

# Group psychotherapy for persons with multiple personality and dissociative disorders

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*Group psychotherapy is a valuable part of the treatment of patients with multiple personality and dissociative disorders. After reviewing the sparse literature on the subject, the author describes the use of group psychotherapy with these patients alone, as well as with two types of groups in which these patients may participate: incest survivors and general group therapy patients. She concludes by emphasizing the need for expert training for therapists who conduct group psychotherapy with multiple personality and dissociative disorder patients. (Bulletin of the Menninger Clinic, 57[3], 362-370)*

**The number of specialized** treatment programs for persons suffering from multiple personality and dissociative disorders is increasing nationwide, concurrent with the more frequent diagnosis of these disturbances. Most of the programs make extensive use of group psychotherapy; however, the literature on group psychotherapy for patients with prominent dissociative symptomatology is sparse and represents a limited integration of theory and clinical experience.

## Literature review

Ross and Gahan (1988) listed group psychotherapy as a "nonessential" treatment technique for patients with multiple personality and dissociative disorders (MPD/DD). The authors said that their personal attempts at group psychotherapy have failed, but that they know other respected clinicians who have found group therapy helpful. Caul (1984) described internal group therapy—that is, conceptualizing the aggregate of a multiple personality patient's alters and host personality as a group and then conducting group sessions with an internal self-helper as therapist. Caul warned that although group psychotherapy with a homogeneous multiple personality group membership may be somewhat helpful, achieving cohesion and clear group direction is quite difficult.

Coons and Bradley (1985) described their experience as cotherapists for a group of women suffering from multiple personality disorder. All members were in concurrent individual psychotherapy, which the authors said was essential due to the chaos and multiple crises typical of their patients' lives. The group members gained hope and worked through their use of dissociation; they also benefited from participating vicariously as other members worked through this defense as a resistance.

Becker and Comstock (1992) reported on the use of a long-term psychoeducational component in an MPD/DD group that was an adjunct to individual psychotherapy. The group traversed a developmental process in which the primary issue was divided into three phases: (1) making a connection to the group, (2) focusing on feelings of entitlement, and (3) providing a period of resolution when feelings of sadness, pain, and loss were central. The authors underscored the importance of group psychotherapy in the treatment of MPD/DD patients.

I contend that group psychotherapy is quite helpful to most patients with multiple personality and dissociative disorders at some point during the recovery process. It is usually most effective when combined with individual psychotherapy and other treatment modalities according to the needs of the individual patient. Group processes, however, can serve quite different purposes at various stages of treatment. Whatever the purpose, all procedures require that the group therapist be an experienced clinician who is firmly grounded in the theoretical understanding of dissociation, multiplicity, and group psychotherapy.

## Group psychotherapy with homogeneous MPD/DD groups

### Advantages

Early in treatment, group psychotherapy is most helpful when groups of multiple personality and dissociative disorder patients are homogeneous. This type of therapy often occurs on an inpatient unit of a psychiatric hospital and is relatively brief. The processes could conceivably be conducted in outpatient settings as well. However, this early treatment stage is often chaotic and filled with crises, so the support of hospitalization is desirable.

Sitting in a room with others who dissociate is one of the most powerful ways for the multiple personality or dissociative disorder patient to begin winning the battle against the sense of isolation and alienation that accompanies these disorders. Yalom (1985) referred to this concept as "universality." At last, the dissociative experiences are speakable; the notion that "going away" was a creative response to unspeakable traumatization signals the beginning of the attenuation of the fear that has hovered in the patient's mind for years—the fear that he or she really is "crazy."

The group offers a peer context, often for the first time. The need to maintain secrecy regarding intra familial or ritual abuse had automatically deprived these people of age-appropriate peer groups so necessary in normal childhood development. They feared punishment from their abusers and rejection by their peers if they disclosed the abuse. Acceptance by group members provides the patients with a safe place where they can experience the group as a whole as a "good mother" (Scheidlinger, 1974) who contains the terror and provides soothing-functions that were missing when the abuse occurred. By

sharing their stories, these patients validate the pain and injustice they feel. The mere act of sharing and being validated leads to a sense of feeling comforted.

In the beginning stages of treatment, the group lays the foundation for starting work on two important treatment goals: (1) accepting the multiple personality or dissociative disorder diagnosis, and (2) learning that talking helps. Often the multiple personality/dissociative disorder patient has been misdiagnosed for a long time. Once an accurate diagnosis has been made, however, the patient is often catapulted into the throes of a mighty struggle over the acceptance of the diagnosis. The presence of peers who are in various stages of accepting their disorder facilitates progress toward overcoming this impediment to treatment. Patients usually first gain an understanding of what precipitated the need for other patients to acquire various alters, then transfer that insight to themselves. Understanding generates hope as patients see older group mates improve. In object relations terms, awareness gradually dawns that abusive relationships during childhood were internalized and involved part-objects, that is, "good" and "bad" objects rigidly separated from one another. Observing the amnesic barrier between personalities in others can be the first step for the multiple personality patient toward discovering the many part-objects, as well as the barriers among them, inside the self.

Members of the group learn that talking helps, not only because it soothes but also because it illuminates cause and effect, thereby facilitating self-understanding and insight. Various alters and dissociative states were created to make psychological survival possible during the abuse. As the function of this defense becomes clearer, rationality begins to prevail and the aura of "craziness" starts to abate.

### **Disadvantages**

Homogeneous multiple personality and dissociative disorder groups also have a number of disadvantages. Group members accept without question the presence of distinct parts of themselves as well as the amnesic barriers among them. Denial that the various parts belong to one person is often tolerated and accepted, thus reinforcing the fragmented identity that is the internal price paid for such extreme compartmentalization. Group work to eliminate a patient's amnesic barrier and to promote the patient's awareness of alters for the sake of internal harmony or integration may threaten the patient's basis for membership in the group, a painful prospect indeed. Without the presence of patients who are not dissociating or switching personalities and who can demonstrate and speak to the benefits of psychological wholeness, group members-as well as the group as a whole- can become stuck in a costly quagmire of symptom maintenance rather than working toward psychological change. The defensive function of dissociation and multiplicity can then become a group resistance.

Especially in cases of multiple personality, focus on the disorder may emphasize the view of the diagnosis as a psychological showpiece. Placement in a group created especially for these patients emphasizes the distinctive aspects of the psychopathology. Members speak to one another in the jargon attached to the disorder of multiple personality (e.g., "my child alters, my internal helper"). Thus patients can receive considerable secondary gain from having such a unique set of problems. On the other hand, homogeneous groups can challenge the MPD patient's sense of uniqueness, leading him or her to experience the group as unpleasant.

The group provides a much-needed sanctuary; reluctance to disturb this peacefulness can lead to an inability or unwillingness to address competitive issues that arise in the transferences and in the real relationships among members. They may then compete to see who can recount the most horrible history, leading to the retraumatization of those present. Members sometimes express sadism in connection with their competitive urges by using trigger words that they know will precipitate distress and dissociation in their group mates. The extreme compartmentalization within individuals, in addition to the cozy atmosphere created by the homogeneity, can make it quite difficult for the therapist to address members' sadism or competition. Concomitantly, the presence of competition or sadism can stimulate a transference replication of the group as a "bad mother" (Ganzarain, 1989), and group members may then experience the group as unsafe and dangerous. Patients may see flight (via leaving the room), dissociation, absence, or tardiness as their only ways of regaining a sense of safety.

*A brief group psychotherapy session on an inpatient unit began with an older member speaking about her increasing sense of inner harmony. The cotherapists praised the woman for her hard work. One of the newer members immediately began to recount flashbacks she had experienced the day before. Having been in the group for more than a week, she knew something of the cult-abuse histories of several members. She repeatedly used words like "hell" and "devil." One member screamed and dashed from the room. Two more curled up in their chairs, becoming silent, and a fourth ran to a corner of the room and sat on the floor. In competing with the older patient for the attention of the cotherapists, the new patient unconsciously expressed her competitive strivings and sadistic impulses by using terminology she knew to be quite disturbing to other group members. The group thus became unsafe, a "bad mother" stimulating the need to leave-either physically or by dissociating-in various members.*

### **Group psychotherapy in heterogeneous groups**

Although much of the early phase of treatment for patients with abuse histories involves mastering the trauma by telling the stories and accepting the diagnosis, these patients also suffer from characterological problems related to the abuse. Extended

group psychotherapy on an outpatient basis with other adult incest survivors or in a heterogeneous population is preferable for this portion of the work. Concurrent individual psychotherapy is also desirable.

### **Incest survivor group psychotherapy**

Multiple personality or dissociative disorder patients are readily accepted into adult incest survivor groups (Ganzarain & Buchele, 1988; Herman, 1992), because most incest survivors have employed dissociation to some extent in coping with their abuse. Thus, although the multiple personality or dissociative disorder patient is accepted, he or she is less likely to be seen as special. Acceptance by the group members makes even further inroads against the tendency to view oneself as crazy. However, giving up the sense of specialness can sometimes be very painful and may be accompanied by fear of a loss of identity (fragmented as it may be). During the lengthy course of therapy, focus on the phenomenology of the disorder, with emphasis on its adaptive aspects, is replaced by a gradual awareness of the costliness of the defense. Patients also discover the availability of other types of defensive functioning that are more adaptive in the present, given that the abuse has ended. This awareness grows through observing how other group members cope and listening to interpretations by group members and therapists alike of the maladaptation inherent in the extensive use of dissociation. As the patients work to resolve their dissociation, group and individual energies become more available for focusing on other incest-related psychopathologies, such as self-mutilation, acting out, and somatic symptomatology (Ganzarain & Buchele, 1988).

The group as a whole, conceptualized as similar to Winnicott's (1953/ 1958) "good enough" mother or as a safe place, can now serve additional functions. Working through the compelling nature of the trauma in early treatment diverts the spotlight away from the betrayal implicit in the incestuous relationship, which later causes major problems and fears in relating to other persons. In the longer term group, issues of trust and the establishment of satisfying relationships are paramount. Slow, careful work is required for group members to become aware of the pervasive sense of mistrust that is fueled by an internal world of part-objects-people, others, and self who are experienced only as all good or all bad. Working through this aspect of the abuse is tedious and painful.

Quite often patients fail to recognize how a scarcity of empathic mirroring in their early caretaking relationship precipitated their narcissistic psychopathology and vulnerability to narcissistic injury. Such a chronic lack of attunement in others seems normal to these people, further complicating their ability to connect in satisfying way with others. As previously stated, other issues must take priority early in the group treatment, but once a cohesive unit has coalesced, group members can see that empathy beginning early in life is perhaps an experience to which all human beings are entitled, and their lack of it becomes ego-dystonic. The group as a whole can then provide an empathic connection, giving rise to the hope for increased fulfillment in relationships.

In extended group psychotherapy, as the chaos in the patient's life subsides, attention should still be devoted to the triggers for dissociative episodes or switching. This task is best accomplished when these phenomena occur within the group sessions. At such times, the therapist must assume responsibility for keeping retraumatization at a minimum by reestablishing the group as a safe place and by helping the patient return to a state of consciousness where learning and remembering the work are possible. The patient can then continue to learn more specifically about the function of the dissociation. Group members should gradually understand that each individual patient is responsible for avoiding retraumatization while working through painful issues, rather than expecting the group as a whole or the therapist to carry the burden.

*As a major national holiday approached, members of an extended outpatient group for incest survivors talked about their plans and then discussed their memories of previous holidays. Susie recalled, for the first time in many years, that most of her childhood holidays had been spent in hospitals recuperating from parental beatings. As she spoke, her tone and expression changed. Another member asked, "Who is here?" Susie replied that she was Dana and had never been in the group before. A third member asked if Dana protected Susie from the pain of the physical abuse, and Dana acknowledged that she did. The therapist told Dana that she was welcome in the group but that Susie was only experiencing a memory, and that she was not alone but with group members who could help her learn new ways to cope with the painful memories. The group then turned its attention to other members. Susie later announced that she had returned but could not remember what had happened. The group described her experience and the psychological work that they had tried to help her do.*

Issues of competition and sadism can be addressed effectively only when the group is experienced as a truly safe, predictable place. Although most persons abused by childhood caretakers internalize both the abusive aspects and the nurturing characteristics of their victimizers, they understandably abhor the idea of an internal abuser; they strongly resist developing a conscious awareness of this part of themselves. A patient's internal abuser is often first seen and accepted, via projective identification with other group members, in the context of a group as a whole serving fairly consistently as a good mother. Multiple personality disorder patients see and deposit sadistic, competitive parts of themselves into their peers- the internal cast of characters is externalized into the group. Patients can often hear and employ interpretations of this defense as it becomes manifest in interactions during group sessions because the group as a whole is experienced as a mother in whom the good aspects will override the bad. As patients become aware of and accept their internal abusers, the changing conditions facilitate increased internal harmony or integration.

## **Group psychotherapy in general heterogeneous groups**

Given certain conditions, much extended group work can be accomplished in a general heterogeneous group. The group must be sufficiently mature and of such a composition that members can draw parallels between their own experience and the dissociation of the MPD/DD patient; otherwise the situation may lead to further isolation and even scapegoating of patients who are struggling with this symptomatology. The MPD/DD patient may very well add to this drama by narcissistically displaying psychopathology in a bid for special status during the struggle to repair self-esteem. In addition, the group therapists must be sufficiently familiar with dissociative phenomena to know when the patient is dissociating or switching so that the group, and eventually the particular patient, can understand the meaning and function of this behavior.

One distinct advantage of the heterogeneous outpatient group is the presence of male members. Quite often, homogeneous multiple personality and dissociative disorder groups and incest survivor groups are composed solely of women. The fact that many abusers are male may contribute to the illusion that all males are dangerous. In addition, the tendency to externalize problems onto men increases when group members are all female. Because establishing the group as a safe place is essential, allowing these perceptions to go unchallenged may be temporarily indicated. However, later in treatment, when the sense of external and internal safety is more available to the multiple personality or dissociative disorder patient, the therapeutic potential is greatly enriched when male-female interactions are available for examination within the group itself.

### **Training of group psychotherapists**

The challenges of conducting group psychotherapy with homogeneous populations of multiple personality and dissociative disorder patients demand careful, extensive training both in the practice of group psychotherapy and in the special techniques required for treating MPD/DD patients. Expertise in group psychotherapy provides the therapist with concepts such as the "group as a whole" (Horwitz, 1986); use of this concept can greatly facilitate creating and maintaining the group as a safe place. In addition, the concept of transference provides group therapists with a rich framework for understanding individual patients within the group context so that issues can be more easily prioritized in the early phase of treatment. Transference occurs in multiple forms in groups (member to member, member to therapist, and member to group as a whole), providing a way to understand patients' yearnings, feelings of specialness, and potential for retraumatization, sadism, love, and curative power. Skill in applying these concepts is acquired only with extensive training in group psychotherapy.

In addition, therapists should know how to modify the group therapy parameters and should employ special techniques when necessary. For example, they should openly acknowledge that a particular patient needs to leave through dissociation; they should help patients ground themselves; and they should accept the need for group members to temporarily leave the room. Through such techniques, therapists can support their patients' efforts to employ defenses other than dissociation to cope with the disturbing affects stimulated by group sessions.

Dissociation frequently signals retraumatization, which should be avoided whenever possible. In addition, patients who are dissociating or switching will often have no memory of the therapeutic work when they return to a normal state of consciousness. Group therapists working with this population must therefore be well trained in detecting dissociation and switching, as well as in working supportively with these phenomena.

Marlene was a relatively silent member of the group. She would occasionally experience dissociative episodes when she "went away," shook violently, and did not respond to verbal interventions. At first, the therapist would move next to Marlene, hold her hand, and talk to her in reassuring tones, thus facilitating the conclusion of the episode. Over time, the patient progressed to the point where she could be grounded with words, and the therapist ceased using touch; group members gradually assumed this function. It eventually became clear to Marlene that she dissociated whenever she started to feel angry about group changes such as the entrance of new members, the therapist's absence, and terminations. She believed unconsciously that changes heralded acts of sexual abuse, just as they had in reality when she was growing up.

### **Conclusion**

Group psychotherapy is a valuable modality for treating persons with multiple personality and dissociative disorders. These patients may initially use it to begin breaking the secrecy, mastering the trauma, learning that talking helps, and accepting the diagnosis in brief group work solely with other MPD/DD patients. Later, extended group psychotherapy for incest survivors or with a general heterogeneous outpatient group can provide an arena for producing further harmony or integration, diminishing resultant character pathology, and healing narcissistic wounds. The challenge presented by these patients, whatever the group's composition and task, requires a therapist well trained both in group psychotherapy and in the diagnosis and treatment of dissociative and multiple personality disorders.

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