client's sense of past and present reality often cries out for external validation. However,

the relationship difficulties and the notoriously distorted and extreme transferences manifested by these clients make the addition of family members to individual therapy too problematic — the cost-benefit ratio is unacceptable. It is unavoidable that long-term therapy must deal successfully with the transference relationship; contaminating that relationship with third parties will ultimately inhibit resolution. Furthermore, no amount of external validation can escape the eventuality that the client must determine what is real and what is not. Therapists would be better off letting the client sort out his or her reality solely within the therapeutic dyad, as uncomfortable as this may sometimes become for both parties.

Confidentiality problems are also troublesome, as the therapist may be presented with thorny dilemmas about what concerns from individual therapy should be shared with family members. This blurring of boundaries and loyalties replicates some of the dynamics of the incestuous family of origin. Ultimately, MPD/DD clients cannot feel safe when the therapist has established relationships with their significant others. Treatment goals are also confused by the one-therapist approach. Individual sessions are more likely to stray into family problems and family sessions may gravitate towards dealing with MPD/DD symptomatology rather than family dynamics.

Finally, conducting both individual and family therapy places the therapist in an exalted and impossible position, trying to be all things to all people. This will foster positive transference while delaying the inevitable appearance of negative transference. The result may be the prolongation of therapy itself. Such herculean strivings on the therapist's part may also increase the risk of therapist burnout.

There are advantages for the family therapist to be a professional who is not seeing any of the members in individual therapy. The therapist's loyalty is to the system and no one individual is favored. Knowing too much about any one individual makes it more difficult to remain balanced, because that individual may be either favored or too often put on the hot seat by their individual therapist. In working towards mutuality in the marriage and clear boundaries between the generations, knowing one family member's dissociative disorder in intimate detail is not necessarily an advantage.

CONCLUSION: A TREATMENT TEAM APPROACH

The effective management of individual and family interventions is best accomplished by a treatment team. Benjamin and Benjamin (1992) describe an ideal arrangement, where many modalities are available to all family members, including individual and group treatment for identified patient, spouse and children, as well as marital and family therapy, with the entire system or subsystems of it.

At first glance it might seem prohibitively expensive, in the age of managed care, to provide all these modalities. However, outpatient individual therapy of MPD/DD is already rather expensive, requiring years of therapy, often more than once a week. Family therapy is typically brief. Family thera-

py in MPD/DD is ancillary and intermittent visits are often effective; i.e., monthly sessions stretched over an extended period. As the various modalities promote change in the family and its individual members, positive results interact synergistically, reverberating throughout the system. The MPD/DD client thus improves more rapidly, reducing the frequency and duration of the primary treatment. This has obvious appeal to managed care organizations.

Ideally, family treatment should be conducted by the team in such a way that confidentiality, transference, and the reorganization of the family system are each awarded a high priority. This means that every family member in individual therapy should have his or her own therapist. The same therapist could serve as both marital and family therapist, but not as an individual therapist (at least for either spouse). The alliance resulting from an individual therapy dyad damages the therapist's ability to work objectively with the system. Group work should ideally be done by therapists uninvolved with any other part of the family.

In practice, of course, there may not be enough therapists to play all the parts. In fact, solo practitioners often provide all modalities because there is no one else handy and trusted enough to refer to. This approach can succeed with relatively undisturbed families but the author submits that there are myriad obstacles and dangers in trying this with MPD/DD families. Furthermore, the difficulties with confidentiality, transference, blurred boundaries and expectations, and therapist burnout are not likely to manifest themselves fully until well into treatment, when they will be compounded by the appearance of negative transference. If there are not enough therapists to attend to all the therapeutic needs, it is recommended that at a minimum, the identified patient and spouse should have their own therapists, with a third therapist seeing the children and the family.

Such arrangements may be cumbersome for solo practitioners and even impossible for some in rural areas. Given the choice between less than optimal treatment with one therapist and no treatment at all, rural therapists may have to muddle through it without assistance, but sensitive to the hazards noted above. Concurrent intensive individual treatment of the MPD/DD client and any other family member by the same therapist is still discouraged by this author. The rural therapist should think in terms of triage, treating the individual in the most need, and serving the family and its individual members on an ancillary and intermittent basis. Where possible, the geographically isolated practitioner may want to refer the family to the nearest family therapist for occasional sessions. A long drive once a month for the family may help the individual therapist be more effective. It is not essential that the family therapist be an expert in MPD/DD. That is the individual therapist's job. The family therapist's expertise is in family transformation. This affords the solo therapist more choices in making a family referral. In most cases, solo practitioners can and should find colleagues to provide family treatment. This would amount to forming, in any given case, an ad hoc treatment team.

It should be obvious that outcomes of concurrent indi-

vidual and family treatment depend on effective communication between therapists. The treatment team must meet regularly, preferably weekly, and be in close enough proximity and contact that problems can be addressed soon after they appear (Chiappa, 1992). Solo practitioners forming an ad hoc team must talk as often as events dictate. The team must be able to demonstrate in its group process all the communication skills it wishes clients to learn. MPD/DD cases are perhaps most likely among all diagnostic groups to produce significant conflict between therapists. Splits within clients and conflicts in their families often appear in parallel fashion during case discussions, as rifts in the treatment team. Therapists may become righteously angry at their colleagues on the basis of the client's report, but it is best to give one's colleagues the benefit of the doubt. I have found it useful to just explore the possibility that the client or the family system has fostered a split. After ruling this out, one can deal with differences in treatment approach or therapist errors. The struggle toward collegiality and deeper understanding of this work is both essential and richly rewarding. Teamwork promotes effective treatment and is the best prevention for therapist burnout. ■

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