Five dissociative disorders are listed in the current Diagnostic and Statistical Manual of Mental Disorders (4th Ed., American Psychiatric Association, 1994): dissociative amnesia, dissociative fugue, dissociative identity disorder (formerly multiple personality disorder), depersonalization disorder, and dissociative disorder not otherwise specified. The essential feature of such disorders is a sudden and temporary alteration in consciousness, identity, or behavior.

The two most severe dissociative conditions are dissociative identity disorder (DID) and dissociative disorder not otherwise specified (DDNOS), a broad category that includes a wide variety of severe dissociative phenomena. The severity of the dissociative disorder determines the degree of identity disturbance, with DID being the most severe form of dissociative disorder. In this article, DID (formerly multiple personality disorder [MPD]) and DDNOS will be referred to jointly as MPD/DD.

During the last decade, DID increasingly has been recognized as a relatively common post-traumatic syndrome, and dissociation has become a matter for serious investigation and social concern. Individuals diagnosed with dissociative disorders almost uniformly report a history of severe abuse usually beginning in early childhood (Braun, 1987; Coons, 1994; Putnam, 1989; Ross, 1989). Patients who are survivors of pro-
longed childhood abuse often experience complex post-traumatic and dissociative symptoms, such as flashbacks, intense affect, altered states of consciousness, and self-destructive impulses (Herman, 1992). These symptoms often seem uncontrollable and unpredictable, leaving the individual feeling overwhelmed, isolated, and powerless. The psychological trauma of childhood abuse, accompanied by failed early attachment relationships, often leads to a profound distrust of others and a lack of support systems (Herman).

Theoretically, during abuse, children may learn to split off their awareness and memories from the rest of their identity to survive (Braun, 1987). Subsequently, the individual will have disturbances of time and identity. The term "alter" is used to describe other identities (also called personalities) that reside within the body. These alters may be helpful or destructive, and may be of different ages and sexes. The host is the main personality of the individual. The host usually is amnesic for the abuse and serves as the system's "ambassador" to the external interpersonal world.

**The Need for Support Groups**

In our experience, individuals with MPD/DD often are estranged from abusive families and have difficulty with social connection. One of the most urgent therapeutic tasks in working with traumatized individuals is the recreation of a sense of human interdependency and community (van der Kolk, 1987). Groups have proven invaluable for survivors of trauma including combat, rape, political persecution, battering, and childhood abuse (van der Kolk). Interaction with others who have undergone similar trials diminishes feelings of isolation, shame, and stigma. Peer support groups offer the individual with MPD/DD the opportunity to establish healthy social interactions and can provide a safe place to discuss the unique challenges that come with being dissociative.

**Group Therapy With Dissociative Clients**

References in the literature to group work with dissociative clients are scarce, and at times, pessimistic. Therapists have come to expect certain behaviors among MPD patients in homogeneous groups. These behaviors include competition for the therapist's attention, frequent switching (the process of changing from one alter personality to another), spontaneous abractions (reliving intense emotions related to a dissociated traumatic experience), and attempts to play one cotherapist against the other (Putnam, 1989).

Caul (1984) found patients with MPD to be highly disruptive in inpatient, heterogeneous groups. Major problems included frequent switching of personalities and intense rivalry among group members for the therapist's attention. Because of these negative and frustrating experiences, some therapists do not pursue group therapy with patients with MPD (Ross, 1989).
LIST OF BYLAWS

DDRS Member Agreement*

1. What is said in group remains confidential, including who is in the group, what anybody else shares, or any information that does not relate to your own individual process.

2. No one will act out any verbal or physical abuse. All will be treated with courtesy and respect. There will be no touching without permission.

3. All are here to give each other support and understanding, not to advise or confront one another.

4. The group’s time will not be used to process memories.

5. Each person is responsible for his or her own actions (including those of the inside parts). A general rule is that alters who are 16 or older and socially appropriate will attend the group. It is okay to bring whatever is needed to stay grounded, such as stuffed animals, a blanket, a stone, etc.

6. Each person is responsible for his or her own safety, and agrees to talk with his or her therapist and get help if triggered in group. It is not okay to leave mid-meeting without “checking out” with the group. If you are having a particularly difficult time on the night of group, you will want to take care of yourself in a safe place, such as home, where you can call your therapist.

7. No one has to talk. It’s okay to “pass.”

8. Everyone needs to have a chance to share during the group’s time. Excessive cross-talk should be avoided.

9. Sharing of phone number or other personal information is not mandatory.

10. Weekly participation in the group is recommended but not required. People may come when they want to come, need to come, and are able to come.

11. If there is personal conflict, the safety and comfort of current group members will take precedence over that of new or prospective group members.

12. Individuals who wish to join this group must have their therapist speak (by phone) with the group’s therapist-contact person to determine whether the group is appropriate for the prospective member, and if so, to receive information about the time and place of the group. The therapist-contact will then provide them with information about the time and place of the group. If there is concern about whether an ongoing member is still appropriate to attend the group (for his or her own safety or that of others), the therapist-contact person may contact the member’s therapist to discuss any possible concerns.

* This agreement is given to all new members and read at the beginning of every meeting.

Trust—the biggest issue

Coons and Bradley (1985) facilitated an open-ended, homogeneous, outpatient group for patients with MPD using a here-and-now, process-oriented group therapy approach. They report that the biggest issue with the patients was trust. These authors found that group members tended to act dependently, looking to the therapists for direction; frequently, a male cotherapist was the object of negative transference. Because of problems involving transference and countertransference, most therapists recommend that a group be led by two therapists (Caul, Sachs, & Braun, 1986; Coons & Bradley, 1985).

Because helplessness and isolation are the core experiences of psychological trauma, trauma expert Judith Herman (1992) considers empowerment and reconnection essential for recovery. Belonging to a group is an important part of the trauma victim reconnecting to others. Buchele (1993) found that group psychotherapy is quite helpful to most patients with MPD at some point during the recovery process. Early in treatment she found homogeneous groups to be the most helpful. According to Buchele, sitting in a room with others who dissociate is one of the most powerful ways for patients with MPD to begin to overcome their sense of isolation and alienation.

Initial goals for group members include:

- breaking the secrecy;
- mastering the trauma;
- learning that talking helps; and
- accepting the diagnosis.

In a published personal account, a psychiatric nurse with MPD reported her personal experience of loneliness, isolation, and rejection ("Living and Working," 1994). By joining a group for women with MPD, she found positive role models and a sense of acceptance and belonging that aided her healing.

In summary, group therapy can be a useful and successful adjunct to individual psychotherapy for relatively stable clients with MPD/DD. Experience has shown that the group’s focus should be here-and-now, supportive, and psycho-educative in nature. Because of problems involving transference and countertransference, a cotherapist should be used.

A male therapist working with female clients should be prepared to be the object of negative transference, and should seriously consider cofacilitating with a female. Groups can be important sources of empowerment and reconnection for the survivor and are especially helpful in helping members reach their initial goals and decreasing loneliness and isolation.

Group Development

Nurse therapists began the dissociative disorder resource and support
(DDRS) group to fill the void after patients with MPD/DD were discharged from the hospital. The group focuses on psychoeducation and support for patients with MPD/DD who are reasonably stable (see “Just the Facts”). The group meets weekly and is facilitated by group members on a rotating basis. A nurse therapist screens prospective members and provides consultation and guidance to the group as needed.

The DDRS group is not a therapy group and memories are not processed. Members are encouraged to take responsibility for their own needs. Members are encouraged to be empathetic and caring, but not in such a way as to encourage dependence or regression on the part of other members. Every several weeks, the group invites community therapists and service organizations to present current and relevant topics for discussion. The group functions democratically and topics are selected by group members.

The DDRS group has continued to function without interruption for more than 3 years. Members tend to come and go, but the group usually has 8 to 12 members, with an average attendance of six to eight people. The group has weathered a number of crises and has adapted by defining its goals and strengthening its boundaries. The support group agreement (see Bylaws) was developed and refined during this 3-year period by self-regulation.

**Selection Criteria**

Based on our experience, each applicant should go through a screening process to ensure that he or she is appropriate for the group (see Screener Guidelines). Safety and confidentiality are stressed as these are of great concern to people whose lives have been lived in secrecy and fear. To maintain the integrity and safety of the group, the safety of current group members must come before the needs of prospective ones.

This guide was added in response to a difficult situation that almost led to the group’s disbandment. The problem arose when a current member was opposed to a prospective member joining the group. The current member knew this person from a prior friendship that had ended.

The two members attempted to resolve the situation by meeting with a therapist outside of group. When they were not able to reach an agreement, the current member considered leaving the group.

The group vigorously opposed the current member dropping out, and some members suggested splitting the group into two smaller groups in an attempt to meet the needs of both individuals. After much discussion, the group recognized that, in the end, this solution would destroy the group and harm everyone involved.

The group decided that the current member’s need for confidentiality and safety must outweigh the prospective member’s need to join the group. In later discussions, the decision was reaffirmed as anxiety about this conflict had caused some members to consider dropping out of the group. Most members said they would have felt resentment toward the new person because of the loss of the current member who was now a valued friend.

In this situation, it was not possible to meet everyone’s needs and the needs of the group as a whole had to be placed above those of an individual. The prospective member was given the name and number of other groups in the area.

**Therapeutic Factors in Group Therapy**

In attempting to answer the question of how group therapy helps patients, Yalom (1985) suggests that therapeutic change is an enormously complex process and occurs through an intricate interplay of treatment factors. In his research on group therapy, Yalom found that the therapeutic group experience...
The facilitator, a volunteer group member, accepts these responsibilities for a 2-month period:

- Attends every group session, or contacts an alternate when unable to attend.
- Keeps group's file of administrative materials: flyer, schedule, guidelines.
- Communicates as needed with therapist-contact person regarding prospective speakers, goals, or concerns about group dynamics.
- Receives call from therapist-contact person when a new person is scheduled to come to group; coordinates the welcome, provides new member with the support group agreement and any other pertinent handouts.
- Delegates responsibilities and asks for volunteers to help with duties as needed.
- Facilitates the weekly meeting:
  - starts and stops on time;
  - keeps members focused and on task;
  - intervenes when unhelpful cross-talk occurs;
  - sees that the group rules are read at the beginning of the meeting; and
  - helps the group pick topics for future meetings.

The facilitator can be divided into 12 factor categories. He developed a 60-item Q-sort to measure the value a group member gives each factor. Because of the laborious nature of the Q-sort, most researchers use an abbreviated version—subjects are asked to rank the 12 categories rather than 60 individual items.

To determine which of Yalom's (1985) 12 factors were most valued by the DDRS group members, the authors developed a 12-item instrument based on his therapeutic factor categories. The group members were asked to rank statements reflecting the 12 therapeutic factors from "most valued" to "least valued" associated with attending the DDRS group. The subjects' length of time in the group ranged from 3.5 months to 2.5 years. Eight group members filled out the confidential questionnaires for a 100% completion rate. The scores were averaged for an overall ranking.

The top-ranked therapeutic factors in order of helpfulness were:

1. **Universality** (learning I am not the only one with MPD and that others have backgrounds similar to my own);
2. **Guidance** (getting guidance from the group or advice on something for me to do. Getting suggestions about how to handle a particular problem I am having); and
3. **Family reenactment** (being in the group is like being in a family, only this time a more accepting and understanding family).

Group members also gave the opportunity to respond to open-ended questions about what they had found to be the most helpful part of belonging to the group and their biggest obstacle to coming to group.

Responses concerning helpful aspects of belonging to this group echo the findings of the instrument:

- "It's a place for me to just 'be.' I have a major problem with isolating, so it gives me a place to come to and be around others who are similar to me."
- "The care and support—not feeling so isolated."
- "Acceptance and talking openly rather than hiding."
- "Finding out how others have conquered or dealt with problems."

Obstacles to group attendance included:

- "Fear of safety issues and enmeshment issues with group members."
- "My fear of groups—people. I have a lot of trouble speaking in groups."
- "Fear of being around people. Fear of conflict."
- "Being exhausted. Not isolating when in pain."

**Discussion**

One of the biggest concerns about forming this support group was the ability of the group to regulate itself without a therapist present. A review of the literature showed that most problems reported in groups for clients with MPD/DD involved issues around transference and countertransference with the therapist(s). Because of these issues, most therapists recommend that a group be led by two therapists. Unfortunately, few communities have the resources to maintain such a group, and few clients with MPD/DD are able to afford group therapy.

The structure of the DDRS group solves these problems. Issues such as dependence and competition for the therapist's attention are avoided by not having a therapist present. The group facilitator is a member of the group and members take turns being the leader (see Facilitator Guidelines). The group is free, so no person is denied access to support based on inability to pay.

The therapist who sponsors the group is a resource person, and does not take an active role in the week-to-week functioning of the group. The group sponsor screens applicants and talks with the prospective member's therapist to ensure that member's suitability for the group and the group's appropriateness for the candidate. The sponsor's responsibilities are not particularly time consuming nor emotionally draining. Therefore, professional burnout has not been a problem.

**Ranking of therapeutic factors**

As mentioned, the most valued therapeutic factor was universality, reflecting the importance of discovering that one is not alone. The prominent ranking given
to guidance has not been described in the literature and supports the need for psychoeducative groups for persons with dissociative disorders.

The value given to family reenactment appears to reflect the lack of a supportive family and the member’s desire for a sense of group belonging and acceptance. The biggest barrier for clients with MPD/DD in joining a group appears to be their tendency to isolate themselves from others because of their fear of people, groups, and interpersonal conflict.

Group therapy can be a useful and successful adjunct to individual psychotherapy with patients with MPD/DD. Shattered, fragmented lives can be rebuilt in the company of others. Relatively stable dissociative individuals may receive benefit from a homogeneous support group. With appropriate boundaries and guidelines, such a group can be self-regulating. Both literature reports and our experience suggest that the group should have a here-and-now focus on mutual support and education.

Getting started

A therapist-sponsor should provide consultation and screen applicants to the group. Care should be taken to set up the group so that there is a minimum of retraumatization. Group members should be firmly established in individual therapy and memory work should be avoided so as not to trigger dissociation. The boundaries of the group should be explicit and carefully maintained as far as time and structure are concerned. The group should be prepared to set additional limits democratically as the need arises.

Being part of self-led group provides the opportunity for dissociative individuals to learn and practice social skills. Collaboration and problem-solving within the group aids in the development of a sense of empowerment and control.

References

Dissociative Disorder Groups

Key Points

1. During the last decade, dissociative identity disorder increasingly has been recognized as a relatively common post-traumatic syndrome.

2. Individuals with MPD/DD often are estranged from abusive families and have difficulty with social connection; an urgent therapeutic task is the re-creation of a sense of human interdependency and community.

3. Group therapy can be a useful and successful adjunct to individual psychotherapy for relatively stable clients with MPD/DD; the group’s focus should be here-and-now, supportive, and psychoeducative in nature.