DEVELOPING AND MAINTAINING A PSYCHO-EDUCATIONAL GROUP FOR PERSONS DIAGNOSED AS DID/MPD/DDNOS

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Little has been written or presented concerning group treatment of MPD/DID clients (Gaul, 1984; Coons & Bradley, 1985; Putnam, 1989; Caul, Sachs, & Braun, 1986; Kluft, 1989; Hogan, 1992; Turkus & Courtois, 1994). Ross and Gahan (1988) believe that group therapy is non-essential and Becker and Comstock (1992) use the group as an adjunct to individual psychotherapy. Buchele (1995) has written that group therapy is "quite helpful to most patients ... at some point during the recovery process. . . usually most effective when combined with individual psychotherapy (p. 86)." The recent International Society for the Study of Dissociation's *Guidelines for Treating Dissociative Identity Disorder Multiple Personality Disorder in Adults* (1994) notes that group therapy is not the primary means of treatment but can be useful as an adjunctive treatment method.

One form of group therapy is the educational support group. This type of group brings persons with like diagnosis together in a bond of commonality of experience and need. Group membership reduces feelings of isolation, stigmatization, and deviance and helps build an identification with others (Briere, 1989). For example, many persons diagnosed as DID state that their condition is exhausting. Hearing this belief from others is normalizing. Yalom (1985) has concluded that group participation can instill hope, impart information, provide a sense of universality, teach socialization techniques and imitative behavior, build interpersonal learning, and correctly recapitulate the primary family group, among other factors. From the humanistic viewpoint, groups are supportive environments for the sharing of experiences and provide opportunities to give mutual self-help and develop interpersonal coping skills.

Turkus (1991) writes that group treatment for clients diagnosed with MPD must occur within a structure. Goals of a group include identification of distorted perceptions and dysfunctional thinking and helping clients to learn self-management behavioral techniques for control of symptoms. The group therefore functions as a setting for responsible alters to practice control and express emotions in a constructive way while members creatively help one another. in addition, the group helps members establish boundaries for themselves, set limits, and build social networks. Members experience the reality factor of sharing common experiences in a confidential environment that fosters group problem solving and practicing of communication skills. In addition, members who are further along in treatment (e.g., who have mapped their systems, have integrated or fused some alters, who have been able to maintain employment while healing) serve as resource persons and role models for those who are newly diagnosed or have less developed self knowledge or coping skills.

HISTORY OF THE GROUP

This educationally-oriented outpatient support group for dissociative disorders was established in September, 1993, as a community service by a private psychiatric facility. The group was supported by the hospital until_ January, 1997. At that time, the group, at hospital direction, was changed to a self-pay group. However, most of the members of the group were unable to maintain even a low fee and membership in the group decreased dramatically. The group continued through Summer, 1997 with a general membership of five to seven persons. When it was formed, the hospital staff envisioned the group as a way to assist members to deal with emotional stresses by teaching new coping skills, educating members about the problem or illness, supporting one another in dealing with new problems, and encouraging one another in treatment outside the group.

The group was originally an open-ended, open membership group with no screening of members. It was advertised in the local newspaper as a walk-in group for anyone with the MPD/DID diagnosis. Members were expected to be in individual therapy. However, there was no follow-up to see if this were the case or if attendees actually had an MPD/DID diagnosis. New members could enter each week, on a continuous basis. This policy was extremely stressful and led to extreme emotional reactivity in many members.

Initially, a totally open format and lack of screening,

though undesirable to the leaders, was the preferred method of service delivery by the hospital. However, it was not until a group member who was not in treatment and did not have a confirmed diagnosis was arrested for stalking another group member, among other charges, that the policy was changed. Group leaders were then able to insist that members be screened through the hospital's First Step Program (an initial screening and diagnostic component), that signed authorizations for participation be given by each member's individual therapist, and that group membership be limited to no more than 16 members at any one time. A series of screening questions were developed by the group members and leaders as a formal screening interview (Yalom, 1985).

COMPOSITION AND STRUCTURE OF THE GROUP

Between the time of its creation and early 1997, this no-fee group met for approximately 75 minutes weekly and was open to new members on the first session of the month. Members developed a group contract which encouraged them to attend regularly and to be on time. If members were going to be absent for extended periods of time, they notified the leaders. There were no age or gender requirements. The youngest group member is 21 and the oldest is in her mid-50s. Members of the group had a diverse phenomenology. The majority presented with high levels of guilt and shame concerning their diagnoses as well as with many interpersonal problems with family members, peers, spouses, co-workers, and fellow students. They frequently exhibited dissociative symptoms during group when painful material was introduced or when they were triggered. Their symptoms were similar to those reported in a variety of research studies of trauma survivors (Briere, 1992; Briere & Runtz, 1988; Brown & Anderson, 1991; Chu & Dill, 1990; Courtois, 1988; Jehu, 1988; Saunders, Villepondeux, Lupovsky, Kilpatrick, & Veronen,1992; van der Kolk, Perry & Herman, 1991; Williams, 1990). The majority were socially isolated; a few members who had been hospitalized together have had occasional out-of-group social contacts with one another. The amount of additional outside contact was decided by the group (Watson, 1994). Members who chose to exchange phone numbers often used one another as a support system when crises occurred and provided each other with specific, situation oriented information (e.g., what to do when, how to cope with various situations) in a very here-and-now oriented manner. Members also helped one another problem-solve, a technique used consistently in group sessions.

The group had co-leaders; however, the second leader was not licensed and could not lead the group on her own. Because group members would not accept a substitute leader, when the first author was out of town, the group did not meet. Co-leaders offered each other mutual support and picked up on each other's blind spots, thereby decreasing both countertransference enactments and vicarious traumatization. One was able to work with individuals who had dissociated to "bring them back" while the group continued under the leadership of the second (Benjamin & Benjamin, 1994).

As was noted, the members of the group had diverse presenting phenomenologies, diverse histories, and were at various stages of the healing process. Because the group was a support group, members did not share their abuse histories or trauma histories. The focus of the group was on present healing and coping, not on uncovering work. Some members were newly diagnosed; others had begun some type of integration. At least five members of the group were receiving disability and did not work. Others are employed as educators, professionals, or businesswomen. Only five of the regularly attending group members were married; several were recently divorced. Many of the members were socially isolated except for limited contacts with fellow group members.

Throughout its existence as a no-fee group, the group had a core of at least six to eight members who attended weekly. Others stayed for a few sessions or had periodic attendance because of work commitments or the need to "take a break." Numerous group members had repeated hospitalizations, particularly as a safety measure when suicidality became intense. Group members consistently exhibited symptoms of hyperalertness under certain circumstances (e.g., when new persons joined the group, when a door slammed at the foot of the stairs, when a child screamed on the inpatient ward above the conference room used by the group). The level of mistrust for new members decreased with the development of stricter screening procedures, the group rules, and the contract. Self-destructive behaviors were not permitted during the group, and anger control by group members was generally good. However, when certain members became exceedingly angry because they had been triggered, other members of the group reacted negatively by shutting down, staying away from sessions or dissociating. Members had begun to discuss the behavior of one another when angry and leaders had suggested to particularly volatile members that they needed to take a sabbatical "time out" from the group while they worked on their more volatile "trigger" issues in individual therapy. Members included a statement in a group contract they helped to develop that encouraged them and gave them permission to intervene if a member was too disruptive or monopolizing of group time, interrupting that member and requesting her/him to cease the behavior.

The first meeting of a month is the "check-in" meeting. During this meeting, each member has the opportunity to share experiences and issues from the past month. The location of this meeting, due to hospital scheduling conflicts, is in a different room. To ease the transition between locations and to help in the entry of new members, group members have a monthly birthday celebration (with cake) at this meet

ing. Having food seems to make the change and the entry easier. This meeting takes place in the locked section of the hospital. If members need to use a restroom during group, they must exit and enter through the locked doors. The group leaders place the key on the table around which group members sit so that they can have free access to it.. This setting is in contrast to the setting for the other meetings throughout the month. The usual setting includes its own restroom, several "nooks and crannies" for privacy should a trigger reaction occur, and has no locked door.

The check-in meeting also is used to acquaint new members with group rules, procedures, and other members. It also generates topics for later meetings. At meetings other than the check-in meeting, the group begins with the discussion of a topic, a review of homework from the present meeting, or a focus on previously decided discussion topics. Earlier in the group's history, members wanted to deal with personal issues or topics that needed immediate attention at the beginning of the group session. This open discussion sometimes became too involved to "cut off" in 30 minutes and the topic for the evening was not addressed as a consequence. As a result, the exercises, homework discussions, topic discussions now last approximately 45 minutes. Members then can "bring up" topics and problems if so desired. Open discussion of a specific member's concerns enables everyone to share their experience with similar situations and the solutions they have developed. This supportive approach helps members think of alternative problem-solving methods and strategies and also challenges maladaptive belief systems and schemas. If no topics are presented, then the leaders introduce other more educationally-oriented topics. At the time this article was written, the group was working on two general areas using written materials: containment techniques, and identification and modification of belief systems (Rosenbloom & Williams, in press). No member is forced to participate in any aspect of the discussions.

BASIC PRINCIPLES IN CONDUCTING A PSYCHOEDUCATIONAL SUPPORT GROUP

Kluft (1993) identified a series of principles in his article "Basic Principles in Conducting the Psychotherapy of MPD" which also apply to some degree to a psychoeducational support group and the roles of group leaders. These principles are presented as suggestions for persons who are seeking to develop an educational support group for DID /DDNOS individuals.

1) Leaders need to set a secure frame and firm consistent boundaries. Through trial and error, and over time, leaders and group members establish a more secure frame and the group becomes a "safer place" for its members. The group described in this article has established group rules and a contract which are available upon request from the senior author.

2) Leaders need to encourage members to focus on the achievement of mastery. Involving group members in planning topics to be discussed helps in this task. Members of the group described in this article are encouraged to give input into the content and process of the group in respectful, assertive ways. They have worked together to develop the contract and group rules. Some of the topics they have discussed and written about include management of anger, self-mutilation alternatives, and mapping. Materials developed by the group on these topics also are available upon request.

3) Leaders need to recognize and constantly stress to group members that safety and trust are the keys to building a group alliance. Making the group a safe place for members must be a major concern of leaders and members alike. Initiating screening procedures through the First Step Program, requiring new members to furnish the name and phone number of their individual therapists, and establishing group rules have helped promote feelings of safety. Threats to the safety of the group are taken seriously and discussed openly. The group must change location the first meeting date of a month, the date on which new members join the group. Allowing group members to choose among possible locations for that meeting helped to lessen anxiety about the change.

4) Because it is a support group, it is not necessary for members to "tell their stories" to one another or discuss their traumas. If a member begins to present too graphic details of abuse, leaders intervene and explain that presentation of such material might lead to abreactions in others and sharing of traumatic material is not to occur in the group. Leaders need to be aware that contagion of symptom presentation can occur; a flashback in one client can lead to dissociative symptoms in another. For example, in this group, a single word (e.g., "shackles) has led to an unexpected abreaction in another group member. Should an abreaction occur, leaders need to ground alters as quickly as is possible to minimize symptom contagion. When child alters appear, leaders need to ask (in a calm, firm voice) for the child to return

to a safe place. Leaders may also ask others in the system to assist in this process. The presence of overwhelmed or frightened child alters is disruptive to the group and triggers other members to dissociate.

Members need to provide leaders with safety mechanisms (pictures, cue words, directions) how to help them return to an adult or older teen (more responsible) alter, should switching occur. When members have been hospitalized together, they often are knowledgeable about each other's process and may be able to help one another "come back" to the group. In this group, members have provided leaders with drawings, lists of cue words that trigger switching, hypnotic induction techniques, and other methods to assist in grounding. Members are encouraged to deal with issues and memories triggered by group members or events outside of group, with their individual therapists, rather than in the group setting.

5) Leaders need to model good communication skills as they build communication networks with each person's individual system. Leaders model communication through appropriate self disclosure and the use of "I" statements as well. They also need to encourage communication between members of the group. Members are encouraged to discuss the topic among themselves, to express themselves assertively, and to discuss the impact that they have upon each other.

6) Leaders need to be consistent, open, understanding, and warm. However, they also need to set limits and inform hostile alters who are abusive that they are not welcome in the group because their presence is too disruptive. Leaders need to reiterate as often as is needed that working on abuse issues per se is not the function of the group. Members who push those limits need to be reminded of group rules and boundaries on a regular basis.

7) Leaders need to provide hope and give positive feedback. They are in a position to help members identify maladaptive beliefs, develop more adaptive beliefs and thereby help members restore shattered basic assumptions, and verbally identify, praise, and thereby reinforce positive beliefs. Members in this group have begun to work on a workbook that identifies and helps them change (if necessary or desired) belief systems about safety, trust, power/control, esteem and intimacy (Rosenbloom &Williams, in press). This structured format helps members identify and correct cognitive errors (the belief that self harm to one alter does not hurt the system is such an error). It also provides an opportunity for members to recognize that others in the group do have positive beliefs about these five need areas (including the group leaders). Information about the workbook is available from the authors.

8) Leaders need to pace the process of the group. If a topic becomes too overwhelming (e.g., self-mutilation), leaders encourage members to ground themselves or leaders may end the discussion, postponing further comments until a later time. The level of structure facilitated by the leaders varies according to the needs of members and the topics being presented (Watson, 1994). Members do a "check-out" at the close of group as a grounding strategy. This technique is used to ensure that each member is in a "safe place" before leaving group and is a means for a responsible alter to be present and be in control to ensure safety on the trip home.

9) Leaders need to model and teach self-responsibility, cooperation, consistency, commitment, assertive communication, problem-solving, and other social skills. They need to take an active, warm, therapeutic stance within the group (Dolan, 1985). Group leaders also need to be active in and feel comfortable with strong emotions as they arise in the group. They try to be non-directive and non-reactive unless they must function to protect an individual member or the group as a whole.

Additional roles of group leaders in a psychoeducational support group mirror those stated by Donaldson and Cordes-Green (1994): messenger, monitor, mediator, and member. Although they are discussed separately in this article, these four roles generally occur simultaneously. As messenger, group leaders model helping skills, teach conceptual information and theory both directly and indirectly, analyze behavior and teach appropriate emotional expression, assertiveness skills, and maintenance of boundaries. Leaders are resource persons, not authorities, who answer questions and provide information according to their knowledge. Group members, as well, serve as

messengers and provide each other with information and resource materials about trauma, post-traumatic stress disorder, dissociative identity disorder, and other related topics. If knowledge is not close at hand, leaders and messengers obtain information and provide the group with handouts, articles, and resource materials. As Turkus (1991) noted, education has a normalizing function Handouts can serve as the ¡mpetus to valuable discussions and activities (e.g., development of a Trigger Mapping Ladder, available upon request).

As monitors, leaders attempt to be vigilant to all areas of process and content of the group. They observe triggers for group members to topics chosen, the reactions of members to one another, silences, eye contact, non-verbal behaviors and other process aspects of the group. They also analyze the "whys" of the process and talk between themselves before or after the group concerning what they see, hear, and conclude. As mediators, the leaders give feedback and information, ask questions, make observations, facilitate group problem solving, and seek to offer help in difficult situations. As members, they are genuine, responsive participants who are emotionally available during the group and, at times, by phone outside the group. They also are learners who are constantly seeking professional knowledge and are examining the impact of the group on their own issues, processes, and selves, with an awareness in mind of vicarious traumatization and compassion fatigue.

BENEFITS OF SUPPORT GROUP PARTICIPATION FOR MEMBERS

Criticism of the use of group interventions with persons with MPD/DID often centers around issues of group contagion. Some critics suggest that a group for persons with this diagnosis serves as a breeding ground of symptom suggestion and memory suggestion. However, structure and format as a psychoeducational group, not a therapy group, limits such contagion. Screening interviews for group membership, in this instance, are conducted by the hospital's First Step program. In the majority of cases, leaders are not aware of the specifics of members' trauma histories. Trauma history and abusive experiences are not topics for discussion during the group. Instead, group discussion and process is designed to deal more with educationally-based issues, coping skills, and ways for members to take care of themselves both in group and in the world. Members encourage one another to take risks, to be assertive, to fight proactively for their rights (e.g., in a divorce, custody battle, etc) and the "victim mentality" is not one that is encouraged or fostered within the group.

Therefore, one of the most helpful and important areas for discussion for group members concerns group and individual member safety. Safety means the need to feel reasonably invulnerable to harm and secure. Many members of the group do not feel safe under a wide range of conditions and situations. Some try to form rigid boundaries around themselves. Others are constantly at risk for self harm when they are threatened, when parts reveal information about the historical or perceived past, or when they encounter persons or events that remind them in any way of earlier abuse.

As Buchele (1995) has aptly noted, the group cannot function unless it is a "truly safe, predictable place" of sanctuary (p. 91). Williams' (1993a, b, c, 1994) techniques for ways to provide safety in individual therapy can also be utilized in the group setting. Discussions of safety and ways to gain safety have assisted members in the "outside group" life choices as well.

Many group sessions have also explored ways to develop coping mechanisms that would lead to a greater perception of safety and the creation of fool-proof safety contracts. Several group members have made their own personal safety contracts available to the group as educational tools.

Each member of the group is encouraged to develop or utilize a previously developed internal or external safe place to use should material become overwhelming or should they begin to be triggered by one another. This place exists either in reality or fantasy, in nature or in a location made by human hands. If group members have become upset during a meeting and need time to ground before leaving the session and before the final "check-out" occurs, group leaders may do a short relaxation exercise while asking each member present to go to that safe place and regroup (Salston & Baker, 1993). Other external sources include written positive affirmations; safety objects such as geodes, stuffed animals or small toys; participation in activities which boost self esteem (coursework, volunteer activities, peer activities); art activities; and reference to treasured items including photo albums, collages, and memorabilia.

Another positive benefit for group members has been their development of cognitive restructuring techniques to change maladaptive thought processes and maladaptive self statements about safety and self harm. The group serves as a form to teach means to identify and attempt to utilize internal sources of self-soothing including intuition, intelligence, inquisitiveness, willpower/determination, self-awareness, problem-solving abilities, religious values, and empathy for others (Feord, 1994) . Group leaders model appropriate self statements, particularly those that involve assertive boundary setting. Self dialogue that is taught is simple and truthful and may include the statement "This is now, not then; I am safe" (Salston & Baker, 1993).

Another beneficial function of the group is discussion about and possible development of procedures, techniques, and strategies for containment of strong affects, compulsions to retraumatize the self, self-mutilatory urges and attempts, suicide gestures, or boundary violations (Miller, 1994). These techniques and strategies include the utilization of contracts, safety plans, self-soothing mechanisms, positive memories, visualizations, cue words, containers in which to place images and affects, and others. Containment (as well as appropriate expression) of anger is another major topic (Grame, 1995; Ross & Gahan, 1988), Different means to express rage in a non-harming manner have been proposed and include utilization of "bop bags," weight-lifting, controlled destruction of glass at a recycling center, batakas, and other physical means to release the anger from its internalized storage places.

The group is not designed to be a member's lifeline; as has been noted, each member has an individual therapist. Group leaders are available by phone to members generally only during a crisis as a "last resort" if individual therapists are not available or when other support systems fail. Leaders may also be available if members' calls concerning potential topics for group or to discuss members' reactions to a particular session when something that occurred left them feeling unsafe or wary. Members do not abuse phone contact with the group leaders and respect leaders' boundaries concerning timing and length of phone contacts.

Many group discussions center around the topics of relationship building and boundary setting. Relationship difficulties that the married members have had corroborate Putnam's (1989) observation that, in many cases, MPD clients often marry mates with significant psychological difficulties. Several of the group members have been involved in verbally or physically abusive relationships. Others have been abandoned by partners as they progress through the treatment process or have partners who are unwilling to acknowledge the diagnosis, even after years of therapy for the partner.

Group members also discuss the topic of boundaries. They relate many instances in which they have been unaware of what constitutes appropriate boundaries and frequently have been unable to set limits (Horning, 1994). As a consequence, they have begun to look for guidelines for intra- as well as interpersonal boundaries and separations and have completed numerous exercises on this topic. Members have noted that discussions of boundaries and assertiveness have been some of the most helpful for them (Courtois & Leehan, 1992) . They are learning to confront one another about issues and behaviors in an assertive manner. However, new members may find this degree of interaction somewhat intimidating until they have acclimated to the group.

Many of the group members believe that their diagnosis must be kept a secret and may be shared only with selected family members and/or close friends. The majority of group members do not believe that the diagnosis means they have the "right" to be a victim. Those who are on disability are learning ways to return to the workforce through successful use of containment strategies learned in the group. The group is not structured to encourage a non-active response to symptornatology. In fact, the philosophy of the group is the development of coping skills that enable life "in the world." Several group members have returned to school to complete advanced degrees. Others have learned how to tap into special education and rehabilitation services through state vocational rehabilitation programs.

Members have related stories of how the revelation of their diagnosis was received by others. One participant related that her younger sister responded that she must be possessed by the Devil and immediately contacted the family's minister and requested an exorcism. A second participant indicated that most people do not want to know about traumatic experiences in others because they fear contagion. Several group members have consciously isolated themselves from family and friends because they believe no one will understand them. Group leaders have encouraged members to share their diagnosis only with persons who are supportive and compassionate. Members have also been encouraged to identify a support team of at least three persons and then use that team to develop a plan of action for crisis situations. However, members are also reminded that a spouse or other support person has the right to refuse to provide crisis intervention at a given time if he/she does not feel emotionally or physically able to do so (Williams, 1991; Williams, 1995). Soliciting support from others, however, does not give a member permission to forego the responsibility of self-care if at all possible. Group members are encouraged to educate their supportive individuals about triggers, specific wants and needs, unique patterns of presentation of alters, and necessary physical and emotional boundaries in a positive manner so as not to alienate them.

VALUES OF THE LEADERS

Leaders of a psychoeducational group need to believe in the values of support and consistency while constantly helping group members strive for personal safety. Their value orientation is to do no harm, to model assertiveness and flexibility, and to allow no destructive contacts between group members if at all possible (i.e., discourage contacts if negative). Leaders need also to value knowledge and seek continually to expand their own knowledge bases in the fields of trauma, dissociation, DID, and other related areas. They also need to have knowledge in the fields of systems theory and child development. Leaders in this present group value an active style of leadership that involves education and sharing of knowledge. Leaders of any support group for persons diagnosed with DID need to realize they are not automatically trusted by members and must earn trust over time.

Therefore they must utilize their intuitive, responsive, warm, genuine styles to work for the good of the group and be generally comfortable with material shared by clients and emotions revealed. This does not mean that they are unaware of countertransference/vicarious traumatization issues, however.

AREAS OF CONCERN AND ETHICAL ISSUES IN THE GROUP

Peer contact for persons with a similar diagnosis can provide validation and lead to a firmer acceptance of that diagnosis. Some individuals, however, believe that such contact can be contagiously iatrogenic and lead to false positive presentations (Simpson, 1995) . Thus, in the group setting, members may come to accept "without question the presence of distinct parts of themselves as well as the amnestic barriers among them. . . reinforcing a (sense of) fragmented identity. . . (and) emphasize the view of the diagnosis as a psychological showpiece. ..(from which) patients can receive considerable secondary gain" (Buchele, 1995, pp. 87-88). It is the role of the group leaders as well as the members themselves to structure a support group in such a manner that individuals remain, to the greatest extent possible, in responsible, adult alters or states. A strong group structure limits reinforcement and encourages a positive, proactive stance to life.

Leaders of any type of group for persons diagnosed with DID must be extremely good managers, particularly when members behave in bizarre or inappropriate ways. Over time, leaders learn to identify specific alters who may appear and become familiar with specific triggers for individual members or for the group as a whole. In this group, members have recognized that certain phrases trigger others and make a conscious effort to avoid the use of those phrases or warn the individuals ahead of time prior to their use. This awareness decreases dissociation and switching. However, particularly when new members come to the group, it is possible for members to dissociate and leave in a tumultuous state without leaders even knowing (Linehan, 1993). This occurred in one instance in the present group when one member did not return home after group and was found hiding in the bushes outside the hospital several hours later. Initiating a one or two sentence check-out by each member in an adult/responsible alter has countered this type of behavioral response.

Barach (1994) wrote that an open group may prompt acting out; new members whose histories are not known or whose styles of presentation of symptoms are not known can be very disruptive as they come and go in the group. This type of group, in other words, can lead to secondary traumatization in others as well as a contagion of symptoms. While these statements are true, it is the belief of the authors of this article that group structure can minimize disruptions. Group socialization occurs quickly. New members have written rules and a contract to sign. The initial screening interview stresses that the group is not therapeutic and that abuse issues are not discussed or worked through; abreactions are not encouraged. Allowing new members to enter only once monthly also limits this type of disruption. At present, the group membership is also limited to 16 persons. Leaders believe it is countertherapeutic to have a larger group because the size would limit the participation of those present.

Members are encouraged to keep group confidentiality. A problem arose when one member called another and revealed information that might be harmful to self or others. In this instance, stalking was involved and the member who made the call did not share the information with the leaders as he had promised. To prevent this from happening again, group members are now encouraged (and expected) to reveal any potentially dangerous information to the group leader so that the leader(s) can deal with the person individually or get in touch with the person's therapist, hospital administration, or the authorities. This information also includes threats of suicidal actions revealed by one member to another. When such information is revealed, the group functions in a supportive role and encourages members to use their safety plans and to follow safety contracts. In more than one instance, the group has encouraged a member to seek hospitalization immediately following the meeting and the member has then gone to First Step and/or contacted the individual therapist. Group members encourage one another to share important information, particularly information about suicide threats and plans in the past and for the present, with their therapists. This is particularly true when a member who has a new therapist has not disclosed self-mutilating or self-destructive behaviors to that new therapist.

Group members are not to give phone numbers, addresses or information about other members to anyone without that member's permission. In an instance in which one member was stalking another, a group member provided the police with names and numbers of other members. The police made calls to at least three members, unaware of their diagnoses, and the consequences were disastrous. Two members were eventually hospitalized. The group leader eventually was able to contact the officer and explain the situation. To be sure, legal prosecution of the group member who was stalking others had to take precedence. However, the officers did agree to allow group members to be interviewed in the presence/with the assistance of their therapists.

Because of these issues, a group for persons diagnosed as DID cannot be a walk-in group. It is essential for persons to have screening first and to provide the names/phone numbers of their therapists who have diagnosed them. This eliminates the arrival of persons who are known to be non-MPD or the attendance of persons who are too disturbed, too new

to the diagnosis, or too fragmented to participate.

Another issue centers around techniques used to deal with problem members or new members. As an ongoing group, the core members react to new members and to change of location and format. However, the adoption of group rules and set times when new members can join the group has helped modify this reaction. Leaders have dealt with members who are consistently tardy; who have wanted to "take over" as leader; who are excessively angry, thereby frightening other group members; who display inappropriate behavior; who begin to self-abuse with keys, plastic knives or other instruments; who demand too much time on a regular basis; who attempt to run out of the room or lock themselves in a bathroom and cause a disruption; who refuse to stop discussing too vivid or grotesque material; among others. Group leaders have established their role as having authority to intervene in these instances. Group members also have intervened; (e.g., members have asked persons who are tardy to be on time so they do not disrupt the process.) Persons who are inappropriate in behavior or who abreact and cannot ground themselves quickly are taken to a hallway adjacent to the room by one leader while the other continues the group. Persons who are self-abusive are either addressed non verbally or verbally by a leader. At times, other members signal the leaders what is happening if the leaders are not already aware. Members frequently believe that they are responsible when others react negatively to a statement they make and that statement acts as a trigger for acting out (anger, crying) or acting in (dissociation). They take on emotions of guilt and shame for their self-presumed responsibility in "causing" the behaviors. Leaders discuss issues of responsibility of self and responsibility for others honestly and openly in order to help members confront these negative beliefs about presumed power.

Leaders insist that implements which might be (or are beginning to be) used in a self-destructive manner are either put away or are given to the leaders. Leaders then use the grounding techniques that members have provided, if necessary. Members also know that long visits to the bathroom (which is in one corner of the room) will eventuate in a knock on the door by a leader. Should no response be given, leaders have a key and will open the door. This is not seen as a violation of privacy, It has prevented dissociative episodes from continuing and enables leaders to help members ground.

COUNTERTRANSFERENCE AND VICARIOUS TRAUMATIZATION

Group leaders realize, as do many others (McCann & Pearlman, 1990a; McCann & Pearlman, 1990b; Daniell, 1994; Pearlman & Saakvitne, 1995), that vicarious traumatization is inevitable and that exposure to traumatic material takes its toll on therapist as well as client. Leaders have strictly limited the amount of grotesque, gruesome material that is shared by members to protect other group members from secondary traumatization and to protect themselves from those vicarious effects. Group leaders, modeling appropriate behavior, also have set personal boundaries. They refuse to be abused verbally by alters, no matter their age. Verbal attacks by hostile alters can trigger many countertransference issues in both leaders and group members. Leaders therefore have taken an assertive stance and have reacted to hostility firmly, without becoming a transferential negative parent. However, it is difficult to maintain a detached stance in the face of a disruptive tirade that then triggers other group members. Leaders also have experienced frustration at the lack of movement of some group members or the resistance they have shown to do the work in group or as homework. Members who attempt to use dissociation as an excuse from doing group assignments are encouraged to examine the reasons behind the resistance. In addition, as Benjamin and Benjamin (1994a; 1994b; 1994c) noted, helplessness and inability to cope exhibited by some group members may prompt leaders to feel helpless and overwhelmed or may lead to rescue fantasies. As the group has continued over time, though, members have become less tolerant of other members' retreats into helplessness or hopelessness. Instead, members are more problem-focused and look toward ways to problem solve and find solutions.

An additional source of countertransference and vicarious traumatization occurs as a result of frustration when group members call a leader outside the group on a less than crisis basis and expect the group leader to provide therapeutic care. In these instances, the group leaders redirect the client to his/her individual therapist and reinforce their roles as back-up when "all-else" fails. However, leaders have also had to let members and therapists know that they do not serve as back-up therapists when that individual therapist is out of town or unavailable. Several group members are in constant crisis and crisis intervention with them can be wearing, frustrating, and exhausting. This is particularly true in instances in which the individual therapist refuses to respond to a crisis phone call that is genuine. Leaders have then contacted therapists and worked out future response scenarios (Coons & Bradley, 1985).

CONCLUSIONS

Providing information and facilitating discussion through the forum of apsychoeducational group has helped members normalize their diagnoses, behaviors, symptoms, and life difficulties through contact with others. Providing members with opportunities to rehearse behaviors, problem-solve, and build connections has been a very worthwhile component of the group process, as has been teaching them trauma and systems models. Structuring the group as a present-oriented, proactive forum has limited the contagion effects

of the "negatives" of DID: switching between alters, dissociative episodes, contaminators, and acting-out behaviors.

Group leaders recognize that working with a group of persons with MPD/DID who are in a vulnerable state is risky; chaos can spread quickly, as can fear and grief. Leaders of any support group for persons diagnosed with DID must be constantly alert to the ways in which traumatic reenactments are frequently triggered through a choice of words, an action, or a reaction of other members, in spite of structure and group rules. Leaders must also learn about the systems of each of the more regularly-attending members. Leaders must recognize that switching is also very contagious and they must be constantly on the alert to "bring members back" to a more adult state.

Developing and maintaining a psychoeducational support group is an extremely rewarding adventure. As members have built a sense of groupness and community, as leaders have gotten to know them and their systems more intimately, a truly unique group structure and process has evolved. Members have taught one another and group leaders much about "what it means to be multiple." It is the writing of one group member (Feord, 1993) that reminds the reader of the impact of multiplicity on each and every participant.

> Although others may not understand multiplicity, they do understand human suffering...Many family members or friends may avoid discussing the...illness because they don't know how to help. (Persons) diagnosed with MPD essentially want and need the same things all other people do. They need love, space, and the happiness that comes from knowing that they are making a worthwhile contribution to the world. However, because they are human, they cannot expect everyone to like them, support them, and express only positive sentiments toward them. Everyone is unique and has inherent attributes that appeal to some people while, at the same time, repel others. Multiples, like anyone else, need both positive and negative feedback from others in order to grow as human beings. Group members (have come to know that) each person is responsible for making his or her own happiness on earth. Multiplicity is not an excuse to deny oneself the right to be happy nor should it be used as a scapegoat for relationship problems...Like anyone else (group members) can examine their lives and identify changes they can make now, and in the future, to fulfill their dreams.

It is one role of the group to help them in that process of growth. ■

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