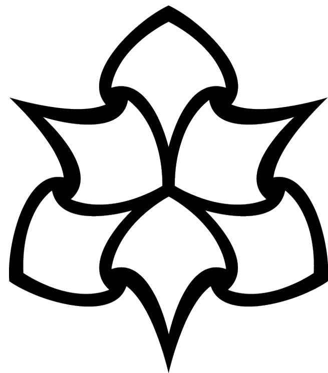


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# THE ABUSED AND THE ABUSER(S): ATTACHMENT RELATIONSHIP IN DISSOCIATIVE IDENTITY DISORDER

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A thesis submitted in partial fulfilment of the requirements of the
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**To my father**

## Abstract

This thesis aims to draw a unified picture of the relationship between *Dissociative Identity Disorder* (DID) (APA, DSM-5, 2013), the affected person's *attachment pattern*, and specific characteristics of their trauma history. In particular, the analysis of these three elements focuses on cases where a person is persistently involved in a life of ongoing abuse, despite years of DID-specific psychotherapy.

Based on attachment, forensic and psychoanalytic perspectives and on my extensive clinical work, I propose several new classifications to help identify and explain such cases, and ultimately improve their treatment.

The first is further classification of the *Disorganized Attachment* (DA) category of attachment theory, to include two new sub-types: *Concrete Infanticidal Attachment (IAc),* which develops when a child needs to engage an attachment figure who only responds while the child is being severely abused, and *Symbolic Infanticidal Attachment (IAs),* which develops in response to severe but not abusive relational trauma, such as neglect.

The second proposes a differentiation between two presentations of DID, *Active* and *Stable*. The first describes people who continue to be involved in a life of abuse even in adulthood, and their DID is thus constantly reinforced and recreated. The second pertains to people who bear the scars of childhood relational trauma but are safe at present and can focus on recovery from their traumatic past.

Finally, I propose *the Cyclical Model,* which describes the relationship between severe childhood abuse, IAc and *active DID* as a self-perpetuating cycle. The term *cyclicity* is used to describe a repetitive, change-resisting quality of people with *active DID*. Cyclicity is attributed to their extreme levels of anxiety and terror. I argue that this quality, while 'quiet' and hard to detect, forms a major obstacle to recovery.

Following these ideas, additional theoretical and clinical considerations are suggested as expansion to the *Phase-Oriented Approach* for the treatment of DID (ISSTD 2011).


Key words: active DID, stable DID, attachment theory, childhood abuse, cyclicity, infanticidal attachment, relational trauma, phase-oriented treatment approach.

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I want to thank my children for their patience, forbearance for and their confidence in me; and above all, my deepest thanks go to my husband, for sharing with me all the highs and the lows.

## List of abbreviations

| | |
|---|---|
| CDS | Clinic for Dissociative Studies |
| DA | Disorganised Attachment |
| DDs | Dissociative Disorders |
| DID | Dissociative Identity Disorder |
| IAc | Concrete Infanticidal Attachment |
| IAs | Symbolic Infanticidal Attachment |

# 1. Introduction[1]

This thesis will explore three related themes. The first is the unique qualities or pattern of the relationship between the infant and his or her attachment figure(s), when this intensely emotional, love-based relationship, on which the infant depends for survival, is also based on continual, severe or life-threatening abuse. I call this pattern *Concrete Infanticidal Attachment (IAc)*; and I will argue that when the attachment figure of a child is murderous, the child's attachment-pattern (i.e., what makes him or her feel safe) will inevitably be linked with murderousness, abuse, danger and pain. As, contrary to its purpose, such attachment pattern leads towards danger rather than towards safety, I suggest it should be deemed an attachment disorder, a condition which requires recognition and treatment.

The second theme is the link between this attachment pattern and Dissociative Identity Disorder (DID). I will suggest that there are two main presentations of DID, *stable* and *active*, and argue that *active* DID and Concrete Infanticidal Attachment form a hard-to-stop vicious cycle.

The third theme is the repetitive, *cyclical*, un-evolving quality of the Self in people with Concrete Infanticidal Attachment. Somewhat simplistically, we may say that a person with IAc is 'frozen with fear' and thus endlessly repeating a defensive pattern, or being locked into many 'vicious cycles'. This *cyclical* quality makes it very hard for any changes to occur in the person's life, both internally (e.g., through developing insights) and externally (through making changes in one's mode of life). I suggest that the quality of *cyclicity* is what makes the *active* type of DID particularly hard to treat.

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[1] Adah Sachs is a UKCP-registered psychoanalytic psychotherapist and a registered member of the Bowlby Centre (centre for attachment-based relational psychoanalysis). For the past decade, she was a consultant psychotherapist and forensic clinical lead at the Clinic for Dissociative Studies (CDS), London. The CDS, an NHS specialist provider, is one of two national centres for the assessment and treatment of people with dissociative disorders, and for the study of this complex phenomenon. Prior to her work at the CDS, she was a psychodynamic psychotherapist in two psychiatric hospitals for nearly a decade. She lectures and supervises world wide on attachment, trauma and dissociation.

Based on these three ideas, and on the clinical work from which they have emerged, I will suggest an expansion to the *Phase-Oriented Treatment Approach* (ISSTD, 2011), which is the most widely acceptable form of therapeutic work with this group.

## *My journey into the field of Trauma and Dissociation*

Dissociative Identity Disorder is the most severe of a group of trauma-related disorders called Dissociative Disorders (DDs). This group has constituted a formal mental health diagnosis for more than three decades (APA DSM-III, 1980; APA DSM-IV,1994; APA DSM-IV TR, 2000; APA DSM-5, 2013; WHO ICD-9, 1994; WHO ICD-10, 2010). The knowledge in this field, however, is still in its infancy compared with other DSM classifications. Subsequently, DDs are not yet taught at most psychotherapy training programmes, and very few GPs or psychiatrists have more than a rudimentary knowledge of their diagnosis or treatment. Indeed, throughout my own training (BA, MA, and four years at the Institute of Psychoanalysis, London) as well as a decade as a psychotherapist in two psychiatric hospitals, I have never come across the diagnosis, nor across any teaching regarding any appropriate treatment for this condition. Like most clinicians of my generation who work with DDs, I have stumbled into this field inadvertently, and my first dissociative patients, self-harming adolescents in long-stay psychiatric care, caught me unawares. As a newly qualified psychoanalytic psychotherapist, I attempted my hardest to practice ‘proper’ psychotherapy (that is, concerning myself almost exclusively with the internal process of the patient). Under constant pressure to also maintain hands-on risk management, this was a rather challenging task, as the two demands don’t naturally mix; and I often found that my ability to care for my patients’ physical safety came at the expense of the analytic exploration, or vice versa. While this was a challenging balance with any of our young patients, there was a particularly vexing sub-group among them with whom I regularly failed on both fronts: I could neither help to reduce their self-harm, nor engage their thought-process, or even their *memories* of their recent past and of what they have done to themselves. Rather hesitantly, I began to comment in my ward-reports that these young people were ‘dissociating’. With that, I started to suspect that their problems

were different to any that I was familiar with, and that they required a different therapeutic approach, if I was to be able to reach them at all[2].

I must emphasize that my clinical and theoretical work did not emerge as a planned research, but as a rather frantic attempt to help young people to engage with their feelings and thoughts while trying to stop them from terrible self-harm. The questions which I address in my theoretical formulations have lagged years behind my clinical answers: I have often responded clinically before formulating a question, let alone an answer, about the situations that I was met with. Indeed, my questions have sprung from observing my own un-characteristic responses to clinical situations: why, I have often wondered, bewildered, have I acted, spoken, felt, thought (or was unable to think), as I did? It may be said that my methodological journey was travelled backwards: the clinical impasses which I have faced, and the failure (or, occasionally, the success) of my various ideas and interventions made me formulate questions about the reasons for what had occurred. I have then spent years looking back, onto my many clinical hours, in an attempt to understand their meaning. This work may thus be described as an analysis of data already gathered.

I would nevertheless maintain that my 'backward journey' falls within the realm of qualitative research (Bondi, 2013; Brikci and Green, 2007; Riessman and Speedy, 2007): the thousands of session hours I have had with patients that I did not understand were my 'unstructured interviews' (Brikci and Green, 2007). At the time, I didn't know what I was trying to find, only that I have always strived to *make meaning* (Bondi, 2013) out of my clinical experiences. But gradually, through 'learning from the patient' (Casement, 1985) and listening to their communications, confusing as these have been, as well as to my own, even more confusing responses and mistakes (Casement, 2002), my questions, answers and some synthesis of these into theory began to emerge.

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[2] An early paper (Sachs, 2004) describes my first insights into the act of self-harm as expressing separate 'parts' of the person: a 'victim' (who gets harmed) a 'perpetrator' (who does the harming) and others. Noting the co-existence of different 'parts', each with its own agency, within one person, helped me to make sense of some of the most inexplicably brutal self-mutilation that we have witnessed, while highlighting the baffling clinical and ethical dynamics in such cases. These insights were my first steps into the world of profound dissociation.

### *Conflicts and ethical questions*

The fact that I did not collect the clinical material as part of a planned research had pros and cons: on the one hand, my learning was less structured, more convoluted and took longer; on the other hand, I was free of an ethical dilemma, as my position as a clinician was never contaminated by a need for data[3]. Arguably, data gathered in this way is of a better quality, as it is more authentic and accurate.

There is nevertheless an inherent conflict in the position of a clinician who publishes clinical papers. While it is essential for the profession to read and publish, so that further learning can take place (ultimately, for the benefit of future patients), it is also essential to preserve the privacy and boundaries of the patients written about. This is particularly important with traumatised patients who have already suffered a great deal of intrusion.

In order to preserve patients' anonymity, many details in their accounts must be changed; but in order to preserve scientific accuracy, it is important to keep the details as accurate as possible, so as not to end up with fictional characters. My solution in most cases was to write amalgamated accounts. These preserve both the realness of cases and the need for privacy. Where I have used a single case with only minimal changes, this was at the explicit request of a patient, who wanted to make that contribution.

Even with all these measures, however, it is important to bear in mind the inherent tension between the individual rights of a single patient versus the need of the profession to grow, and between the clinicians' duty to their own patients and the clinician-researchers' aim of enhancing knowledge.

In 2004, I left my staff psychotherapist position at the hospital to take up a position as consultant psychotherapist at the Clinic for Dissociative Studies (CDS), and my interest expanded from self-harm into a broader study of dissociative disorders. The

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[3] with the exception of paper 7; but this researched clinicians, not patients.

CDS, a 4$^{th}$ tier NHS provider, is one of the two UK national centres for study, assessment and treatment of dissociative disorders.

My work, as well as offering psychotherapy to people with DDs, included assessing patients, supervising a large number of professionals across the country, teaching and lecturing, providing training days and risk-assessments to local health authorities (and sometimes to prisons), producing reports for the use of the referring services and, on two occasion, providing the court with an expert witness report. This wide-range of activities brought me into contact with many professionals working with DID, and to hear about the problems they encountered; and it gave me the opportunity to learn from their experience, as well as my own, and to share my thinking with them.

It should be noted that the CDS (and subsequently myself) saw far more people with DID than people with other dissociative disorders (amnesia, derealisation and depersonalisation). I have no way to asses whether this reflects the relative prevalence of these disorders in the UK, or the greater toll that people with DID have on the health system, and thus their more frequent referrals to 4$^{th}$ tier services.

The most troubling issues which professional in this field struggled with, in my experience, were: difficulties in maintaining one's normal professional boundaries (see paper 7, appendix); a sense of helplessness and hopelessness, faced with a lack of progress around repeated victimization of the patient (chapters 4, 5, 6); a pervasive experience of professional isolation, as though the clinicians were somehow in the wrong and ashamed (chapter 3); and secondary traumatisation (chapters 2, 3, 8), that is, when the therapist begins to suffer effects of trauma as a result of working with a traumatized patient. Indeed, therapists in this field show a higher burnout rate than their colleagues (paper 7, appendix).

I would like to point out that all these problems are closely connected; furthermore, they all mirror the experience of the patient: people with DID invariably had their boundaries violated (chapter 3), and were subsequently traumatized (chapters 2, 6); they generally live the very isolated lives of those who are prohibited to tell (chapters 2, 3, 4), and they feel in the wrong and ashamed. The feelings of

wrongness and isolation do not allow for the trauma to be soothed or processed, and the trauma increases the sense of isolation and shame. Most importantly, I suggest that these vicious cycles (chapters 5, 7) are at the heart of the lack of progress in the therapy; and the lack of progress increases the shame, helplessness, isolation and traumatisation (chapter 7).

I believe that the most effective way to loosen the hold of such 'vicious cycles' is not to be isolated. Secondary traumatisation, like the primary trauma, thrives when one is alone; and it is far less damaging when one is well supported. Analysing the relationship between these components, I hope to contribute to our shared understanding, and help in reducing the traumatic experience of therapists and patients alike.

## *The journey through my writing*

The publications (8 papers and a co-edited book) on which my analytic commentary is based were written gradually, starting in 2007, and the progress of my learning and thinking can be traced through them. For easing the flow of reading, as well as for highlighting the key issues and the development of my thinking, I have included an edited-down version of some of the papers within the body of the text, in smaller print and indented. Full text version of all the papers is reproduced as an appendix. Further reference to these publications will quote them by the following numbers:

> **1.** Sachs, A. (2007). Infanticidal Attachment: Symbolic and Concrete. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis, 3,* 297-304.
>
> [This paper has been reproduced: Sachs, A. (2010). Infanticidal Attachment: Symbolic and Concrete. *Interact, Journal of Trauma and Abuse Group*, *10*(1).]
>
> **2.** Sachs and Galton (eds.) (2008). *Forensic Aspects of Dissociative Identity Disorder*. London: Karnac Books.

**3.** Sachs, A. (2008a). *Introduction*. In A. Sachs & G. Galton (Eds.) (2008). *Forensic Aspects of Dissociative Identity Disorder*. London: Karnac Books.

**4.** Sachs, A. (2008b). The link between DID and Crime. In A. Sachs & G. Galton (Eds.) (2008). *Forensic Aspects of Dissociative Identity Disorder*. London: Karnac Books.

**5.** Sachs, A. (2008c /2013a). Intergenerational Transmission of Massive Trauma: the Holocaust. In J. Yellin & O. Bedouk-Epstein (Eds.) *Terror Within and Without: Attachment and Disintegration: Clinical Work on the Edge*. London: Karnac Books.

**6.** Sachs, A. (2011). As Thick as Thieves, or The Ritual Abuse Family: an Attachment Perspective on a Forensic Relationship. In V. Sinason (Ed.) *Attachment, Trauma and Multiplicity, second edition*. Hove: Brunner-Routledge.

**7.** Sachs, A. (2013b). Boundary Modification in the Treatment of People with Dissociative Disorder. *Journal of Trauma and Dissociation, (14)*2, 159-169.

[This paper has been reproduced: Sachs, A. (2013e) Boundary Modification in the Treatment of People with Dissociative Disorders: international perspective. In V. Sar, W. Middleton, & M.J. Dorahy (2013) *Global Perspectives on Dissociative Disorders: Individual and Societal Oppression*. London: Taylor & Francis.]

**8.** Sachs, A. (2013c) Still Being Hurt: The Vicious Cycle of Dissociative Disorders, Attachment and Ongoing Abuse. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis, (7)*1, 90-100.

**9.** Sachs, A. (2013d) Commentary on “Parent-child incest that extends into adulthood: A survey of international press reports” and “Ongoing

incestuous abuse during adulthood" (Middleton) *Journal of Trauma and Dissociation, (14*)5, 580-583.

Paper **1** (2007) is my first formulation of dissociative disorders in the context of the *attachment theory* 'map'. Drawing on Hesse's (1996) finding of a 'can't classify' group within the *disorganised attachment* category, this paper suggests further sub-classifications within this category, each attempting to engage an even more dysfunctional (=dangerous to the child's survival) attachment figure by 'speaking its language'. For the most severely dysfunctional attachment relationship I suggest the name *Concrete Infanticidal Attachment*. This attachment pattern is linked with dissociative disorders as a mode of survival. These ideas were formulated through the clinical picture and personal accounts of many of my patients, and were further developed in subsequent papers**.**

Following the publication of paper 1, I was commissioned to edit a book (publication **2:** Sachs, A. & Galton, G. (Eds), 2008) for Karnac's forensic series, as the forensic aspect of DID had not been hitherto much explored. Most studies of this condition focus on the internal process of dissociation as a protective reaction to unbearable events by 'disowning' them. Much less has been written on the unbearable events themselves, or the lives of the people experiencing these events. The book is a collection of papers by a range of professionals (psychotherapists, counsellors, medical doctors, academic researchers and law enforcers), describing their encounters with the forensic material which came to their attention in the course of their work with people with DID.

Papers **3** (2008a) and **4** (2008b) examine the connection between DID, crime and infanticidal attachment. Paper 3 focuses on the social isolation of the severely traumatised person, stemming from their inability to 'tell secrets' about the crimes they have endured or witnessed, and society's inability to listen to these secrets, as they portray realities we would rather not accept. Paper 4 explains the role of concrete infanticidal attachment as the link between crime (which all childhood abuse is) to deep dissociation.

Paper **5** (2008c/ 2013a) defines and explains *symbolic* infanticidal attachment in the relationship between Holocaust survivors and their offspring, and the process of intergenerational transmission of massive trauma, in cases where the parenting is traumatizing, yet entirely non-abusive.

Paper **6** (2011) analyses 'normal life' in families who practice ritual abuse (definitions in the paper), from both forensic and attachment perspectives. These families represent some of the most extreme examples of abuse and the most severe manifestations of infanticidal attachment.

Paper **7** (2013b) is a piece of quantitative research, focusing on the clinicians rather than the patients. Examining the boundaries which professionals keep when they work with this patient group, the study finds a nearly ubiquitous tendency for modifying clinical boundaries. Further papers suggest that this finding is linked with the attachment pattern typical of this patient group, namely, concrete infanticidal attachment.

The most disturbing problem in treating people with DID, however, is that some of them never get better; worse still, some of them continue to be abused, and appear to be unable to get away from their abusers even in adulthood. Despite their expressed wishes for independence and safety, and in some cases despite years in therapy, they remain as vulnerable as they have been in childhood. I call this presentation '*active DID*', that is, DID which continues to be created through fresh trauma, in contrast to people with 'stable DID', where their state is stable and therapy attempts to improve it. Papers **8** (2013c) and **9** (2013d) offer a model which explains *active DID* as a *cyclical* relationship between abuse, dissociation and concrete infanticidal attachment. Paper **9** further highlights the significance of the context in which the abuse takes place for creating the cycle.

The most widely researched and agreed upon for treatment method for DID is the 'Phase-Oriented Treatment Approach' (ISSTD, 2005, 2011; Van der Hart, Nijenhuis & Steele, 2006). This approach suggests that establishing safety and the stabilisation of symptoms (phase 1), needs to be well underway before trauma work (phase 2) could safely begin. However, people who continue to be abused can never

achieve phase 1, and their chances for recovery are thus very unpromising. The final chapter of the thesis suggests that therapy for this group should focus on facilitating the emergence of a *secondary attachment pattern,* based on *attunement* (Stern, 1985) and *empathic mirroring* (Winnicott, 1967; Kohut, 1977), to help the Self to 'spiral' and evolve, rather than endlessly 'cycle'.

It should be noted that I use the term 'Self' in its broad sense, to denote one's overall sense of identity, experience and agency.

## *Summary*

Dissociative disorders are an emerging field, with many theoretical, clinical, ethical and legal question still being debated, and new definitions continue to develop. A significant shift in the perception of DDs is evident in the change of their placement within the latest DSM (APA, 2013): while in the 1994 and 2000 editions DDs were placed next to Factitious Disorders, the 2013 edition explicitly places DDs next to Trauma and Stressor-related Disorders, "reflecting the close relationship between the two" (APA, 2013, p. 291). These two views, of the disorder being somewhat suspect (factitious) vs. it being of a traumatic origin, have been heatedly debated for nearly three decades. The prevailing current view is that DID and OSDD (formerly DDNOS) are the consequence of severe and prolonged relational (attachment) trauma and abuse. Evidence regarding other DDs is at this time inconclusive (Dorahy et al., 2014).

From the perspective of attachment theory, the worst consequence for any person's psychological development, mental health and future resilience would follow trauma inflicted, actively or passively, by a child's attachment figure(s) (De Zulueta, 1993; Freyd, 1996; Herman, 1992; Liotti, 1999; Southgate, 1996). My own thinking assumes these views.

## 2. DID in the context of attachment theory: Infanticidal attachment, symbolic and concrete[4]

Kahr, (2007); Laing, (1959); Lidz, (1973); Ross, (2004) and others link relational childhood trauma to *schizophrenia*; De Zulueta (1993); Hesse (2008); Liotti (1999) Southgate, (1996) and others link such trauma to *disorganized attachment*, and subsequently to Complex PTSD and DDs; and some (Moskowitz, 2011; Ross, 2004) talk about DID as a dissociative sub-type of schizophrenia, given the shared, trauma origin of both conditions and the presence of dissociative symptoms in both.

In this chapter I suggest that *a dividing line between the two conditions (schizophrenia and DID) could be found in their attachment patterns*, and is due to differences in specific characteristics of the attachment relationship they have each experienced.

> "Individuals with Dissociative Identity Disorder frequently report having experienced severe physical and sexual abuse, especially during childhood" (DSM-IV, 1994 p.485).
>
> Many authors have written about this link between abuse and dissociation. Schore (1994, 2003a); Davies and Frawley (1994); Van der Kolk, Weisaeth and Van der Hart (1996); Mollon (1996,1998), Wilkinson (2003) and others have written on the neurobiological process that leads from extreme trauma to dissociation, as a bodily 'shutting down' response. Ross (2000) describes a deliberate creation of DID through government-sponsored Mind-Control programmes. Ross (2004) links DID to a history of particularly severe childhood trauma, demonstrating the very high proportion of such trauma in this group in a large number of independent studies. Van der Hart, Nijenhuis and Steele (2006) coin and describe *Structural Dissociation* as the result of chronic, especially early traumatisation. Sinason (1994,

[4] This chapter includes a combined version of papers 1 and 4.

1998, 2002) and others have written about the link between trauma and dissociation from an Attachment perspective, focusing on Disorganized Attachment as the inevitable sequel of severe relational trauma.

I would like to add to this discussion by focusing on the special role that *Infanticidal Attachment* (Kahr, 2007) plays in the most severe forms of Dissociative Disorders. And as infanticide—the practice of killing infants—is amongst the worst of crimes, I would emphasise the forensic aspects of the trauma in the lives of people with DID, and the special significance of this element.

**Infanticidal Attachment**

*"Francine still believes that Daddy was trying to kill her, and that if she'd been a good girl she would have stopped breathing and died".*
*…"I just have to lie really, really quiet and still and see if I am dead later".*

*('Aahbee' in Sachs 2008b, p128)*

The words "Infanticidal attachment" are very evocative, which suggests that they are describing something that we can recognize. I would like to place this "something" in the context of attachment theory.

The term attachment is used in this paper specifically as coined by Bowlby (1958), to signify a survival instinct (not an emotional longing): the young of every species instinctively holds on, follows and acts in ways that engage the adult's attention, to maintain their close contact. It is important to note that the task of the young is not to choose an attachment figure, but to engage it. The survival of the young depends on their ability to draw the closest attentiveness from the parent that he or she has.

Some parents respond most readily to cries; some to sweetness; some respond best if baby is quiet. As the proximity and the full

engagement of a protective adult is a matter of life and death, the baby learns very quickly how best to reach it, how best to engage their own parent. The particular ways of reaching which each baby learns becomes their blue-print of relating, their enduring, usually life-long attachment pattern (also referred to as attachment style or attachment type).

Disorganised attachment is said to occur where the attachment figure's responses are random and unpredictable: where, for the same behaviour, the child may get a hug or a beating, or perhaps no response at all (as in neglect). The child is thus left in a constant, frantic, chaotic search for effective ways to engage the attachment figure.

It is my view, however, that disorganised attachment is not truly disorganised, because the parental reactions are not really random. They follow the parent's mental states and preoccupations, however dysfunctional these may be, and the baby or child does learn to find the internal logic of these reactions.

The following diagram shows sub-groups within disorganised attachment in the general context of attachment theory. Each sub-group, like all other attachment patterns, aims to engage a particular kind of parent or caregiver. The sub-groups are arranged in decreasing order of their usefulness for survival.

Hesse (1996) noted that in conducting the Adult Attachment Interview, some people, who were most similar to the category of Disorganised Attachment group, didn't exactly fit the criteria for it in that the lapses in their narratives were too extensive. He suggested a new classification which he very modestly named "cannot classify".

Liotti (1999) delineated three ways in which people with disorganised attachment may reach a semblance of attachment relationship: through an erotizing pattern, where the intensity of

erotic relationship is used as a replacement for the need for closeness; an agonistic pattern, where an aggressive grip is used in order to stay close; and through a care-giving pattern, where caring for others is used for reaching closeness.

Kahr (2007) explained that an Infanticidal Attachment pattern aims to engage an attachment figure who is deeply and constantly preoccupied with death. The language of this attachment pattern thus involves constant brushing against danger, illness or death, as these would be of most interest to such an attachment figure. Kahr includes self-harm, suicidality, frequent illness, various forms of self-destructive behaviour, some personality disorders and even schizophrenia among the expressions of infanticidal attachment.

I suggest that this attachment pattern should be named, more accurately, Symbolic Infanticidal Attachment (Sachs 2007, 2008, 2011). That is because in this pattern of relationship the harm to the child is neither directly caused nor is it intended by the parent. Instead, the harm occurs through the child's attempts to represent, for the parent, that which for the parent is most engaging, i.e. death (Green, 1986; Hollins and Sinason, 2000; Kahr, 2007)[5].

However, in some cases the infanticidal preoccupation is not symbolic, but is acted upon concretely and directly. The actual relationship of the child with the attachment figure, in these cases, includes repeated acts of abuse, torture and overt death-threats to the child. Most importantly, the deepest and most powerful engagement between the child and the attachment figure occurs during abusive acts. For this group, I've suggested the term Concrete Infanticidal Attachment.

Because the attachment figures of these children engage most deeply while hurting the child, these infants feel a reduction of

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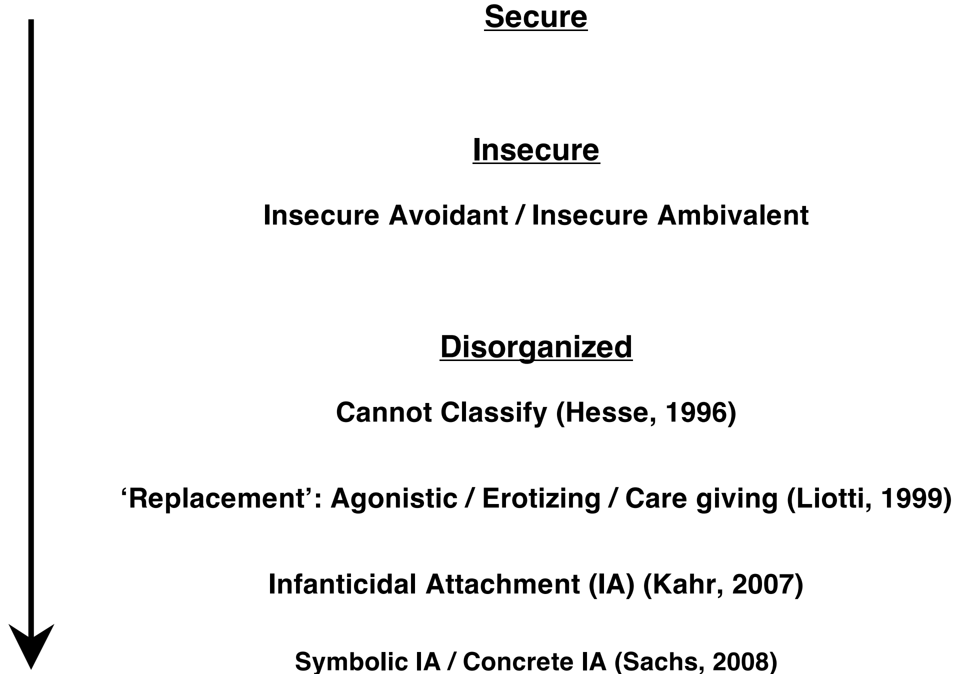
[5] Also see paper **5, appendix**

distress, the relief of feeling safe in the embrace of loving arms, at the moment in which the abuse starts. The heightened engagement of the abuser at these moments is the signal of safety, the mark of being truly connected to their attachment figure. Such a child's sense of safety is thus linked to pain, hate, sexual arousal or sadistic thrill as though it were mother's voice singing a lullaby. When distressed, this child will actively seek being hurt by the attachment figure, as this is the only way to engage it fully, and thus feel safe.

On the continuum of functionality, Concrete Infanticidal Attachment is the most dysfunctional, as it increases, rather than reduces, the risk to the child's safety or even life. As this attachment pattern does the opposite of what it is meant to do (that is, aiding survival), I suggest it should be classified as an attachment disorder.

## Attachment types in decreasing order of providing safety




**Concrete and symbolic types of Infanticidal Attachment: Clinical examples**

A child who is attached to an infanticidal caregiver experiences reduction of stress when he or she is in the proximity of a person who aims to hurt, torture or kill them. This Attachment further exposes the child to danger, with no way of abating it. It is thus dangerous, as well as traumatising. I would now like to draw a distinction between infanticidal ideation or intentions that are symbolically implied, and those that are concretely acted upon. The severity of either can vary, but, to my mind, there is a qualitative difference between them.

The following are short examples, which may illustrate the difference between symbolic and concrete parental murderousness:

***Christina***, a young woman with Schizophrenia, said she was named after Christ, because she had to die for the sins of others. She knew that she really was Christ, because she could walk through walls; in fact, she was compelled to walk through walls, explaining that if she was only allowed to do so, "peace will come to earth, and all the sins will be forgotten." Naturally, hospital staff were not in favour of this behaviour, as she had already broken her nose and a knee-cap in these attempts.

Christina was conceived when her mother had an affair with a married man. The man didn't want to leave his wife, and Christina's mother, who was Catholic, could not have an abortion. She married another man, whom she didn't love, and had a very unhappy marriage. Christina felt she really should have died, "walked through the wall" of her mother's womb, and then her mother's sin would have been "forgotten". Instead, they all lived very unhappily together.

The infanticidal ideation that the mother may well have entertained had never been acted on, but implied in a hundred ways; for one, by telling this story to Christina as soon as she reached puberty, as a warning. Also, mother never had any other children, saying that "more children would kill her". Mother and Christina were very close and "had their own (symbolic) language", having this big secret to keep. Christina's language was equally symbolic: she was Christ, because she was to die for the sin of her mother, and she had to walk through walls, i.e. not have a physical body, in order to bring peace to earth. In the therapy, much of the work was to do with me having to find the meaning of each symbol, in answer to her desperate plea for being liberated from the deadly secret.

***Emma***, by contrast, had a completely different language and a different trauma history. Aged 15, she was an extremely ill patient whose self-harm behaviour was particularly dangerous. We knew that she had been badly abused as a young child, but she never

let on any details of the abuse, the identity of the abusers and, in particular, the way in which they used to get hold of her each time. Emma communicated mostly through drawings, and a few written words. She hardly talked. In her art therapy sessions, she repeatedly produced images of many arms reaching to grab a little person who was chained to a table, and of a *key*. The art therapist and myself tried for months to follow her line of communication, expecting the arms images to be the *key* to the riddle of the people who harmed her. In other words, we understood the images of the key to have the symbolic meaning of a key, i.e. a clue. But we were wrong. Emma kept producing the same images, and to all our explorations of hidden clues she answered a definite “no”.

The breakthrough happened one day when, despairing of ever understanding, I asked Emma “was there a real key there?” She looked at me with relief, and nodded “yes”. Emma herself, under threats, had given the abusers a key for the back door of the house. It was not a symbol, but a straightforward, concrete description of the way the abuse took place.

***Jo***, a terribly thin and grubby young man, used to tell me extremely lengthy stories involving his visits to ancient Egypt, where he was the king’s hieroglyphics writer, and lived in the City of the Dead. Jo was a professional translator of eight languages when he wasn’t in psychiatric admissions, and an interpreter of dreams for the ward when he was in hospital. He repeatedly told me that I’ll get nowhere without ‘learning the secrets first’. The secrets, of course, were not about the Egyptian Royal Court but about the home that he grow up in, “the City of the Dead”, where his father, the king, didn’t want any children. Jo’s father had always maintained that he, father, “needed (Jo’s) mother more than anyone”.

Here, too, the symbolic language of hiding the truth that was used by the whole family could be seen in the highly symbolic, Schizophrenic language of Jo.

***The 'young Virginia Woolf'*** (Lidz, 1973) could serve as another example of Symbolic Infanticidal Attachment. She was a Schizophrenic patient of Lidz, and I've named her 'the young Virginia Woolf' because her mother, who adored the famous author, regularly likened her daughter to her in talent and in personality. The girl, tragically, ended up committing suicide. We may suspect that the nature of her Attachment to her mother was Infanticidal, which may have been the reason for her tragic death. The quality of the Infanticidal Attachment was symbolic: for all we know, the mother had never attempted to kill the girl or hurt her. On the contrary, she rather idealized her daughter as being of a rare literary talent and sophistication. One had to know the life (and death) story of Virginia Woolf to see the significance and intensity of the mother's message to the girl: "I'll love you best when you're dead".

***Jane***, (15) by contrast, told me a lot of stories about the pets that had died in their house, and how upset she was when the man in the pet shop, to whom she went for advice, tried to comfort her by saying that 'these things just happened'. She went on to tell me the details of how the dog bit her because he was scared, because the pet rat had bitten him; and that the pet rat was missing some toes and was bleeding.

Jane was brought to hospital in her parents' arms, near death, her bodyweight at 50% of normal- a level of starvation from which recovery is rare in medical literature. The obvious question, why did the parents wait so long before seeking help, was not answered; but it is hard to miss the infanticidal quality of such lack of action. She was not psychotic, and, I'd add, not symbolic. She was a survivor of ritual abuse, in a family where children were made to cut, kill and eat body parts of animals from an early

age, as part of their "training". Her stories about the dead and mutilated animals were not, as I first suspected, a symbolic description of her own self-hatred and death-wish. She did not want to die. She wanted someone to notice what was *actually* happening at home, hence her upset about her unsatisfactory 'consultation' with the man in the pet-shop, who attempted to comfort her by saying "these things just happen". Her refusal to eat was not due to anorexia, but to her revulsion at being forced to ingest the body parts of her pets. Her story had a partial corroboration by other family members and a social worker.

## Discussion

I suggest that what differentiates these cases from one another is that in the 'Concrete Infanticidal Attachment' group (Emma and Jane) the Infanticidal ideation was not covert, not implied, not hidden, not feared or symbolised. It was acted upon, as though there was nothing to hide or to cover. What is grossly forensic, and thus normally hidden, was simply allocated to another, 'not-me' part of the self (both in the parent and in the infant), and therefore did not need to find a complex way to be 'lived with' or integrated.

Christina, 'the young Virginia Woolf' and Joe, on the other hand, came from families who symbolised their murderous feelings, and expressed them in a way that made them almost unnoticed. The three young people that I have described similarly expressed their fears and anguish in symbolic, complex ways that made them appear rather mad, but which did not expose (even to themselves) the murderousness of their Attachment-figures.

It is my clinical experience that people with DID are remarkably literal. When they draw a baby they mean a baby, not a representation of a needy part of the self; when they say a knife they mean a knife, not a representation of danger or sexuality. When they say "I can not talk to you about these things" it is because they were 'trained' or brainwashed not to be able to

betray secrets, which made them literally not able to do so, rather than embarrassed to discuss a shameful topic. Often, when their accounts seemed totally implausible to me, I have tried to find an alternative explanation that could make sense of what they have said. Almost invariably, I have subsequently learned that the account was literal and accurate, if not complete. And the missing information was due to dissociation, either spontaneous or induced, and not to elaboration of the truth[6]. We may say that these stories are quite simple and single-layered in their meaning: Jane was afraid of being forced to actually kill her pets and eat parts of their bodies, and this is what she tried to express. Her stories about frightened, dead and mutilated animals, as well as her severe anorexia, were like a trail of breadcrumbs leading to the truth: whispered, but not symbolised.

Conversely, the Symbolic type of Infanticidal Attachment produces "nameless dread" (Bion, 1967). Because the reason for the fear, namely, the Infanticidal Intention of the caregiver was covert, hidden, symbolised – the dread was detached from its "name", from its cause. Joe was terrified of a King in the City of the Dead, not of Dad. Lidz's (1973) patient, if the analysis is correct, went to the $n^{th}$ degree in trying to appease her infanticidal mother, who loved Virginia Woolf. None of the infanticidal ideation or wishes were directly expressed. Subsequently, all the terror got expressed by the child (and later, the adult) in that same covert, hidden, symbolic way, which protected everyone from knowing about the parental murderousness.

Making the distinction between the symbolic to the concrete may help our understanding of dissociation on the Attachment map, but it has another, far more uncomfortable aspect. It states a difference between the tragic damage done to a child through their Attachment to a person with infanticidal ideation (symbolic

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[6] Some 'elaboration of the truth' does occur in people with DID, as they try to construct plausible stories to fill in the (dissociative) gaps in their memories. It is for this reason that such accounts need to be considered carefully.

type), to the criminal damage done to a child through their Attachment to a person or a group who openly act in a murderous way (concrete type). For the therapist, this represents an almost unknown level of new challenge, as the forensic becomes a centrepiece in the therapeutic process.

## 3. DID, an uncomfortable diagnosis[7]

In 2007, following the publication of my paper *Infanticidal Attachment: Symbolic and Concrete* (chapter 2), I was invited to edit a book on DID for the Forensic Series of Karnac Books. Through my work as a psychotherapist within a multidisciplinary team in a long-stay psychiatric hospital, and later at the Clinic for Dissociative Studies, I was aware of the overlap between my dissociative patients' internal (dissociative) process and their shocking history of childhood abuse. This overlap has been noted extensively (Davies and Frawly, 1994; Bromberg, 1995; Chu, 2011; Herman, 1992; Kluft, 1984; Ferenczi, 1949; Bowlby, 1988; Freyd, 1996; Ross, 2000, 2004 2007; Sachs, 2007, 2008a, 2011, 2013b; Sachs & Galton, 2008; Stein, 2007; Salter, 2013 Schore, 1994, 2003a; Van der Kolk, Weisaeth and Van der Hart, 1996; Wilkinson, 2003; Van der Hart, Nijenhuis and Steel, 2006; Liotti, 1999; Southgate, 1996; Sinason, 2002).

The DSM-IV (1994) observes: "Individuals with Dissociative Identity Disorder frequently report having experienced severe physical and sexual abuse, especially during childhood" (p. 485).

Ross (2004, p.114) states plainly:

> " in clinical practice, I have never seen an inpatient case of DID in a person who did not experience a profoundly disturbed and traumatic childhood. Nor have I ever heard such a case described clinically, at a conference presentation, or in the written literature."

My own clinical experience fully concurs with Ross's (even omitting the word 'inpatient'). Moreover, in order to reach further than the circle of my own patients, colleagues and supervisees, I have also posted an enquiry on two international professional list-serves which focus on working with DID (7.3.2014):

> Dear all,
>
> I wonder if any of you could point out to me any properly documented cases of

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[7] This chapter refers to publication 2 and includes an edited version of paper 3.

> DID which are *not* trauma based, or perhaps trauma based but not *abuse* based. My own clinical experience is only with overt abuse.
> I'm writing my PhD at the moment, and would like to be able to demonstrate a spread of DID histories.
> With thanks,
> Adah

Of all the responses that I have received, not a single one reported a case where DID was not linked to a reported history of severe and prolonged childhood abuse.

Nevertheless, the controversy regarding the link between trauma, abuse and dissociative disorders is fierce. Some of this controversy is to do with the questionable reliability of memory regarding abuse which is reported to have occurred in childhood, especially in reports by dissociative patients (Sinason, 1998; Mollon, 1998; Sandler and Fonagy, 1997). It has also been noted that an overlap does not prove a causative relationship. Ross (2007, 2013) discusses at length the controversy regarding the aetiology of DID. While agreeing that a link between two phenomena does not prove a causative relationship between them, he argues that there are clinically convincing reasoning for the view that DID is trauma based, and none to the contrary.

It is interesting to note that a very similar discussion was topical in the mental health field regarding the possible effects or even existence of domestic child abuse, some 30 years ago. Bowlby notes:

> " at least… some states of amnesia, both minor and major, including cases of multiple personality, can be shown… to be the outcome of such experiences [described in his "violence in the family"]. Why then has [research of this] been so woefully neglected? One adverse influence… is the strong tradition within the psychoanalytic school… focusing attention on fantasy and away from real-life experiences… during childhood. …. Even the fact that some children are physically or sexually assaulted by their own parents, often repeatedly and over long periods, has been missing from discussions of causal factors in psychiatry" (Bowlby, 1988, p.112).

While the recognition of domestic child abuse is now commonplace, there is still a great deal of reluctance to accept the far reaching damage that we see in people with DID and link it to what they had suffered in their childhood. My introduction to Forensic Aspects of DID (paper 3) considers some of the causes for this reluctance. As well as the influence of psychoanalytic principles (mentioned by Bowlby), the paper also notes the problem of the uncertainty which the therapist (and other professionals) feel about the truthfulness of such strange, sometimes extreme, and mostly unproven accounts of crime.

The following is an example of an incident in the life of a DID patient of mine, whom I named Sam. It has been pieced together from accounts of several of her alters, over a few years; and it is related here with her permission.

***Sam***

*Kim distracted everyone's attention by starting a family row. While a dozen people were shouting at each other, she sneaked out of the house, taking her younger sister, Polly, with her. Once on the train, she rang John: "I'm on the train, John! I can't wait to see you and the baby." Polly, now realizing that they were going to meet John, was horrified. She tried to object: John was a very dangerous man, he had hurt them badly in the Past. Kim told her to shut up and mind her own business.*

*Kim and John, her cousin, were married as children. It was like a Romeo and Juliet story, Kim told me: they loved each other, and had a baby when she was 12. But then there was some serious feud between their families, and she and John were torn apart. John's parents, her aunt and uncle, ended up raising the baby. Kim was now 39. Her baby, that she was about to meet for the first time since he was two years old, was 27.*

*Two hours later, with Polly still frantically bagging Kim to turn back, they stepped out of the station. A blue van waited for them right in front of the exit, and a man's voice that Kim recognised shouted, 'Get in, quick, he is waiting for you'. Three men*

*helped them in, shut the doors and drove off. The small space reeked of garlic, alcohol and sweat. Kim looked around: No John. No baby. She went numb after that. Next to her, Polly was being brutally raped by the three men.*

*They were let out of the van in an unfamiliar street. Lea, beside herself with worry when she realised they were gone, had found them there: Polly dishevelled, shaking and crying, Kim silent and pale. Lea phoned me up in panic, and we spent the next two hours on the phone, while I directed her through bus lines and trains on her way home. As well as being upset, Lea was worried about how to tell the story to the family: "they can be very funny about things, you know, with beatings and punishments and you know, I don't want no one hurt". We agreed that she should settle the girls first, help them change and put all their clothes into a plastic bag to take it to the police, before talking to the rest of the family.*

*When they arrived home, they received a very mixed reaction from the family: some were furious with Kim for taking such a risk. Some never noticed that the girls were gone, and didn't believe any of it. Some didn't want to hear Lea's story. Some were deeply upset, one felt suicidal because it reminded her of her own history. Kim herself, sniggering, went to have a bath: She couldn't stand all this fuss over her private affairs. Someone else - I don't know who - took the plastic bag with the clothes and washed everything. Polly was too distraught to talk to anyone. She had a bleach bath, because she felt dirty. The next morning, at Lea's insistence, Polly went to see the GP, because she was in so much pain. The GP said that Polly had grazes and bruises around her genitals, ribs, ankles and wrists, but having washed herself with bleach, no other signs of rape could be found.*

*And was there a rape?*

*Sam is a woman with DID. She has over 90 alters, including Kim, Polly and Lea. They all share one body. Kim maintains that it is her body, and that she was never raped. Polly believes that the body is hers, and that she was. Lea believes Polly, but she wasn't there when it happened so she can't testify. The 'main person', Sam, knew nothing of the whole affair: she was at home, ironing. It is impossible for her*

*- or for any other person - to be able to say with certainty what exactly had happened on that day.*

It is my impression that the frequently reported-but-unproven allegations of extremely serious and often bizarre crimes are a major stumbling block in the work with DID patients, as they place the therapist in a sharp conflict between believing and not believing their patient. It focuses the mind on proof, belief and probabilities, the tools of a judge, instead of on listening and thinking together, the tools of a therapist. This shift from the normal therapeutic stance is very uncomfortable, and many therapists attempt for years to by-pass the forensic material which is brought to their session, so as to be able to avoid the conflict. In my opinion, however, such attempts are not useful, as with this population the forensic material is a central feature of the patient existence, and avoiding it means avoiding real contact with the patient. I shall return to this point in the last chapter, *attachment as a second language.*

*Forensic Aspects of DID* aimed to highlight the centrality and psychological significance of crime in the lives of people with DID. As well as the devastating impact of the abuse itself, it points out, there is additional damage caused by an upbringing in the shadow of criminal activity (which all child abuse is), with its resulting secrecy, lies and alienation from the rest of society.

The papers in the book were written by mental health practitioners, lawyers, law enforcers, medical doctors and social workers, as well as by people with DID. Crime, lies, secrets and a subsequent great deal of confusion featured in all of them.

The following is part of the introduction to the book (paper 3).

> Lily, 13, was the sweetest girl you can imagine. Big blue eyes, a lovely, soft smile, and a gentle voice. She was admitted following a massive overdose, as well as repeated episodes of head banging. At the time of her admission her forehead was so hugely swollen that she looked quite deformed. She appeared insightful regarding some school problems she had and was

generally charming and warm, showing every sign of being a normal "troubled adolescent". That was rather at odds with the level of her self-harm and with our knowledge of severe abuse in her history. Lily, I might add, had always maintained that "nothing bad had ever happened to her".

On her second session, Lily came wearing her hair in pigtails and holding her teddy, which made her look about 6 or 7 years old. Still at the door, she asked me sweetly if I'd look after her teddy for her. I asked if she felt that he needed help, too, and she said that we were all making a mistake: he was the one "in danger"; she was fine. At that, she sat on the floor, carefully placing the teddy on the patient's chair. After a moment of silence, she said she was very worried about him; he would die if he wasn't watched. I asked what did she fear may happen to him. To my shock, her sweet little face suddenly became white and contorted, and in a monstrous, croaking voice that sounded like it came straight from The Exorcist, she roared: "I–I–I–I will kill him!"

Now who is "I", and where does it live: in the teddy, which she had put on the patient's chair? In her harmed body? In the contorted faces of her abusers, who were suddenly visible on her own face? Or perhaps in that Lily she had told me about, the one whom "nothing bad had ever happened to"?

For Lily was actually many "Lily's", who were largely unaware of each other. Most of them were very distressed in different ways, but one of them was a bright and lovely girl, with some minor difficulties at school, who was completely baffled by her strangely swollen forehead and had no idea why she was in a hospital at all.

One night, with great consternation and rather shakily, a white-faced Lily told the ward nurses that she had murdered her sister. She was then sick and couldn't go back to sleep for a long time. The incident was recorded as an "hallucination". But was it? She had never hallucinated before and did not again, to my

knowledge, after that night. In a session she had with me some days later, she alluded again to that murder, adding her sister's name.

I was haunted by questions: Was it a phantasy? What does such phantasy mean? Did it express her secret wish to be rid of her sister? But her record showed that she was an only child. Did her mother know about these thoughts? Did the family therapist understand any more? Could it—could it possibly be true? Did I have a duty to report it? To whom? What would happen if it were true, and I treated it as a symbolic expression? And what if it was the opposite? Should I become Sherlock Holmes and try to investigate? What would happen to the therapeutic relationships? To the mother? To the girl? What would happen to me? Could I be prosecuted for withholding information about a serious crime? For disclosing confidential material? For wasting police time? For being stupid?

One of the most uncomfortable aspects of offering therapy to people with dissociative identity disorder (DID) is that, sooner or later, most of them begin to talk about horrendous crimes. Crimes that were committed against them, crimes that they have witnessed, or crimes that they have been made to commit or have deliberately committed themselves. The crimes that they describe are always shocking. They sound unlikely, mad, impossible. Almost always they are unproven, and there are so many bits missing in these stories that one can hardly think how they can ever be proven, or proven wrong.

Dissociative identity disorder (formerly known as multiple personality disorder) is a baffling, confusing and seemingly bizarre condition. Although DID is a formal DSM–IV diagnosis, it is controversial, and many professionals hold the view that it is extremely rare, doesn't exist at all, or is factitious (pretended).

There is, on the whole, a fair interest in the "mechanism" of dissociation, which is quite fascinating. Much less interest is

usually found in the background to DID. Similarly, there is much more openness among therapists to techniques of "grounding" the traumatized person than there is to listening and bearing witness to a traumatic history. This is rather at odds with the normal therapeutic stance, which is that listening to and understanding the history of a patient are prerequisites to any helpful therapeutic process. I would like to highlight here the rather obvious fact that therapists, while aiming to help, are aided by—and hampered by—their own emotional and mental scope, not least by their capacity to hear evil.

Furthermore, therapists are generally interested in and are trained to delve deeply into the internal processes of the psyche. Our consulting room is deemed best used as a place for thinking, feeling, and reflecting, and what we normally hope for is an internal development or transformation. Being called upon to respond to serious, sometimes ongoing crimes is not usually our area of interest, training, skill, or competence. It forces our attention outwards rather than inwards. We become worried about our own responsibility for what was—or is—being done to, or by, our patient. We feel unsure whether what we hear is an internal, psychological process or whether it is in the external reality of the person. We get caught up in trying to figure out "what really happened" and in doubts about the truthfulness of the narratives that we hear. We feel guilty and anxious when we don't believe the person's story—and perhaps even more guilty and anxious when we do believe it, as this may mean that we should be doing something of which we aren't sure. Not to mention the anxieties about being simply wrong, misled, taken in. Of all the forensic stories that one may hear in the consulting room, the ones told by people with DID are probably the most unbelievable, the most shockingly grotesque, and the least corroborated. It is not surprising that these accounts are met with a great deal of suspicion and often outright hostility; and the field of trauma is marred by fierce political debates, aggressive legal

battles (e.g., regarding false memories), and bitter professional disagreements, as if in resonance with the violent nature of the clinical material.

Whether one is a therapist, a police officer, a clergyman, a GP or a lawyer, listening to accounts of people with DID is confusing, owing to the multiplicity of speakers and all the contradictions that arise from that. A person may relate an event, while another alter of that same person completely denies it, has a different version of what happened, or is shocked at the fact that you ask questions about a subject that she or he had never told you about and is a secret.

But perhaps even more than the minefield created by multiplicity and dissociation, DID is hard to engage with because of the traumatic content of the accounts and the unnerving, unproven claims about terrible crimes. These create an overall sense of a looming pitfall which one is constantly on the verge of, while grappling with difficult clinical, ethical, moral, and legal questions. Subsequently, psychotherapists are often very reluctant to work with this group of patients.

I'll return to my young patient, Lily.

Sadly, at the time that I attempted to treat her, I knew very little about dissociation, and I was of very little help to her. I did not ask more about her sister, nor did I think that there might be other alters, inside Lily, who knew about things that she didn't know, or that could explain things that she was not allowed to talk about. Through several years of psychiatric admission, most of which were spent in intensive care, locked units, Lily had never been assessed for having a dissociative disorder of any kind. She had an array of other diagnoses and a poor treatment outcome. Her tormented world remained intact, unreachable, untouched by any understanding.

> Dissociative identity disorder is considered to be very difficult to treat. In looking at the forensic side of this disorder, I hope to highlight what, to my mind, makes it so difficult: the terror, the secrets, and the defensive (or protective) chasm between the traumatized person and all those who have not been tortured. I believe that reaching across this chasm is the true work of integration.

### *Further comments*

When I wrote this paper, six years ago, I held the view that the most difficult aspects of working with DID was its grossly traumatic and mostly uncorroborated background. The exposure to traumatizing material, combined with the difficulty in bringing to supervision uncorroborated material which the supervisor may not believe (and indeed, in which the therapist has doubts), mirrors the condition of the survivor of trauma who faces disbelief, potential ridicule and subsequent isolation, all of which deepen the impact of trauma. I believe that material which is both traumatic and uncorroborated is thus particularly noxious, and greatly increases the risk of vicarious traumatisation to the therapist, due to the intensified connection between the therapist and the mirrored patient.[8]

There is now, thankfully, a growing body of research that corroborates the presence of severe childhood abuse in DID (Kluft, 1984, 1999; Freyd, 1996; Ross, 2000, 2004 2007; Stein, 2007; Salter, 2013; Lewis et al., 1997; Middleton, 2013a, 2013b). There is also strong evidence that, far from malingering, people with DID tend to under-report their abuse histories, as dissociation makes much of their memories unavailable to them. Lewis et al. (1997) demonstrate this in 12 cases of convicted

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[8] The key point is the intensified identification with the traumatised patient. A similar effect occurs in trauma therapists who have a history of trauma in their own lives, owing to the factor of increased identification with their patients. A number of studies confirm that these therapists are at a higher risk of ‘burn out’, ‘compassion fatigue’ or secondary traumatisation, (Follette, Polusny & Milbeck, 1995; Baird & Kracen, 2006; Pearlman, Mac & Paula, 1995).

murderers. None of the 12 had attempted to use their DID as a defence; indeed, they were unaware of having DID, as well as of their (proven) childhood abuse.

As Lewis et al. (1997) correctly point out, however, neither corroboration nor proof is normally available to the single clinician sitting with a patient who discloses extreme levels of childhood abuse. The traumatic experience of holding such material is indeed still a common difficulty for therapists in this field.

However, based on the large number of therapists which I have supervised since, I now consider that even more than the traumatic past which people with DID report, therapists get disheartened or 'burnt out' by repeated incidents of fresh trauma, and the therapist's inability to make these stop.

The next two chapters explore the forces which keep some people with DID unable to extricate themselves from a life of on-going abuse. These forces do not operate in every case of DID: chapter 6 will make a distinction between two presentations of DID, one in which abuse has stopped and another in which abuse is on-going.

# 4. As thick as thieves, or the ritual abuse Family: an attachment perspective on a forensic relationship[9]

## *Note on the definition of Ritual Abuse:*

Out of the many definitions of this term (Miller, 2012; Noblitt & Noblitt, 2008, Sinason, 2011) I chose to use the one published on the website of *Survivorship,* an organisation supporting survivors of ritual abuse:

> *"(Ritual abuse is) Repeated, extreme, sadistic abuse, especially of children, within a group setting. The group's ideology is used to justify the abuse, and the abuse is used to teach the group's ideology. The activities are kept secret from society at large, as they violate norms and laws". (Survivorship, 2014).*

In my own clinical experience, this definition fits the experience that some DID patients report in their therapy. Out of the ones describing such abuse, many (but not all) state that the 'group' within which they were abused included at least some of their family members. The following paper analyses the impact of Ritual Abuse (RA) practiced within a family on the attachment pattern of family members, and the pathway between family-RA to DID. The paper then begins to reflect on the implications of this analysis for the practice of therapy.

> In this chapter, I'd like to look at Ritual Abuse-produced DID in the context of family life, rather than the context of an individual predicament or a societal problem. And that is because, in my view, the family aspect of Ritual Abuse-produced DID is one of the most powerful elements in creating it, maintaining it, and, potentially, in healing from it.
>
> The largest-to-date survey on extreme abuse (Becker et. al. in Sachs and Galton, 2008), the EAS, recorded the responses of over 2,000 survivors and professionals to a lengthy

[9] The chapter is an edited version of paper 6.

questionnaire. In that survey, 84% of people who had a diagnosis of DID reported some form of extreme abuse: various forms of torture, multiple rapes, incest, forced abortions, forced perpetration of torture and murder and others. Obviously, all of these are serious crimes. In the cases of RA families, however, these are not seen as 'wrong': They take place regularly between family members, as part of the ongoing family relationship and belief system. We may call it *a forensic family relationship*: a family relationship that is based on committing serious crimes against each other.

Remarkably, perhaps, these families are very tightly knit. The expression, 'As thick as thieves', is particularly apt, describing the particularly strong bonds as well as the forensic content of the relationship.

The person from such background who comes to therapy usually starts by stating that, more than anything, she or he wants to be free of these forensic relationships. But this appears to be the hardest thing to do. Something pulls them back, time after time, right into the arms of the people who would hurt them, or force them to hurt others.

This distressing (for therapist and patient alike) 'pull to return' to the abusive group or family has been explained in different ways: as "programming", as an expression of terrorised subordination or as being manipulated or 'tricked'. I would prefer to describe it as a vicious cycle, in which DID and RA support each other:

- DID is created and then maintained through RA (continual abuse and torture)

- The existence of DID then allows further crimes to be committed, by

  - alters who are cult-loyal

- alters who are too young, weak or frightened to resist family demands for compliance or perpetration
- alters who are sadistic
- alters who can't remember any torture, and thus feel safe and trusting in the family
- alters who remember, but can't talk.

- The trauma caused by continual involvement in these crimes necessitates further use of dissociation, thus enhances the DID.

In addition to these explanations, however, I would like to suggest that people who are unable to free themselves from a relationship that is based on extreme abuse should be understood as occupying the most dysfunctional of attachment classification, *Concrete Infanticidal Attachment* (chapter 2).

The following is a clinical example of such family relationship.

***Bella***

*At the end of her long working day, wishing she could just go home and put her feet up, Bella, aged 35, drove down to her Grandmother's house. It was her uncle's 70th birthday, and she was expected to be there. She was his eldest niece, and she was going to hand him his present. Bella never liked her uncle or her grandmother: "they somehow scare me, I don't know why". She hated her grandmother's house: "it is a weird place. Not exactly dark, but very big, formal and unpleasant. You can't laugh there". But a family occasion prevailed, and she went. It was a big event, and, still on the drive, she could hear music and see the white vans of the caterers. Looking at the vans, she suddenly felt a cold wave of sickness and terror, and an almost unbearable urge to turn back and go home. But the next moment the feeling passed, and she knew that she was going to the party. She thought of how much she looked forward to meeting her little nephews and nieces. They would all be there, no doubt, she*

*thought. Inexplicably, the thought of them only made her feel worse.*

*She remembers parking her car near the large house, next to one of the stone lions that guarded the gate. She remembers getting out of the car, picking up the birthday card and the present that were on the back seat. She remembers walking up the gravel path to the front door, and reaching her hand to the doorbell.*

*Sometime later, she was in her car, driving in the dark. She had no idea where she was. Her body felt numb; she could see large stains on her dress, and she smelt sweat and smoke and something else. Her mobile phone was ringing.*

*It was her husband, worried, as it was so late. Rather cheerfully, she said that she was on her way home, and reminded him that she had to go to the birthday party. 'How was it?' he asked. 'Oh, fine; you know them, a bit stiff and tedious', she said. It really is late - don't wait for me, darling, I'll just have a bath and a cold drink when I get home, and I'll sleep downstairs, I know you have an early start tomorrow.'*

*The next day, Bella wasn't there at the start of her session. Instead, I met Little Bellina. She was in a lot of pain, but had no idea why. She was at a party, she said, and she played with the pets and the other children in the garden, and uncle gave her some presents, and played hide-and-seek with her. 'He always wins, he always finds me!' she said in childish disappointment. Then she added that she got very scared when the dogs came, and she hid in the dark.*

*Then Sylvie, another alter, said she just loves uncle. She gave him his present, and a kiss, because she loves him so much - she's always been his favourite, since childhood, and used to go and stay in his house on school holidays.*

*Rebecca couldn't speak. She looked at me imploringly, until I asked 'were you hurt?' and she nodded, yes.*

*Alice, shaking, then sat on the floor by my feet and silently offered me her wrists to handcuff.*

*Evan drew a picture of a large, white van, and whispered that he didn't want to go inside it.*

*Someone I didn't recognise started to retch in the corner of the room, crawling on all fours.*

*Bella suddenly looked at me, very puzzled. 'I can't remember a thing about that party last night. I got an e-mail from my uncle this morning, thanking me for his lovely present, so I must have given it to him. He's always polite.'*

Clearly, that party was not a benign, if somewhat tedious family occasion. The accounts of the different alters reveal a very different story: Bella was very apprehensive about attending, and, disturbingly, the knowledge that her beloved little nephews would be at the party had made her feel worse, rather than better. Her last memory was reaching for the door bell; then she switched- perhaps into Sylvie who loves her uncle, or into little Bellina, who played hide-and-seek with him and with the other children, and disappeared when the dogs joined the party. At some point Evan was pushed into the white van. Alice's wrists got tied. And Rebecca, always mute, was hurt.

And what about Bella?

Bella knows that some terrible things happen on these family occasions. She has some memories of herself being hurt, and flashbacks of abuse done to faceless children. Her greatest dread is that she herself, or one of her alters, unbeknown to her, has also perpetrated these acts. Although she loves her husband, she has frequent episodes of sex with other people, and she can't bear the idea of having children. And for days,

before each family occasion, she is in a state of terror. What brought her to therapy was the tormenting questions “I don’t know how it is that I’m always back there’. Three years into her therapy, she is starting to realise, with enormous trepidation, the intensity of her attachment relationship with her family. She starts to notice how, whenever she is really scared (e.g., prior to family functions), she ‘absolutely must go home’.

**As thick as thieves**

The expression “as thick as thieves” points to the strong links between people who are engaged in criminal activity together. The attachment connection is readily seen: the danger that faces all the thieves together, should one of them give the others away; the identification of all ‘outsiders’ as ‘the enemy’; the need to seek security with each other as the only possible attachment figures, when fear runs high.

In a family where normal behaviour patterns involve ‘thieving’, that is, criminal acts, the bonds of dependency are stronger than in families where the outside world is more-or-less in harmony with their values. This is not to say that they love each other more; rather, that they have to rely on each other with greater intensity. The adults have to rely on children’s ability to keep a secret. The children have to rely on the adults to not actually kill them. Everyone needs to rely on everyone else to stay ‘in’ with the group, cult or family, so that nobody loses their attachment figure.

The ubiquitous practice of incest in RA families, and the common reality of not being raised by one’s real parents, and often not even knowing who they are, further enhances a sense of a ‘tribal’ bond of attachment. The whole group is, so to speak, ‘in one boat’. And if this boat is a pirate ship on the high seas, the need for total loyalty is paramount, for everyone’s survival. In families in which terror is a constant state, the intensity of attachment behaviour is, therefore, the highest.

On the scale of usefulness for survival, *concrete infanticidal attachment* is the lowest, and attachment needs are thus the highest: the greater the fear, the greater is the need for the attachment figure. Where fear is extreme and almost constant, one is permanently and frantically seeking to be near the attachment figure, which is the extended RA family.

This, in my view, is what makes any attempts to leave an RA family so near impossible. Paradoxically, leaving the abusers goes against the most basic survival instinct, which we call attachment.

The ability to separate, the wish to explore reality and the world, the capacity to build a solid sense of self and independence all require a state of safety, where attachment needs and attachment behaviour are not called upon too frequently. In other words, as close as possible to a secure attachment. It is only in the gaps between the moments of attachment cries that we can look out, to see the world, and look inside, to see ourselves.

**Implications for therapy**

Therapy for survivors of extreme abuse is notoriously difficult, for both therapists and survivors. The difficulty is further compounded by lack of theoretical thinking to support the clinical work. This often leaves professionals in a defensive position regarding their clinical choices.

Based on the idea that the main damage to RA survivors is the corruption of their attachment system into a concretely infanticidal one, my suggestion is that the therapy should aim to foster the development of a 'secondary attachment pattern', one that would be higher on the scale of usefulness to survival.

Attachment patterns are enduring structures. Indeed, the research around the Adult Attachment Interview (Main, Kaplan and Cassidy 1985; Fonagy et al., 1991) shows that 70%-80% of

children have the same attachment pattern as their parents. But it also shows that there are at least 20% who break away from their original pattern.

Given that attachment patterns are based on the actual relationship with the attachment figure, it appears that the most likely opportunity to change them would be through the creation of a new attachment figure, who may respond to, and thus evoke, a new attachment behaviour.

But in order to 'qualify' as an attachment figure, not just a positive presence, one must be a rescuer at the time of the greatest distress.

Unfortunately, abusers are very well placed for becoming attachment figures: the person who inflicts torture, simply by stopping the hurt, becomes the person who helps. Obviously, the therapist cannot resort to perpetration of abuse; and the therapy relationship can never mimic the level of need and life-and-death dependency of the victim of torture towards an abuser.

The only way by which the therapist can, ethically, become a new attachment figure is by offering help at the moments of real danger. And it is my impression, through all my conversations with colleagues and supervisees, that most therapists in this field tend to do exactly that, instinctively. But they then feel very uncomfortable with being so far out of the usual therapy boundaries, with no theoretical framework with which to explain these choices.

I suggest that the therapeutic aim of helping to create a new attachment language, which can only be reached through becoming, for the duration of the therapy, an attachment figure, is the theoretical reason for offering as far-reaching support as any therapist can personally manage.

The advantages of practicing within this approach, and the problems of doing so will be discussed further papers. The following is a small example.

**'Wait with me'**

Carla was at home. It was Good Friday, and she was feeling very agitated and quite unwell. We were talking on the phone, as we did every Friday afternoon, but then she said to me, in a rather formal tone, "Excuse me, I can't go on talking now, I'm in a bit of a hurry. Would you please call me tomorrow?" and hung up the phone. Concerned, I called her mobile phone. The same polite, impersonal voice said: "I have explained, haven't I, that I really do need to go now". "Could you tell me where you are going?" I asked. "Ah - no, not really" came the answer.

I could hear the noises of driving, and said, rather clumsily, "I can hear the car, are you going somewhere nice?" to which she said, "I don't know".

I could hear her getting out of the car.

"Where are you now?" I asked. "Ah - at the train station" she said. "I'm just sitting down, if you must know". "Waiting for a train?" I asked. "I don't know", she said. "Just waiting".

"Could you just go back?" I asked, desperately. "I'm afraid that something bad may happen, if you stay there. You can drive back home, now, and no one would get hurt!"

"Oh, no, I can't do that" she said, in a measured voice. "I must be here, at the station. Waiting".

"Well', I said, my heart sinking, "if you are waiting there, would you like me to wait with you?"

There was silence. Finally, in a whisper, she said, "Yes, if you like".

> We waited together. Some minutes later, I could hear a train coming into the station. An older woman's voice said, "Hello, Irma" and the line went dead.
>
> I felt sick. It was like I was watching someone taken to the gallows. And there was nothing more I could do.
>
> I couldn't stop Carla from going to the station, where she was to be met by someone who took her for an Easter ceremony. But Irma, an alter who had never talked to anyone before, had let me wait with her, and took some comfort from not waiting alone. From that day, she had a friend.
>
> In subsequent months, she became the main agent of change in her internal system. She took risks in speaking to me, to the police, to her GP; and, some years later, she was the first one who dared **not** to go to a ceremony. Because in that terrible pre-abuse half-hour, I was with her; and, knowing full well that there was not going to be a happy end to this waiting, I waited with her. That shared wait was the birth of a new attachment pattern, and the start of her healing.

## *Further comments*

This paper started to look at the way in which people can be locked into an inextricable bind, through the intense relationship between the abused and the abuser: this attachment relationship inevitably leads into further harm. This idea will be elaborated in the next chapter.

It also started to look at what is, in my view, a critical therapeutic issue: the need for the therapist to become an attachment figure for the patient, in order to facilitate the development of a healthier attachment pattern. This topic will be discussed in depth in chapter 8. For the moment, however, I'd like to highlight the particularly controversial issue of modification of professional boundaries (for full discussion, see paper 7, appendix). This issue is inextricably linked with becoming an attachment figure, as my earlier statement puts it: "the therapeutic aim of helping to

create a new attachment language, which can only be reached through becoming, for the duration of the therapy, an attachment figure, is the theoretical reason for offering as far-reaching support as any therapist can personally manage".

By way of illustration, the clinical example above ("Carla") includes a list of actions which are very different from my normal professional boundaries: having a regular phone call with a patient; calling her after she said she didn't want to talk; staying on the line for half an hour listening to her actions; trying to 'tell her what to do'. More of these examples can be seen in the case of "Sam" (chapter 3), where I spent two hours on the phone, directing them back home. While in these examples the impact of my actions proved to be beneficial to the patient's development of safety and trust, such may not always be the case. In particular, creating expectations which could not be fulfilled, or making the patient feel that their privacy is intruded upon can be very harmful. My well-meaning offer of a Friday call to a patient who was particularly vulnerable on that day ended up causing a setback, when I once had to cancel it; and a therapist who hugged a crying child alter in a session was deemed to be an abuser when an adult woman alter appeared, and found herself hugged by her male therapist. Such actions thus must be very well considered. Indeed, secure attachment can only be formed where the attachment figure is consistently thoughtful regarding the needs of the child.

# 5. Still being hurt: the cyclical model

## The Vicious Cycle of Dissociative Disorders, Attachment and Ongoing Abuse[10]

One of the most disheartening discoveries that a therapist can make in working with people with DID is that their invariably traumatic childhood histories are, sometimes, not confined to their past. For some people with dissociative disorders, severe abuse continues into their adult life, into the present, into the gaps between their therapy sessions; and it appears extremely resistant to change, despite the person's and the therapist's best efforts.

In this paper, I will describe the relationship between dissociative disorders, on-going abuse and attachment as a vicious cycle, in which each of these three elements perpetuates the cycle. People who are thus caught up may find it extremely difficult to break free from a lifetime of abuse and to get better.

***Rona***

On her birthday, Rona arrived to her session late, and completely drunk. This had never happened before: she came in reeking of alcohol, giggling and humming a song. With her step unsteady and her speech slurred, she explained to me: 'I met some people at the station, and we had a loooovely time together. I'm sure you can understand!' At which point she winked at me, like we shared a little secret together.

Rona, a woman with DID, is a fifty-year old professional. She is tall, slim, always immaculately dressed and perfectly spoken. My face must have betrayed how taken a back I was, for suddenly she looked down, and when she looked up again there was no trace of the drunk Rona, other than the smell. Instead, I saw a serious, tight-lipped woman, who shook her head disapprovingly

[10] This is an edited version of paper 8

and said in a cut-glass, elderly voice: 'Alice should not have spoken this way. Rona had met her brother and cousins at the station. They all wished to congratulate her on her birthday. Naturally, they spent some time together.' Lea, a teenage alter, then whispered to me, 'the old bitch got us drunk. Rona 's brother took us to the men's loos at the back of the pub. I didn't look'. Liam, a teenage boy alter of Rona, was very drunk and clearly enjoying himself He said he loooooved playing with his big cousins- they are so naughty! 'They always hide in toilets and lock the door, and it is so funny when other men want to use the loos but can't get in'. Another alter, Maria, sobbing, said she'd been raped by a group of men she'd never met before. She'd tried to call the police, she said, but her mobile phone was stolen. The older woman was back for a minute, hissed 'oh stop this nonsense!' and then Rona was there, looking pale. She said she'd had a birthday card from her brother the day before; and she doesn't know what happened after that. She now felt sick and sore, and was wondering about the alcohol smell in the room. Her face suddenly ashen, she looked up at me: 'do you think...?' she started.

Rona had an extremely traumatic childhood, and she now has a diagnosis of DID. She has a large number of alters, of all ages and both genders. Some of these alters felt that the birthday card from Rona's brother, which included an invitation to lunch, was a lovely treat, and were happy to accept the invitation. The alters who hated and feared him were 'not around' as Rona, apparently willingly, went to meet him at a pub near my practice. This meeting had ended up in the men's toilets, with Rona having sex - or being raped, depending on the point of view - by her brother and her cousins.

It is important to note that the older woman, who is an alter modelled after Rona's grandmother, treated the incident with respect and dignity: "naturally, they spent some time together." In her eyes, there was nothing unnatural or wrong about what

happened, and the alter 'Alice' was simply rude. In her words, "Alice should not have spoken in this way".

Rona, however, feels very differently. Coming from a multi-generational, ritual abuse family, she calls her grandmother 'a witch'; and her alters described witnessing 'the witch' cruelly abusing children, animals, adults and sometimes Rona herself. As for her brother, the very notion that she might have a sexual relationship with him is completely abhorrent to her.

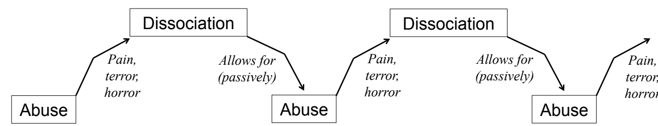
Yet on every family occasion, every holiday or birthday, Rona ends up meeting with these family members. By the injuries on her body she can later tell that she had been hurt; and her greatest dread is that she herself might, unbeknown to her, through some of her alters, have done 'bad things' to the younger children in the family.

It may seem hard to understand the power which brings Rona, a successful fifty year old, into these repeated situations. Especially as her scary grandmother had been dead for thirty years.

This was exactly the question which brought Rona into therapy.

### Abuse and dissociation: a cycle

We can readily see two elements of the vicious cycle operating: abuse and dissociation.




Dissociation, which includes the experience that some of our history, feelings, thoughts or body parts do not belong to us, is instrumental in surviving the physical pain of severe abuse, as well as the psychological horror of it. It is the greatest tool that the mind has for coping with the unbearable. But it is also a very dangerous tool: it undermines the person's ability to learn from his or her experiences, as these experiences are not available. As a result, the capacity to recognise danger and to act for safety is seriously impaired. This perpetuates a vicious cycle: the continuous exposure to abuse increases the need for the dissociation, as a defence; and the dissociation allows for more abuse to happen, as the person is not aware and does not fully realise what really goes on in his or her life.

## Perpetration of abuse

From accounts of people with Dissociative Disorders (DDs) who were able to recall abusing others, it appears that memories of perpetration are the most traumatic of all of their experiences, and the hardest to heal from. Not surprisingly, these experiences are the most heavily dissociated, and often do not get reached in therapy.

In families where abuse is multigenerational, subjugation and perpetration of abuse are both part of people's lives from the

youngest age, and cannot be avoided. As therapy aims to help people process their traumatic history, rather than hide it, therapists must consider that a blanket condemnation of all perpetration may tar their own suffering and victimised patient with the same brush, as the person who has suffered may have also caused harm to others.

Accounts of perpetration reveal moments of sadistic frenzy that a tormented person was suddenly overwhelmed with; being forced to hurt others under threats of being hurt; abuse perpetrated in an altered state; perpetration that the person realises that he or she has committed (through obvious evidence), but is amnesic to; and, in DID, perpetration carried out by specific alters, unbeknown to the main person.

Typically, such recall is extremely distressing for the person, and requires from the therapist, in the first place, a great deal of willingness to listen and to acknowledge their traumatic nature (Miller, 2012). Where such willingness is lacking in the therapist, memories of perpetration experiences would simply get pushed deeper into the shadows of dissociation, where they could not be thought about or grieved for, where no thinking or remorse is possible and no healing can reach.

It is notable that in DID, alters who are perpetrators are indeed the last ones to emerge. Child-alters, who are not burdened by the same level of crushing guilt and shame, and by the horror of realising what they had done are usually the quickest to reach out for the therapist, longing for protection and kindness. Adult or elderly alters who may recall harming others may not appear in therapy for many years, or ever. Indeed, the traumatic reality of perpetration is often the main force that keeps the dissociation intact.

Furthermore, as long as one's perpetration remains dissociated, further harm to others may continue to be committed by the person, setting in motion new cycles of trauma and dissociation.

*John is serving a prison sentence for a succession of rapes. His eyes fill with tears when he talks about that. He is a very meek man, and he is sure that he couldn't have possibly been aggressive towards anyone. He has had several courses of therapy over the years, mainly 'anger management' CBT, but as he is completely unaware of these dissociated events, the therapy could not address them.*

## Abuse and Attachment: a cycle

I'd like to suggest that attachment is the third, and perhaps the most powerful element perpetuating the vicious cycle of abuse in dissociative disorders. This idea is supported by the fact that most of the known cases of ongoing abuse involve abuse by close family members, that is, attachment figures (Courtois, 2010; Freyd, 1996, Herman, 1992; Middleton, 2013a, 2013b).

As every new hurt causes fresh distress, the child will seek the engagement of the attachment figure with renewed intensity, perpetuating yet another vicious cycle.

Abuse
*Pain, terror, horror*
Concrete infanticidal attachment
*Seeks (actively)*
Abuse
*Pain, terror, horror*
Concrete infanticidal attachment
*Seeks (actively)*
Abuse
*Pain, terror, horror*

Abuse, Crime and Isolation

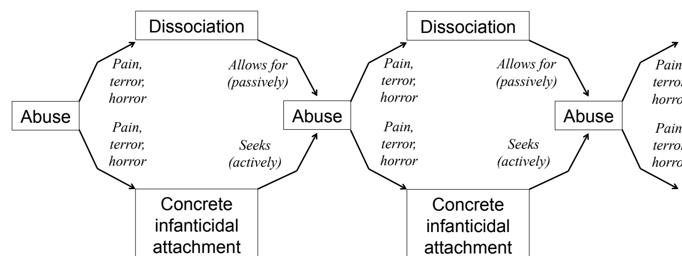
This cycle gains additional velocity from the fact that the abuse element of it is a crime. Children who grow up with crime as an integral part of their lives are taught to be quiet, and never tell.

Not only does this increase their physical risk, but it also creates a psychological isolation, as though they live in a separate world to the one which the non-abused occupy; and the isolation, in turn, further increases the dependency on the attachment figure.

Isolation from the rest of society is characteristic of families and groups whose beliefs and values are in strong dissonance to the rest of society (typical examples, as related in therapy, include the assertions that incest is love; pain is purifying; telling is a sin). Acts which are committed under these convictions (most notably, all child abuse) are not seen as bad or wrong. They take place regularly between family or group members, as part of their ongoing relationship, values or belief systems, and the fact that these acts are illegal in the wider society only serves to increase the alienation from it.

## Dissociative disorders, Attachment, and on-going abuse: the double vicious cycle

I would like to suggest that people who are subject to on-going abuse which they are unable to end, despite years of therapy and all other support, are caught up in a double, infinity-shape cycle:




The effects of abuse, in these cases, manifest simultaneously in two different ways:

The traumatic experience becomes dissociated (through any of the dissociative pathways- amnesia, derealisation, depersonalisation or dissociation of identity). The person loses the awareness of their link to the trauma; and being protected from the knowledge of it, is unable to guard against a repetition of it.

At the same time, the extreme distress which is caused by the trauma activates the attachment instinct, with an instant reaching towards the perceived safety of the attachment figure. In order to fully engage the attachment figure, the person actively and urgently seeks an abusive contact, in such a form as will please and engage their attachment figure. The role that the person has been brought up to fulfil will dictate their actual behaviour when highly distressed, making them act as victim or as perpetrator of abuse.

The relational (rather than purely internal) element of this dynamic allows for abuse to be inflicted on others, as well as on oneself, and thereby can start new, endless cycles of abuse, dissociation and disordered attachment.

## Conclusion

In some cases, abuse that had started in infancy or childhood remains ongoing into adulthood, and does not give way to the persons' expressed wishes to be free of it, nor to years of therapy.

This paper suggests a model which can explain the great difficulty in breaking free from a lifetime of abuse. The model describes this phenomenon as a double, infinity-shape vicious cycle, where severe abuse activates both a dissociative (passive) reaction and an attachment (active) reaction, both of which lead the person back into abuse.

The paper also suggests that the roles of victim and perpetrator are both manifestations of exposure to severe abuse, and are by

> no means 'opposites'. Both victim and perpetrator reach for their attachment figures, as well as for the oblivion of dissociation, in order to cope with their trauma: the pain, horror, and the experience of their loss of humanity. Through dissociation, both victim and perpetrator can passively disown and survive the abuse. And through reaching for their infanticidal attachment figures, both victim and perpetrator actively seek to engage in further abusive acts.
>
> In the light of this model, it appears that, in order to facilitate change in cases of ongoing abuse we must address, simultaneously, all three elements of the cycle: the reality of the abuse itself, the dissociated parts of the person and, perhaps most importantly, the disordered attachment.

## *Further comments*

The clinical recognition of these two cycles, the abuse-dissociation one and the abuse-attachment one, and their meeting point (abuse) has led me into some important insights:

**Firstly, it shows the actual pathway which links DID and attachment, through their meeting point, which is abuse. It thus highlights the critical role of abuse in certain attachment relationships, which are at their highest during abuse, and the critical role of attachment in the creation of DID.**

An interesting illustration for this can be found in the rape episode of Sam (Chapter 4). This abuse episode was driven entirely by an attachment relationship between abused and abuser: the alter Kim went to meet her two attachment figures - her lover and her baby. Through dissociation, she was unable to realise that both men participated in her rape. The alter Polly realised the danger, but was helpless to stop Kim from going, apparently willingly, to a meeting in which she herself (Polly) was to be raped. The alter Lea knew, from long experience, the outcome of reaching for the attachment figure; but she did not stop them from going, as attachment needs are stronger than any sensible consideration. The best Lea could offer was to appear

at the end of the rape to 'pick up the pieces'. Other alters made sure no-one went to the police. This, and many other, meetings with the attachment figure took place unobstructed.

**Secondly, it suggests the existence of two different presentations of DID, as not all people with DID experience on-going, attachment-related abuse into adulthood.**

**Thirdly, it made me aware of the rather large number of 'vicious cycles' which seem to operate and even govern the lives of people with DID.**

The next two chapters will elaborate the second and third points.

## 6. Active vs. stable DID.

Most people with DID, once embarked on appropriate therapy, make good progress and the quality of their lives improves (Brand, et al., 2013). They make good connection with their therapists and develop some level of trust. They start to talk about their traumatic history and to link it to their dissociative internal structure. Gradually, more of their alters surface and join the therapy; gradually, alters start to make contact with the therapist, and then with each other. Over time, they develop confidence in their external relationships with benign people, and in their internal relationship between alters. They develop insight into the connections between their past trauma and present dissociation; learn to recognise their 'triggers' and find ways to be less affected by them, and, most importantly, find a great sense of care and compassion, a sort of 'camaraderie' between their alters, as they all recognise their shared wish to be safe and maybe even happy.

Some of them end up 'integrating', that is, develop a sense of an overall Self which all the alters have a share in. If this state is reached, alters no longer experience themselves as separate people, but as different states of mind of the same person - which is closer to how non-dissociative people experience themselves.

But this is not always the case.

Some people with DID, once embarked on appropriate therapy, make good progress. They make good contact with the therapist, reveal more of their internal structure, develop some deep insights - and then appear in their next session as if none of this took place. All progress is lost; the person had 'forgotten' their insights, hates their other alters or returns to a stage of not even knowing that they exist. The relationship with the therapist reverts to confusing sessions in which nothing is said or everything is denied; the patient appears terrified that, through ignorance or deliberately, the therapist will lead him or her into terrible danger. The sessions become - or feel - completely stuck, with the therapist quite discouraged. Worst of all, some patients come to their sessions bearing fresh evidence of being 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, 2013; Miller, 2012; Ross, 2004; Salter, 2013).

These incidents are sometimes said to be 'accidents'; sometimes they are explained by the patients as punishment (by their abusers) for telling secrets in their therapy sessions; sometimes they are said to be 'self-harm'. At other times, the patient offers no explanations: he or she appears to be in a state of shock, unable to speak or completely amnesic, unable to recall how the injuries happened. The amnesia may be so profound that a person may not be able to recall their own name, or how they made their way to the session.

Most distressing, however, is the fact that with those patients, such incidents occur *repeatedly*, in some cases even frequently; and nothing that the therapist offers, explains or does seems to have any effect on their reoccurrence. The therapy seem helpless to improve the person's safety; quite to the contrary, some of these people seem to accumulate an ever growing history of fresh hurt in between their session.

*The repetition of* ***Rona's*** *abusive contact with her family had already destroyed several of her attempts at therapy. Sometimes it was Rona who could not make real contact, because she was afraid of being punished by the family, or of appearing disgusting 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.*

Such cases raise a serious ethical question: does the therapy actually help the person, or does it just give him or her enough support so that he or she can bear more of the bad life without rebelling, and the therapist becomes, in some way, almost an accomplice to the crime? Therapists thus often consider that unless the person is able to stop the re-occurring of abuse, the therapist will not be able to continue working with that person (Richardson, 2012). Therapists of people like Rona struggle with the worry and frustration regarding the safety of the patient, as well as with the anxiety regarding the usefulness, quality and ethical grounds of

their own practice, especially when comparing themselves to other therapists, who appear to have achieved safety in their patients' lives.

I would like to suggest that the success of some therapists vs. the failure of others regarding patients' safety is due to there being two different presentations of DID, which do not respond to treatment in the same way.

## *Stable DID*

I suggest the name '*Stable DID'* for those cases where the childhood trauma that caused the DID, has stopped. The patient remains severely dissociative and traumatised, but fresh trauma only occurs through random elements which re-evoke the terror of the original trauma, known as triggers.

Almost anything can be a trigger: a face, a voice, a date, a smell; certain words, colours, a name: anything that is linked to the original trauma, and may appear, innocently enough, in one's life in the present. Because the traumatic link is so intense, it immediately connects the person to the dread and horror of the original situation; and if there was a specific alter who functioned during these situations, that alter will surface at the bidding of the trigger, and the person will act just as he or she did at the time of the original trauma.

***Jim,*** *a man who as a toddler was often locked up in a small cupboard as punishment was 'triggered' by being stuck in a lift, at the age of 35. When the lift doors opened, after some ten minutes, 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****, a woman with DID, 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 in some situation they are dangerous (e.g., the man in the red tie may have accepted my patient's sexual offer). However, the danger is incidental; there is no fresh threat to the person's safety, no fresh abuse or malicious attempts to hurt him or her. The therapy, therefore, can focus on reducing the impact of triggers or on 'stabilising of symptoms' (phase one of the Phased Approach, ISSTD guidelines 2011); on processing the original trauma (phase two); and finally on recovery.

## *Active DID*

By contrast, I suggest the name *'Active DID'* to those cases where the person, like Rona, is still actively involved in a life of abuse.

This may not be initially apparent: A forty-year-old Jenny had told me, at the start of her therapy, that she had lost all contact with her abusive family over twenty years ago, that her last visit to her mother's home was at her 16th birthday, and that none of them knew where she now lived. However, after a few months of therapy it transpired that while Jenny, who initiated the therapy, was indeed estranged from her family, many of her alters were visiting the family regularly, some spoke to her mother on the phone every day, and the family was certainly aware of her phone number, home address and all that she was doing. Furthermore, specific alters were responsible for telling her family everything that had been said in therapy, which explained how they knew when to punish her for telling the family secrets. After years in which she believed that the family had magic powers, she realised that their accurate knowledge of her whereabouts were a feature of her own DID. She also realised that the many injuries on her body, including two pregnancies and two abortions, corresponded with her family visits.

Jenny, at that point, had never actually left home, though she had a bedsit of her own. She was actively connected to her family, where being abused- or abusing others- was an ordinary way of relating. Indeed, over time she had recalled many situations in which she, or, rather, some of her alters, have abused other people. And because the abuse she had been part of, as a victim as well as a perpetrator,

was too unbearable to keep in mind, she dissociated, time and time again, with her DID becoming further entrenched with every new episode.

### *Stable vs. Active DID (summary)*

I suggest that many of the professional disagreements about the 'right' treatment modalities for dissociative people reflect the existence of more than one kind of this disorder, each responding to a different treatment modality.

People with *stable DID* carry the 'scars of trauma', but at the start of their therapy they are safe, and are able to focus on processing their traumatic past and, in due course, on recovery.

Conversely, people with *active DID* are still involved in a life of abuse. As every fresh hurt causes fresh dissociation, their DID is constantly being re-enforced and re-created. This group is not able to reach safety at the start of their therapy, and thus requires an alternative mode of therapy, as will be described in the chapter 'attachment as a second language'.

### *Some applications of the concepts of active and stable DID*

In the *Dissociative Mind* (2005, p. ix), Elizabeth Howell writes: "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."

Using the concepts of stable and active DID, as well as symbolic and concrete infanticidal attachment, I suggest a link between:

- specific characteristics of the trauma which the person was exposed to
- specific types of disorganised attachment patterns
- specific disorders which may develop as a result.

I further suggest that all these elements form a *continuum*, from trauma that causes IAc to trauma which does not affect the attachment pattern (though still produces symptoms).

| **Table 1: The continuum of trauma, with attachment and symptomatic sequels:** | | | |
|---|---|---|---|
| | **Trauma characteristics** | **Resulting attachment** | **Symptomatic sequels** |
| A | Ongoing abuse by original, multiple perpetrators | IAc | Active DID |
| B | Ongoing abuse by secondary (replacement) attachment figure. | IAc develops towards IAs | Active or Stable DID<br>Other DDs<br>Other disorders (e.g., personality disorders) |
| C | Ongoing hurt by symbolised perpetrator (abusive alters, self harm, 'accident proneness') | IAs | Stable DID<br>Other DDs<br>Other disorders |
| D | Long-term relational trauma, but no abuse: (e.g., neglect; depressed, psychotic or otherwise dysfunctional attachment figure, who is deeply preoccupied with death) | IAs or other disorganised attachment | Other DDs (stable)<br>Other disorders<br>No disorders |
| E | Non-relational trauma (E.g., war trauma, famine, terrorist attack, serious accident, rape, other violent crime, natural disasters) | No effect on attachment pattern (attachment remains as was before the trauma) | PTSD |

### *Discussion of table 1*

A. In 'true' IAc (group A), the person is in an ongoing attachment relationship with the ***original perpetrators***, which the person has never left, and can't leave. The attachment relationship is to a group (e.g., a family) to which one belongs (for the importance of this context, see paper **9**), and in which one plays a known role. For some this means being repeatedly hurt; for others it means being the perpetrator of hurt for the ones who get hurt. This level of involvement indicates that **the**

**intensity of the fear** in one's life **has never allowed any distance from the attachment figure(s)**, even in adulthood.

B. A somewhat lighter form of IAc, with some degree of symbolization, may be seen in people (Group B) who have managed to disengage from the original, perpetrating attachment figures, but keep their alliance or 'loyalty' to them **by maintaining a lifestyle of on-going hurt** through new perpetrators, e.g., a new abusive partner. The person had left the original attachment figure(s), but replaced them with other(s) who are similar in their values, and 'speak a similar language'. While active engagement in a life of abuse continues in a concrete form, there is a movement towards symbolisation as the new attachment figure mimics, that is, symbolizes the original one, rather than being it.

The fact that the person was able to distance him- or herself from the original attachment figure(s), to whatever extent, suggests a lower overall level of terror and a lesser intensity of the IAc, with a movement towards IAs. Moreover, as hurt which is inflicted by a secondary attachment figure is less terrifying than hurt inflicted by the primary one, DID does not constantly re-enforce itself, and may remain stable.

C. A third group (C) may appear to be active DID, as harm continues to occur, but this harm is not inflicted on the person by the attachment figure. Instead, we see a great frequency of accidents, illnesses, attacks, high-risk life style or self-harm. This form can be classified under symbolic infanticidal attachment, as the damage to the person is done through the person's striving to attract and engage the attachment figure by fitting in with his or her death-preoccupation (IAs; see group D). Self-harm, a drug overdose or an accident 'erupt' when the person is in a state of distress, and can be seen as attachment behaviour, a call on the attachment figure. The damage to the person is not caused by the attachment figure, but by the striving towards it; and as the striving (as well as the abuse) is done by the person him or her self, it represents some level of agency, which differs from the utter helplessness of being abused by others. It should be noted that, owing to dissociation, the person may be unaware that the harm is caused by their own hands.

D. This group had suffered profound, but not abusive, relational trauma. Their attachment figures, following exposure to severe trauma and pervasive losses, are deeply preoccupied with death, and can only be engaged with through sharing this preoccupation. People in this group may be involved in a life of on-going losses and high-risk behaviour, which are actually their attachment behaviour, i.e. the way that they can engage their attachment figure. For full discussion of the complexities of attachment in these circumstances, see paper 5.

E. Non-relational trauma has no bearing on the person's attachment pattern, as it does not link trauma with attachment. Subsequently, the symptoms (PTSD) are linked to the trauma (e.g., amnesia to the event, flashbacks), but not to the person's perception of his or her identity in general.

In my clinical experience, there are consistent factors in the lives of people with the less severe forms of IA (group B and C), which may well have contributed to their ability to distance themselves to some extent from the original attachment figure. In these cases, at least one of the following conditions apply:

- The abusive attachment relationship was limited to only one person, and thus was not a pervasive presence. Other important relationships provided the notion of safety, at least as a possibility.
- The abuse stopped relatively early (e.g., the abuser died or left when the person was still young).
- The perpetrator was not the child's main attachment figure, but had a secondary role in his or her life (e.g., a teacher, a priest, a babysitter).
- The person was a victim or a witness of abuse, but was never a perpetrator.
- The attachment relationship was traumatizing, but not abusive.

Conversely, people from group A (active DID with IAc) tend to have the following life experience:

- A childhood (or longer) of involvement in violent, sadistic and life-threatening abuse as a victim, witness or perpetrator or a combination of these.

- The abuse is carried out by multi-perpetrators, and within a group to which one belongs (willingly or otherwise), such as a family, a religious sect, a care home, a military offshoot, a paedophile ring, a concentration camp etc.
- This group serves as the person's attachment figure (note the attachment plurality, mirrored in the structure of DID).
- Within the group, the relevant crimes are deemed normative, moral or even virtuous (if not legal).
- The deepest moments of relatedness to the attachment figure (the group) are reached during the performance of these crimes.
- The severity of the DID is related to the perceived cohesiveness, size and power of the group as a whole, as well as to the intensity of the violence. People who perceive their group to be large, well organised and possessing extraordinary powers are the most terrified, hence the most intensely dependent on their attachment figure (the group).

Groups B and C, who are able to allow some distance from their original abusive attachment figure(s), may find it easier to attach to another figure, which may even be benign (e.g., a therapist). Group A represents the greatest challenge to any therapeutic work, as the intensity of their fear had never allowed any distancing from the attachment figure, and the process of attaching to a different figure is thus very restricted.

In particular, those who recall having abused others tend to be the hardest to reach, due to *their own perception* of their loss of humanity, which makes them feel incapable of making a deep link with people who have not committed abuse. Subsequently, their links with their abusers are deeper, as they feel that these are the only people who could tolerate them. These feelings find expression in comments such as 'only in my family I'm normal, for you I'm a monster'; 'how can you sit with me in the same room?'; 'I can't look at you, it will make you dirty'; 'God will never let me get better, it's my punishment.' It is also apparent through the increased suicidality at the point of recalling one's own perpetration.

My clinical experience shows that the 'phased approach' (ISSTD guidelines 2005, 2011) is unsuitable for group 1 and is liable to miss it completely. Because of the

above reasons, people in this group are unable to relinquish the bonds with their abusers and ‘stabilise’ prior to in-depth therapeutic work (a detailed discussion of this problem will follow in chapter 8).

Concrete infanticidal attachment is the lowest in its usefulness for survival. Unfortunately, this is exactly what intensifies attachment needs: with less safety comes greater fear, and thus a greater, more desperate need for closeness to the attachment figure. Where the fear is extreme and almost constant, one is permanently anxious to be tightly linked to the attachment figure, which is the abusive family or group. This is exactly why the attempts to leave an abusive attachment figure (especially when that it is a group) are so near impossible: instinctively, if paradoxically, escaping the abuse goes against the most basic survival instinct, which we call attachment.

# 7. Cyclicity

The paradox of intense attachment to the abuser means that people caught up in it are forever in danger, and thus their primary preoccupation is fear. Heightened attachment needs (evoked by the fear) then keep the person doing all in his or her power to remain close to the attachment figure. This, in the case of IAc, entails an active reach towards an abusive situation: a vicious cycle.

There appears to be a surprising number of 'vicious cycles' in the lives of people with IAc and active DID. The following are a few examples:

- Abuse and dissociation cycle (chapter 5): dissociation is created through abuse; the existence of dissociation then allows further abuse to be committed, as the experience is disowned and future danger ignored. The trauma caused by continual exposure to abuse (as a victim, witness, perpetrator or a combination of them) necessitates further use of dissociation.

- Abuse and IAc cycle (chapter 5): the person actively seeks the abusive contact, as are no other means by which the attachment figure can be engaged. The terror induced by the abuse intensifies the need to engage the attachment figure (this cycle can be seen as a more severe case of 'ordinary' Disorganised Attachment (DA)).

- The double cycle of abuse - attachment - dissociation (chapter 5).

- DA and traumatizing parenting is, by definition, a vicious cycle (Main, 1995; De Zulueta, 1993).

- The double shame-and-humiliation cycles, shared by the abused and abuser. Note that both cycles meet at the point of abuse (Dorahy, 2014a):

    - Perpetrator cycle: shame (at being a bad person) - humiliation (you/everyone is looking at me and thinking me bad) - rage at victim (my humiliation is your fault) - further abuse (as punishment for the fault) - shame (at being a bad person).

    - Victim cycle: needing the attachment figure (the abuser) to ease the terror of abuse-shame (I love/want a bad person) - rage at oneself (I'm bad because I want him/her, this is all my fault) - accepting abuse (punishment makes me good and loved) - needing the attachment figure to ease the terror of abuse.

- The repeated phenomenon of 'losing ground' in therapy, especially regarding safety, contributes to another vicious cycle, which we may call 'the cycle of rejection in the therapeutic relationship': the therapist becomes exhausted and disheartened by the constant, seemingly futile struggle for safety; the therapist withdraws their engagement a little; the patient panics at the perceived loss of interest by the therapist and redoubles their attachment calls, which are, for this attachment pattern, anything that may cause them serious harm or even death; the therapist re-engages to help in the emergency; the therapist becomes exhausted and disheartened. Indeed, paper **7** (study of boundary modifications) shows that clinicians with a high proportion of DDs in their caseload reported a high burn-out rate (30% more than their colleagues).

It is noteworthy that all of these cycles are related to lack of safety, and to patterns of relationships. Both are thus evidence of a disordered attachment: lack of safety increases fear and heightens attachment needs; and relationships are always influenced by one's attachment pattern, the 'blueprint of relatedness' that we each have.

Observing all these cycles, I began to consider that the very propensity to 'go around in cycles' instead of change or progress may, in itself, be a quality or a symptom of concrete infanticidal attachment: an expectation of the attachment figure that the child would never grow, change or make choices, but remain always

the same. Indeed, despite the fact that people with IAc (and the related active DID) appear to have a highly dramatic and eventful life, their internal positions regarding who they are, their relationships, their loyalties or how they live remain unchanged, with no concept of other possibilities in the future (and often with no concept of future). Though the person may appear hungry for a supportive and understanding relationship (e.g., with a therapist) and a safer, more fulfilling life, this is extremely hard for them to achieve, and he or she often remain subject to on-going abuse, in one form or another. Their daily behaviour, as well as their behaviour in times of distress, is made of a small, predictable set of responses to danger-signs or 'triggers'. These responses occur almost automatically, with no space for feelings, thoughts or choice. The clinical examples in this work almost always demonstrate this state (e.g., Rona, Sam, Jenny).

Middleton (2013a) surveys a large number of well documented, court-proven cases of father-daughter incestuous abuse, which not only occurred while the girl was young and obviously helpless, but continued well into her adult life. Middleton's survey and his subsequent in-depth interviews with 10 such cases (2013b) demonstrate that a) such cases are less rare than we'd like to think; b) they always involve years of violence and brutality in the home, as well as incest; c) in many of these cases, the sexual abuse of the daughter included pregnancies and the bearing of babies, fathered by the father; and d) the daughter was kept as a virtual, if not actual, prisoner by the father. She was either prevented from having relationships outside the home, or continued her sexual contact with the father even when she got married.

The horrendousness of these cases, so shocking on the rare occasions that they become well known through the press (e.g., Joseph Fritzl in Austria), obscures a second, equally awful aspect of them: the fact that they are ongoing, and the *cyclicity* which keeps them going (see paper **9**).

Cyclicity as a process is a little invisible, as nothing new ever happens, and nothing draws our attention to it. Unlike the flamboyant presentation of 'switching' in DID and of constant danger in active DID, cyclicity is repetitiveness itself. I would argue, however, that it represents the main obstacle to any healing from trauma, as

it prevents development and change. A person caught up in it is unable to try new ways of responding, consider what things mean for them, absorb new experiences or learn from them. All that is needed in order to develop and grow is out of reach, and therapy itself becomes caught up in futility.

IAc may then express itself in two ways, both fitting with the deepest needs of an infanticidal attachment figure: the first is the active reach towards an abuse situation, which is the way to engage such attachment figure. This way may be akin to the 'positive symptoms' (or 'Schneiderian symptoms') of schizophrenia, in that it produces very visible, dramatic results (in the case of IAc, some serious harm). The second way is *cyclicity:* being almost invisible, it bears resemblance to the 'negative symptoms' of schizophrenia, in that it reduces the expressions of the Self rather than intensifies them. From the point of IAc, it conveys the message that the Self has already been killed, thus no progress or change can ever occur.

Mary Sue Moore (2014, private communication) holds that a person may have different attachment patterns with different attachment figures. She points out, however, that the more dysfunctional the primary attachment pattern, the less flexibility and variation can be expected in the other attachment relationship which the child forms. This implies that a very low capacity for flexibility and variation may be an expression of a very dysfunctional primary attachment relationship, or of having only one kind of attachment relationship - a very dysfunctional one - with all of one's attachment figures. The lack of flexibility is probably due to the extremely high level of anxiety, fear and dissociation which accompanies such relationships. This view fits with one of the basic concepts of attachment theory, which is that the more secure the child is with the attachment figure, the more open to learning and exploration he or she will be.

This last assertion also implies a *continuum* of the capacity for flexibility, learning and change. Introducing the concept of cyclicity as the inability to evolve, places it right at the lowest end of this continuum. It thus links Concrete Infanticidal Attachment, active DID and cyclicity, and forms a cohesive clinical picture of the trauma (childhood abuse in group context), the attachment pattern (IAc), the resulting disorder (active DID) and the agent which hinders change and healing

(cyclicity). This self-perpetuating, complicated clinical picture requires some special considerations regarding therapy.

# 8. Therapy: attachment as a second language

Evidence is accumulating (Brand et al., 2009c, 2012, 2013; Brand, Loewenstein & Spiegel, 2014; Dorahy et al., 2014) to show that by and large, DID is well amenable to psychotherapeutic intervention along the lines of the ISSTD Guidelines for treatment of DID in adults (ISSTD, 2011), the *Phase-Oriented Treatment Approach ('the phased approach')*. This encouraging finding fits well with the observation that, although this is not specifically stated, the guidelines are soundly based on attachment principles. Throughout this substantial document, the guidelines consistently advise the therapist to act in a similar manner to that of the safe, reliable, attentive and thoughtful attachment figure. As I hold the view that DID is a symptom of the most severe attachment disorder, I fully concur with the guidelines' emphasis on repairing attachment as an essential part of therapy.

In this section, however, I would like to draw our attention to those cases where improvement is *not* reached, despite careful and attentive therapy along the lines discussed. I suggest that in these cases, the problem may lie in *mis-attunement* (Stern, 1985) *between the therapist's and the patient's attachment language*: the therapist acts or 'speaks' secure attachment, but the patient is unable to understand or relate to that language. In these cases, I propose that the first step needs to be attuning with the patient, *by speaking his or her attachment language*. That is because secure attachment is not driven by any particular, 'secure' way of parenting, but by the level of attunement that the parent has with the child.

## *The Phased Approach as an attachment-based intervention*

The Phased Approach (ISSTD, 2011) stipulates that at the start of therapy (*Phase 1)* the focus must be on establishing safety and the stabilisation of symptoms. Once these goals have been met, therapy can progress into *Phase 2*, in which the traumatic memories of the patient and the phobia of remembering them become the focus of the work. *Phase 3* prepares the patient to face normal life, while the process of *integration* begins.

Phase 1 includes psycho-education regarding the patient's condition, practical ways to improve the safety of everyday life, and work on reducing dissociation and the chaos that it creates. It also encourages learning self-soothing methods (e.g. EFT, EMDR) in order to reduce extreme anxiety, and its associated risks of suicidality, substance misuse, self-harm or other destructive behaviour. The therapeutic 'frame' or boundaries are discussed and agreed, to promote a sense of predictability and safety in the therapy room; and most importantly, this phase aims to establish trust and depth within the therapy relationship itself, as a model to the kind of relationship that the patient had never experienced before. All of these elements are part of building a secure attachment relationship with the patient, a relationship that teaches, offers and facilitates trust and safety.

"The phobias of attachment and attachment loss are pervasive in survivors of chronic traumatisation and manifest in the therapy relationship through all phases of treatment. Overcoming these phobias is essential for further therapeutic gains, as attachment is the matrix in which all therapy takes place." (Van der Hart, Nijenhuis and Steele, 2006, p. 278).

The idea that attachment and its concomitant safety must be urgently addressed and repaired appears to be widely shared by clinicians of all persuasions and modalities. Achieving it, however, can be challenging.

People with IAc and active DID (group A) tend to be in a frequent - or in some cases, perpetual - state of emergency, which 'bursts' into consulting room with its urgent and pressing need for real-life responses. Patients come into their sessions injured, but unable to recall how the injury occurred; they tell the therapist that they have been followed, that their car was smashed, that their pet was killed. They report accidents, rapes, pregnancies or attacks, as well as threatening phone calls from their abusers; they attempt suicides. These are not only expressions of their external realities, but also a concrete demonstration of their powerful attachment pattern, which engages the therapy through the physical reality of their risk and injuries.

Attachment, the blueprint of our relatedness, is formed between a newborn baby and a mother and/or other caregivers. It is a relationship of complete, life-and-death dependency, and it goes on for 24 hours a day, for several years. In order for an attachment to be *secure,* this relationship needs to start with a complete absorption of the mother (or her replacement) in the baby and his or her needs, and an unwavering commitment to protect the baby. The therapist who sees an adult patient for two hours a week is obviously very far away from the mother-baby situation. He or she may get a flavour of the patient's desperate need for safety, but be unable to fulfil this need. Instead, the clinician may experience the great disparity between these most urgent needs and what therapy offers. It is not unusual for professionals to feel that the most therapeutic act would be to break the therapeutic frame, and look after the physical safety of the patient.

It has been my impression, through conversations with dozens of colleagues and supervisees, that many therapists in this field tend to become involved in a very high level of patient's support, such as late night phone calls, emails while on holiday or trips to A&E. A survey which I ran in 2013 (paper 7) gives quantitative support to this impression, demonstrating an almost ubiquitous tendency of professionals to modify their boundaries to some extent when working with people with DDs, despite the great inconvenience that these modifications entail.

In the survey, 163 mental health clinicians (psychologists, psychotherapists, social workers, counsellors, art therapists, psychiatrists and medical doctors) were asked to compare their professional boundaries with their DDs patients to the professional boundaries which they kept with all their other (non-DDs) patients. The results showed that 85% of the participating professionals kept a different set of boundaries with their DDs group, compared with their boundaries with all their other patients. In particular, boundaries were modified regarding un-scheduled availability of the clinician to the patient (e.g., responding to calls out of normal working hours), that is, an attachment relationship.

Such extensive modifications of boundaries reflect the struggle that even well-seasoned professionals face in their attempts to teach and offer secure attachment to people with a highly disordered attachment pattern. The struggle is between solid

and reasonable principles, which are widely agreed and practiced, and the clinicians' experience that with *some* of their patients these principles are unpracticable.

*Phase 1* requires that much of the chaos in the patient's life needs to stabilise prior to commencing any more unsettling work. *Phase 2* is concerned with overcoming the phobia of *remembering* highly traumatic events. I propose, however, that neither phase matches the reality of people with IAc and active DID. For these patients, the 'chaos' or the on-going danger and hurt in their lives is the very essence of their pathology, that is, it is their attachment language. The attempt to start therapy on solid foundations and through careful pacing (Phase 1) are so far removed from their life experience that, rather than reassure, it is rejected by them as irrelevant, alien, shallow or cold. Furthermore, for people with active DID the most terrifying trauma is not the one in a dissociated memory (as is the predicament of people with *stable* DID), but the trauma still to come. Phase 2 is thus also mis-attuned with their greatest concerns.

Van der Hart, Nijenhuis and Steele (2006, p. 217) allude to such complication in a much neglected paragraph:

> "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, 2010; Steele et al., 2005; Van der Hart et al., 1998). This implies that as needed, Phase 2 … will periodically alternate with Phase 1; and later…be alternated with Phase 3."

It is always a challenge to keep the therapy of DID progressing in a linear way, as all DID is complicated. But for people which we can identify as 'group A', that is, IAc with active DID, I believe that the suggested phasing is essentially unsuitable. As the attachment language of these patients is inextricably linked to traumatic experience, they are unable to connect to a therapist (or anyone else) without the heightened stress that accompanies trauma. It is thus not possible for them to engage 'safely', as the concept has no real meaning for them. Instead, they need the therapist to relate directly, and right at the outset, to their past and present traumatic experiences. The rigidity that characterises attachment communication on the more

disturbed end of the continuum (Moore, 2014) makes it impossible for them to join in with the therapist's use of a secure attachment communication: for this group, stabilisation of symptoms may only be reached much later in therapy, after substantial work on trauma (Phase 2) and on co-consciousness or integration (Phase 3) has occurred.

***Clinical example: Helen***

*On her second session with me, Helen suddenly switched into Pauline, a 15-year old alter. Pauline looked at a point above my head, and said quietly: "You don't know anything about us. We are monsters. We have killed 11 babies. Helen doesn't know".*

Helen and Pauline clearly did not seek a careful introduction into therapy. They did the introductions in their own way, in the IAc's language of horror. I reeled with shock; my mind raced between 'is this really true?' to 'should this be reported?' to 'why does she trust me with this information?' to 'how can she survive this?'. In the most sickening way, I was engaged.

Ten years later, Helen's therapy ended. She is now mostly 'merged' (her preferred word to 'integrated'); she is safe, she has friends, she is deeply absorbed in her art work and writing, and she is very insightful about her process. According to her, the key to our successful work has been my initial willingness to follow her into her world of darkness, at her dizzying speed and (up to a point) on her terms. That included out-of-hours phone calls and emails, escorting her to the police to make statements, and continuing her therapy while we both knew that she was still fully involved in a life of abuse. Had I insisted on 'taking things slowly' on that second day, my message would have been read by her as 'I don't want to come near you'.

***Clinical example: Olivia***

Olivia taught me some of my earliest lessons about dissociation and infanticidal attachment. Tragically, I knew too little at the time to be of help to her.

*I first met Olivia in the day-room at the hospital. She had just been transferred from a surgical ward, after a stomach operation to remove a knife that she had swallowed. She was lying on a sofa, wrapped in a blanket, and looked very small, pale and fragile.*

*I said hello, and that I had come to help her to come to my room for her therapy session. She looked at me, and said, 'I swallowed a knife'. Looking her in the face was different from reading her file. Imagining her actually doing it made my skin crawl; and all the words wilted on my lips, seeming trite and irrelevant. Shuddering at the thought of the pain, I finally said to her: "it must have hurt a lot'.*

*"Yes", she said softly. And then, to my shock, her face lit up. She looked at me again, this time radiant, and whispered: "Yes, it did. But it was worth it".*

Olivia, too, did not seek a well-paced introduction, as her first sentence to me showed. Months later, she said to me that she had only told me the truth ("it was worth it") because I had told her the truth (that I was horrified by the physical pain). In my language today, I would say that she sensed her engaging me, which made her feel safe.

Olivia and I spent countless hours together. I gradually learned about her horrendous childhood trauma. I learned about dissociation, and how one can swallow a knife: different parts of her described it in detail, some as the ones being cut and some as the one doing the stabbing. They were experts: by the time we had first met, Olivia had done it five times. I also learned, with bewilderment, that there was something deeply cherished and precious for her about that act: she talked about it making her feel at peace, and completely safe.

It took years before I began to consider that when she let the knife in she felt safe because it fully engaged her attachment figure, who was excited and thrilled by her and loved her. Because when she was in agony and nearly dead, she and her attachment figure were deeply bonded. They were bonded by the extremeness of their shared practices, the extremeness of the sadism, the obedience, the fear and

the pain. She was the most special girl in the world; everyone loved her, and no harm could befall her.

Olivia's attachment was truly and very concretely infanticidal. She followed it to the end. And she did not survive.

A bond of this intensity will not dissolve by sensible discussions, by gentle persuasion, by the patient's willpower or by a demonstration of what safe attachment looks like. Such a bond may never dissolve at all. It has been my clinical experience, however, that it is sometimes possible to build a second attachment language alongside the first, infanticidal one. And that as the secondary language develops and grows in strength and in its capacity to reassure, the reliance on the original one may gradually lessen.

## *Learning the second language*

Although I describe the process of learning a new attachment language as a two-step process, I want to emphasis that both steps occur repeatedly, many times over, and that both are essential.

### *Step 1: keeping safe*

An attachment relationship can develop at any point in one's life, even without the 24-hours-a-day total commitment of the mother to the newborn baby. It does require, however, a situation that (like the original one between parent and infant) involves **dependency, distress, care and a relief from distress**. These conditions can occur in a variety of abusive and non-abusive life situations, including psychotherapy. Bowlby (1985/ 2013) puts it simply: "We have to be the patient's attachment figure…we have to be a companion who gives them courage" (p.40).

Secure attachment is not reached by any specific behaviour on the part of the attachment figure (note the huge variations in parenting methods and styles throughout history and among cultures), but by the ability of the attachment figure to respond in a way that mirrors the baby's communication (Kohut, 1977; Shore, 2003b; Winnicott, 1967). If we model therapy on the principle of building a (more)

secure attachment in the therapy space, the first step must be attuning with the patient, that is, listening and responding to *their* way of expressing their calls of distress, as the 'good enough mother' (Winnicott, 1960) would do.

In the case of persons with IAc, this means responding to their IAc language, rather than to act with the sensibility of secure attachment, as the latter, though better in every way, does not mirror the patient's experience. Mirroring it will include following the patient's lead regarding communication with and between alters, and regarding the timing for processing traumatic material; tolerating discoveries of current involvement in abuse; allowing and offering out-of-session contact, as far as practically manageable; supporting the patient during police interviews and other similar measures. Indeed, as the boundary modifications study (paper 7) shows, it appears that most clinicians intuitively act in these ways and respond to the attachment calls of this group.

However, while attuning with and responding to the existing attachment language is key to making an initial deep contact, it is fraught with very serious problems. In the long run, continuing to respond on an IAc level is unsustainable, clinically, practically and theoretically.

On a clinical level it is unsustainable because it conveys the message that only the patient's weakness, suffering and death-risk are of real interest to us. By frequently responding with 'pulling out all the stops' at the moments of danger, we are, as well as helping, also perpetuating this attachment pattern: we state that, indeed, the way to our heart, to our deepest engagement, is through the patient's repeated trauma, continual pain and extremeness of suffering. We may appear, like the abusers, to be thrilled or seduced by pain, fear or blood, no matter how much we speak to the contrary, and we may end up inducing a 'negative therapeutic reaction', by causing the patient to fear that the attachment connection will be broken or lost without being regularly re-fuelled by fresh trauma.

On a pragmatic level, it is unsustainable because the therapist will eventually become exhausted. As we see in the boundary study (paper 7), professionals working extensively with this group had an alarmingly high rate of burnout. The

withdrawal of an exhausted therapist will inevitably be perceived by the patient as betrayal, and increase their long-term hopelessness and mistrust.

On a theoretical level, it fails because if we model the therapy on the idea of building secure attachment we will naturally expect that the patient will grow in confidence and begins to explore the environment, thus becoming gradually more independent (like the 'secure' infant in the strange situation procedure, Ainsworth and Bell, 1970). A therapeutic stance of permanent 'being there' creates an un-natural situation of a baby who does *not* grow, despite all the care. The relationship becomes stale; the care becomes a burden. Like a child who loses interest in her doll, because the child grows, but her doll doesn't, therapists become disillusioned when years go by, the therapist grows older, but it appears that the patient has not been able to grow and their level of dependency on the therapist remains similar.

The problem lies in the fact that the therapist has, intuitively and successfully, stepped into the role of an attachment figure. But finding him- or herself in that role, became trapped by it.

For the purpose of fostering a new attachment language, it is essential that the therapist will become a new attachment figure. But the next, equally essential question must be, 'so I am an attachment figure; now what?' which echoes so much the delirious first moments of actual parenthood. This is the point at which we must start to build the ***secondary attachment language***, ***alongside the existing, infanticidal one***.

***Step 2: the unique Self***

Observing the behaviour of the 'good enough mother' (Winnicott 1960), we can see two basic dynamics. The first is her engagement in safety. The second is her engagement and absorption in the baby's development and emerging personality.

She looks at her baby. She listens. She is immensely interested, and is attuned not only to baby's needs and distress, but also to what baby enjoys and follows. She knows what baby likes and dislikes; what she is interested in, what makes him laugh. Mother is fascinated by and absorbed in learning who baby is, and her

affective responses, *mirroring* (Winnicott, 1967) the baby's affect, help to teach the baby about the realness of her own experience.

And baby, through mother's fascination, attention and learning, makes the most important discovery of his life: his own Self (Winnicott, 1960, 1967). The baby learns that she exists, because she is seen, heard and understood; because mother is passionately interested; and because it feels good.

Mollon (1993, p110) sums it up: 'the basis of the sense of self is the capacity to evoke a thoughtful emotional response in the other (originally the principle caregiver)'. So baby seeks mother's interested eyes, and grows through finding in her facial expression, her actions or her voice the recognition, the affirmation of baby's self.

By sharp contrast, the baby who is severely neglected or abused is not an object of fascination. Their uniqueness, discoveries and development do not engage the attention of their attachment figure. The only meaningful connection between them occurs while the attachment figure expresses and satisfies its sadistic, narcissistic, murderous or sexual urges, with the child's mind and body serving this purpose. Expressions of fear or pain increase and intensify the connection between abused and abuser. No other areas of the child's life or personality are of interest, and changes to the rote are deemed an act of rebellion and get punished. The relationship is thus kept static, throughout childhood and often into adulthood. This negative attitude to change, which is ubiquitous in people with IAc, is reflected in their tendency to cyclicity.

In the therapeutic relationship, the constant emergencies, pain, fear and suffering of the person with IAc tend to focus the therapy relationship on 'putting out fires', and often results in the therapy becoming unchangeable, static, spinning round various vicious cycles that do not allow real development and change. Dealing with that which is *urgent,* all too often, takes precedence over dealing with that which is *deep.*

The sense of Self, of one's existence, and therefore the possibility of development and change is further narrowed through dissociation, in its different forms: amnesia takes away one's past, derealisation and depersonalisation take away one's present, by making it unreal or not belonging to oneself; DID splits one's experience into many fragments, frozen in time, pigeon-holed into narrow roles. And most deeply, the sense of Self is destroyed through IAc: one only really exists, for the attachment figure and thus for oneself, as a nearly-dead body.

I therefore propose that the second step which is needed in order to help the Self evolve out of the cyclicity and repetitiveness of IAc is to *notice and foster any sign of individuality, personal preference, interest or uniqueness,* so as to help the Self grow. Like step one, this step requires *empathetic mirroring* (Kohut, 1977) and *attunement* (Stern, 1985).

For people with IAc, this may be alien and even frightening: they may not know anything about their own uniqueness or Self, having spent years cultivating only their near-death affects. We may have to look hard to find where some individuality has been retained; and the most likely, the safest place, in DID, is under the cover of dissociation: in the person's alters. As alters have been separated by their trauma at different points in time, and because each of them copes with different aspects of memory and of functioning, the differences between them are often easy to see. And as each alter ultimately holds memories, abilities and qualities of the whole person, becoming aware of these will, in the long run, enrich the person as a whole.

***Clinical example: Clare***

I gradually got to know Clare's alters: there were over a hundred of them, of both genders and of all ages, from babies to ones who were 200 years old. Some introduced themselves as animals, monsters, spirits or computers. Two of them had had trouble with the law, and had served a prison sentence. Most of them knew that there were other alters who shared the same body, and hated these 'others'. Some had no notion of any 'others' and when I once phoned and asked to speak to Clare a different alter answered, and said to me very impatiently that I should check the number I'd got, that there was no Clare living there and it was tiresome to always answer people asking for her.

Contrary to this colourful picture, the ‘publicly known’ Clare was a shy, non-descript woman in her forties, who worked as a cleaner. Fairly early in her therapy she made the connection between her ‘feeling dirty’ through years of abuse to her becoming a cleaner. She knew she was still hurt sometimes; she also knew she had some ‘others’ in her, but was ashamed of that and had no interest in finding out more, or in communicating with them.

Most of her therapy time was used by her alters. They were not shy, and certainly not non-descript. Two teenage boys admitted to jointly beating up a policeman, who caught them mid-burglary; this was the offence for which they have served a prison sentence. Another alter was blind, deaf and mute. A dog alter could only eat dog food, which had to be served in a dog a bowl on the floor. One of them professed to be the consort of Satan. Another one lived in a different address to Clare.

In therapy, I made a point of relating personally to each alter, noting any shred of Self that I could notice and highlighting their special qualities, abilities and personal life experience. Even though much of it, at the start, was very negative (e.g., the alter who always got raped, the alter who loses all her babies), being seen for who they know themselves to be created a first sense of ‘I-ness’, a sense of a real existence. My keen interest in the particular characteristics of each one of them, even if it was only their strength to withstand their lot, made them see themselves as worthy, interesting, and powerful choice-makers: I highlighted their selflessness in stepping forward to be hurt, and by doing so sparing another alter from hurt. When an alter told me of how he hurt another child because “they would have killed me if I didn’t”, I noted his commitment to staying alive. The huge burden of shame which both abused and abusers carry, which deepens dissociation, became laced with a sense of pride, which made them want to be seen. They were already seen by me; now, presumably due to the good feeling that this brought, Clare started noticing ‘them’: that is to say, aspects of herself which were relegated to deep dissociation because their existence was unbearable, became more acceptable and even interesting to her.

The limited, usually negative points of contact which started the relationship between Clare's alters and the outside world (in this case, myself) developed and increased, as they felt themselves valued as indispensible for Clare. Encouraged by my interest in who they were and enjoying the recognition, they became more confident and interested in the exploration, and their pleasure in having a relationship with another person after years of isolation made them reach out of their 'trauma-only' mode of life and into the richer arena of 'thinking together'. One of the most moving moments to me was the first time that an alter of hers, rather than acting his one-dimensional role of cigarette-burning another alter, started to feel that he had several feelings (which he called 'parts') in him, that were not all the same, and then an *internal conflict.* He said to me: "part of me just wants to kill Billy (another alter) for what he'd done, but I also understand why he'd done it. May be I shouldn't burn him."

Internal conflicts imply choices and responsibility for these choices, which replace the dissociative pathway underpinning the splitting, which allocates all bad experiences to other alters. Alters with some internal movement (e.g. conflicts, empathy, doubts), rather than fixed roles, develop as a result of this internal movement. They develop complexity, memories, considerations, likes and dislikes. All of these come closer and closer to the mental and emotional functioning of a non-dissociative person: they constitute an *evolution* of the Self.

Clare is now a published author, and her poems are moving, beautiful and sometimes funny. They express her trauma, but also her compassion for herself, and her gratitude to her Selves: she certainly knows them well. In terms of the phased approach, I would say she is now working within Phase 3.

***Phase 3***

Phase 3 in the phased approach is concerned with the challenges of normal functioning in the world, a particularly challenging task for group A, who always lived in a high state of isolation or 'parallel reality'. While I propose that Phases 1 and 2 are not practicable for group A, and may have to be substituted by step 1 and 2, it appears to me that this diversion can re-merge at the point of Phase 3.

### *Summary*

It is my view that, in order to help people with IAc, the first and most *urgent* step is to become a new attachment figure, that is, follow the patient into their world of trauma, be horrified by the cruelty, the pain and the losses, and be guided by our professional knowledge, common sense and compassion in doing what we can to help their survival. But if we stop there, we will keep the patient in a perpetual childhood, and forever speak their attachment language of extreme suffering. It is therefore essential that we also take the second step, which is to connect deeply not only with their intense suffering, but also with their individuality, which has hitherto been of no interest to anyone, in order to help them evolve and grow. The place where individual qualities are the most visible, in a person with DID, is their alters. I therefore suggest that it is important to use this pathway into the matrix of the patient's complexity, and develop meaningful and personal relationship with as many alters as we can. Ultimately, their combined characteristics will enrich the whole person.

# 9. Final remarks.

There is now evidence that the majority of people with DID who receive specialist therapy do get better (Brand et al., 2013; Brand, Loewenstein & Spiegel, 2014). Given the severity and complexity of this condition, this is an extraordinary achievement for the mental health professions, and an extraordinary tribute to human resilience.

This thesis, however, addresses the *other* side of the moon. It focuses on a sub-group within the DID population, which does not appear amenable to the accepted treatment methods, and constitutes many of our therapeutic failures. Through my extensive work with psychiatric inpatients and at the Clinic for Dissociative Studies I have met many of these people, and have struggled for years to reconcile what I knew about therapy for DID with what I knew about these people. Over time, an outline of differentiations began to emerge between the two groups, the 'getting better' group and the ones who did not, which tied the more difficult-to-treat presentation of DID (active DID) to a particular attachment pattern (IAc). This attachment pattern develops between an abused child and his or her abusers, when the abuse is particularly severe and, most importantly, when it constitutes the cornerstone of the attachment relationship. Furthermore, I gradually became aware of the relentless repetitiveness (cyclicity) which characterised the physical and mental actions of this group, precluding any change or development. Such inability to develop or learn signifies a most profound lack of security in the person's attachment pattern (Ainsworth & Bell, 1970; Bowlby, 1958), and an almost total lack of attunement (Stern, 1985) or mirroring (Winnicott, 1967) by their attachment figure.

I subsequently concluded that therapy in these cases had to start with attunement: meeting the person on his or her own, inevitably traumatic emotional turf before it could be possible for the person to follow the therapist into a safer and happier relationship. I propose this departure from the Phased Approach as a necessary measure with Group A (IAc and active DID, locked in a cycle).

## *Future plans*

From a research point of view, I see this work dovetailing with the work of Brand et al. (2009, 2012, 2013), which studies effective treatment for people with DDs. Brand's work demonstrates the effectiveness of the *phased approach;* this thesis focuses on the minority group of patients in the studies who did *not* improve. I'd be very keen to collaborate with Brand's research and analyse the history, attachment patterns and symptom picture of the non-improving group, so as to be able to establish if it fits with my formulation of Group A (chapter 6). Furthermore, the non-improving group can be offered therapy where a succession of step 1 and 2 would replace the traditional phase 1 and phase 2. If this proves to help this group, it will provide an important breakthrough in the treatment of the most difficult group of DID patients.

In order to disseminate this work to other professionals, I have submitted a proposal (now accepted) to co-edit a special issue of a professional journal on this topic. In addition, a version of chapters 6, 7, and 8 will be submitted for publication as journal papers; and I will be presenting chapter 6 in the next ISSTD conference. I have also started to work on a book version of this thesis.

This work is offered as a starting point for further clinical consideration, study and debate. It is indeed my sincere hope that it will prove useful in inspiring such development.

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## Appendix: previous publications

**1.** Sachs, A. (2007). Infanticidal Attachment: Symbolic and Concrete. Attachment: New Directions in Psychotherapy and Relational Psychoanalysis, 3, 297-304.

**2.** Sachs and Galton (eds.) (2008). Forensic Aspects of Dissociative Identity Disorder. London: Karnac Books.

**3.** Sachs, A. (2008a). Introduction. In A. Sachs & G. Galton (Eds.) (2008). Forensic Aspects of Dissociative Identity Disorder. London: Karnac Books.

**4.** Sachs, A. (2008b). The link between DID and Crime. In A. Sachs & G. Galton (Eds.) (2008). Forensic Aspects of Dissociative Identity Disorder. London: Karnac Books.

**5.** Sachs, A. (2008c /2013a). Intergenerational Transmission of Massive Trauma: the Holocaust. In J. Yellin & O. Bedouk-Epstein (Eds.) Terror Within and Without: Attachment and Disintegration: Clinical Work on the Edge. London: Karnac Books.

**6.** Sachs, A. (2011). As Thick as Thieves, or The Ritual Abuse Family: an Attachment Perspective on a Forensic Relationship. In V. Sinason (Ed.) Attachment, Trauma and Multiplicity, second edition. Hove: Brunner-Routledge.

**7.** Sachs, A. (2013b). Boundary Modification in the Treatment of People with Dissociative Disorder. Journal of Trauma and Dissociation, (14)2, 159-169.

**8.** Sachs, A. (2013c) Still Being Hurt: The Vicious Cycle of Dissociative Disorders, Attachment and Ongoing Abuse. Attachment: New Directions in Psychotherapy and Relational Psychoanalysis, (7)1, 90-100.

**9.** Sachs, A. (2013d) Commentary on “Parent-child incest that extends into adulthood: A survey of international press reports” and “Ongoing incestuous abuse during adulthood” (Middleton) Journal of Trauma and Dissociation, (14)5, 580-583.

# Infanticidal Attachment: Symbolic and Concrete

Adah Sachs

As I read Brett Kahr's (2007) evocative paper about infanticidal attachment and its links to schizophrenia, I was struck by the similarity, and then by the difference, between the traumatic history of sufferers of schizophrenia, and the traumatic history of people who are diagnosed with dissociative identity disorder (DID). The similarity that I saw was in the centrality of infanticidal attachment to both. The difference was in the character of their traumatic attachment history, and in the subsequent expressions of their attachment behaviour (or symptoms).

Placing infanticidal attachment on a continuum of attachment relationship, from the most to the least secure, I suggest that Kahr's new term should be subdivided. I shall try to show that infanticidal attachment, this long-needed term, covers two different types of actual relationship between baby and attachment figure, resulting in two different types of attachment behaviour. I would like to call them the symbolic infanticidal attachment and the concrete infanticidal attachment.

While it appears that a large percentage of people with schizophrenia have suffered parental infanticidal ideation or intentions, I would like to emphasize the predominantly *symbolic* form of these death threats. I suggest that the symbolic form in which the parent's murderousness is expressed shapes, as it always does, the attachment behaviour of the baby, and leads to the highly symbolic language of schizophrenia. The history of people diagnosed with DID, on the other hand, seems invariably to include early exposure to parental *concrete acts* of torture or of murder, which the infant endures, witnesses, or is forced to commit. This, I would argue, is a necessary condition for developing the concrete language of DID.

The trauma history of people with DID is therefore unique amongst the histories of other people with disorganized attachment, not only by its severity, as Ross (2004) suggests but by its quality. The qualitative difference, I suggest, is in that the infanticidal ideation was not covert, not implied, not hidden, not symbolized. It was acted upon, as though there was nothing to hide

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or to cover. What is grossly forensic, and thus normally hidden, was simply allocated to another, 'not-me' part of the self (both in the parent and in the infant), and therefore did not need to find a complex way to be 'lived with' or integrated.

The parallels between the type of parental expression of murderousness and the attachment language in the child (symbolic leads to symbolic, concrete leads to concrete) should hardly be surprising to us: attachment behaviour always reflects the attachment figure's mode of communication; the baby always modulates his or her 'reaching out language' to that of the parent.

## Infanticidal attachment

> Francin still thinks that daddy was trying to kill her and that if she'd been a good girl she would have just died. [Aahbee, 2007]

> I just have to lie really really quiet and still and see if I am dead later. [Aahbee, 2007]

The words 'infanticidal attachment' are very evocative, which suggests that they are describing something that we can recognize. I would like to place this 'something' in the context of the other types of attachment that we know. Given that attachment behaviour is an innate structure that exists for the purpose of survival, it may be reasonable to look at its different forms as occupying points along a continuum of effectiveness in achieving the purpose of survival.

*Secure attachment*: a stable, organized structure, allowing for separation, exploration and play, and enabling the formation of future relationships based on secure attachment. It thus supports short as well as long-term survival.

*Insecure attachment – avoidant and ambivalent types*: more painful, but still functional structures. They represent specific kinds of deficiencies in the actual relationship with the attachment figure, and are likely to lead to varying degrees of difficulties in forming future intimate relationships (e.g. with partner, children). However, these insecurely attached babies were consistently able to reach the attachment figure, although they had to go about it in a round-about, painful way. Attachment behaviour of the kind that the parent could tolerate was effective, consistently producing the proximity, safety, and comfort needed. The attachment style that resulted was thus organized and stable, if not happy.

*Disorganized attachment*: here we move to the sphere of trauma. The baby never knows what would bring comfort or safety, as this is unpredictable. In the case of neglect, for example, the baby gets no comfort at all for lengthy periods, no matter what attachment behaviour is expressed. In the case of abuse, the confusion and terror are greater, as the attachment figure, towards





whom the child turns in distress, is also the one causing the hurt. In the case of a mentally ill, depressed, or dissociative parent, there are so many variables affecting the parent's capacity to respond helpfully that no consistent way of reaching comfort can possibly be found, and the child is in constant, frantic search for the parental closeness.

Disorganized attachment, while reaching for safety, may also become a hindrance for it, in two ways: by linking the infant to a figure that may cause harm, and by causing serious damage to the child's development in many ways.

Disorganized attachment is the single most important predisposing factor for dissociative traits in adult life, from developing dissociative disorders to a high propensity for post traumatic stress disorder (PTSD). It also predicts a much higher likelihood for psychiatric distress or for criminal activity (Hesse & Main, 2000). Hesse and Main also point out that these outcomes would occur with parents who are excessively frightened, as well as with parents who are frightening. Ross (2004), in a large number of studies, links DID to the greatest severity and pervasiveness of abuse in infancy.

Perry and colleagues (1995), describing the way in which the damage is done, explain that when the infant's stress levels continue to rise and no comfort is present to reduce them, there comes a point where the baby (or the adult, in certain situations) cannot withstand the arousal any longer, and dissociates, 'shuts down', 'removes oneself' from the unbearable experience. That 'state' (of dissociation) becomes a 'trait' when frequently repeated, especially in infancy. We may say that it is as though the dissociation itself becomes the comforting mother, who takes the pain away, when all else fails.

Further research has suggested a further category in the adult attachment interview, identified as the 'cannot classify' (Hesse, 1996). This category is thought to be a more severe and pervasive form of the 'disorganized' category, where the 'disorganization' appears throughout the interview, and not just at specific, difficult points of it. One may speculate that this result may belong to people with DID.

Liotti (1999) talks about three motivational systems that could replace the painful experience of the disorganized attachment system being activated. He calls them the sexual, agonistic, and care-giving systems, and explains that each of them is a way of being close to the longed-for figure in a less painfully vulnerable, dependent way. We may consider these systems as three more sub-types of disorganized attachment, as they fulfil the same role (immediate reduction of distress by achieving proximity to the attachment figure).

In all of these examples, the actual relationship between attachment figure and disorganized-attachment baby are traumatic and traumatizing. Severe neglect, mental illness, physical or sexual abuse cause unspeakable damage to the infant. *But they do not necessarily intend to cause damage.* The parent may well love and attempt to protect the baby when and where they can, despite the

damage that they inflict at other times. One may say that these parents 'take out on the baby' their own uncontainable emotions of aggression, despair, sexual arousal or fear, unable to care, in these moments, for the baby's feelings or needs. It is as though the baby becomes, temporarily, invisible to the parent, not a real person.

Now let us consider the additional harm where *there is* an intention, a wish, or an actual attempt to mutilate or kill the child. The child, in these cases, is not invisible: he or she is specifically targeted by the attachment figure as a 'chosen sacrifice' or as an object of hate, in fantasy or in practice. This, I suggest, is where infanticidal attachment will result. On our continuum of functionality, it is the most dysfunctional, as it increases rather than reduces the risk to the child's well being or even life.

Attachment needs, however, can't be 'switched-off'. An infant cannot 'forgo' having an attachment figure, whatever the qualities of that figure may be. Furthermore, one's attachment-style will, inevitably, mimic the person to whom the infant is attached. If that person wants the baby dead or mutilated, the baby will become attached in that particular way: 'Mum loves me when I'm screaming in pain. Dad will be with me if am good and dead.' The baby's feeling of comfort will, thus, be linked to death, hate, or sadistic thrill in the same way that it is linked to being distant if their parent is AAI dismissive. The sight of torture will be linked to the feeling of safety (or even love?), in the same way that the sound of mother's voice singing a lullaby is linked to it. I suggest that *infanticidal attachment,* the term coined by Kahr, would correctly fit the attachment style of babies whose parents are not just unable to contain their aggression or despair, but who actively want or need to see them dead or mutilated, whether they imply that wish or act on it.

Parents who feel forced to see their children tortured or dead have an extremely traumatic history themselves. And it is the inevitability of further trauma, generation after generation, that makes it so critically important to offer therapy to persons of any age who present with this type of attachment style.

## Two types of relationship, two types of infanticidal attachment: the concrete and the symbolic

A child who is attached to an infanticidal care-giver experiences reduction of stress when he or she is in proximity to a person who aims to torture or kill them. This attachment further exposes the child to danger, with no way of abating it. It is thus dangerous, as well as traumatizing. I would now like to draw a distinction between infanticidal ideation or intentions that are *symbolically implied* and those that are *concretely acted upon.* The severity of either can vary, but, to my mind, there is a qualitative difference between them.





The following are short examples, which are meant to illustrate what I mean by symbolic and concrete:

*Christina* said she was named after Christ, because she had to die for the sins of others. She knew that she really was Christ, because she could walk through walls; in fact, she had to walk through walls, explaining that if she was only allowed to do so, 'peace will come to earth, and all the sins will be forgotten'. Naturally, hospital staff were not in favour of this behaviour, as she had already broken her nose and a knee-cap in these attempts.

Christina was conceived when her mother had an affair with a married man. The man didn't want to leave his wife, and Christina's mother, who was Catholic, could not have an abortion. She married another man, whom she did not love, and had a very unhappy marriage. Christina felt she really should have died, 'walked through the wall' of her mother's womb, and then her mother's sin would have been 'forgotten'. Instead, they all lived very unhappily together.

The infanticidal ideation that the mother may well have entertained had never been acted on, but implied in a hundred ways: for one, by telling this story to Christina as soon as she reached puberty, as a warning. She never had any other children, saying that 'more children would kill her'. Mother and Christina were very close and 'had their own (symbolic) language', having this big secret to keep. Christina's language was equally symbolic: she was Christ, because she was to die for the sin of her mother, and she had to walk through walls, i.e., not have a physical body, in order to bring peace to earth. In the therapy, much of the work was to do with me having to find the meaning of each symbol, which was her desperate plea for liberation from the deadly secret.

*Emma,* by contrast, had a completely different language and a different trauma history. Aged fifteen, she was an extremely ill patient whose self-harming behaviour was particularly dangerous. We knew that she had been badly abused as a young child, but she never revealed any details of the abuse, the identity of the abusers and in particular, the way in which they used to get hold of her each time. Emma communicated with us mostly through drawings and a few written words. She hardly talked. In her art therapy sessions, she repeatedly produced images of many arms reaching to grab a little person, and of A KEY. The art therapist and I tried for months to follow her line of communication, expecting the ARMS images to be the KEY to the riddle of the people who harmed her. In other words, we understood the images of the key to have the symbolic meaning of KEY, i.e., a CLUE. But we were wrong. Emma kept producing the same images, and to all our explorations of hidden clues she answered a definite 'No'.

The breakthrough happened one day when, despairing of ever 'getting it', I asked Emma 'was there a real key there?' She looked at me with relief, and nodded 'yes'. The abusers had the key for the back door of the house. It was not a symbol, but a straightforward, concrete description of how the abuse took place.

*Jo*, a terribly thin young man, used to tell me extremely lengthy stories involving his visits to ancient Egypt, where he was the king's hieroglyphics writer, and lived in the City of the Dead. He was a professional translator of eight languages, when he wasn't in psychiatric admissions, and an interpreter of dreams for the ward when he was in hospital. He always told me that I will get nowhere without 'learning the secrets first.' The secrets, of course, were not about the Egyptian Royal Court but about the home that he grew up in, 'the City of the Dead', where his father, the king, did not want any children (the Pharaoh who put to death all the Israelites' first born?). Father was fifteen years younger than mother, and said that he 'needed her more than anyone'.

Here, too, the symbolic language of hiding the truth that was used by the whole family could be seen in the highly symbolic, schizophrenic language of Jo.

And to use Lidz's example, from Kahr's paper:

*The 'young Virginia Woolf'* patient ended up committing suicide. There is certainly no doubt about how severe her condition had been. There is also strong evidence to the nature of her attachment to her mother being infanticidal, which may have been the reason for her tragic death. The quality of the infanticidal attachment was symbolic: for all we know, the mother had not attempted to kill the girl or abuse her. On the contrary, she rather idealized her as being of a rare literary talent and sophistication. One had to know the life (and death) story of Virginia Woolf to see the significance and intensity of the mother's message to the girl: 'I'll love you best when you're dead'.

And again, by contrast:

*Jane*, fifteen, told me a lot of stories about the pets that had died in their house, and how upset she was when the man in the pet shop, to whom she went for advice, tried to comfort her by saying that 'these things just happened'. She went on to tell me the details of how the dog bit her because he was scared, because the pet rat had bitten him; and that the pet rat was missing some toes and was bleeding.

Jane was brought to hospital in her parents' arms, literally dying. Her bodyweight was at 50% of normal, a level of starvation from which recovery is rare in medical literature. The obvious question, why did the parents wait so long before seeking help, was not answered; but it is hard to miss the infanticidal intention of such lack of action. She was not psychotic, and, I would add, not symbolic. She was a survivor of ritual abuse, in a family where children were made to cut, kill and eat body parts of animals from an early age, as part of their 'training'. Her stories about the dead and mutilated animals were not, as I first suspected, a symbolic description of her own self-hatred and death-wish. She didn't want to die. She wanted someone to notice what was actually happening at home; hence her upset about her unsatisfactory 'consultation' with the man in the pet shop. What she told me was a concrete description of actual events, and her refusal to eat was her revolt at being forced





to ingest the body parts of her pets. Her story had a partial corroboration.

It is my experience that people with DID are remarkably literal. When they draw a baby they mean a baby, not a representation of a needy part of the self; when they say a knife they mean a knife, not a phallic object. When they say 'I can't not talk to you about these things' it is because they were trained not to talk, not because they are embarrassed. Often, when their accounts seem totally implausible, we want to find an alternative explanation that could make sense of what they've said. Almost invariably, I have subsequently learned that their account was literal and accurate, if not always correct. And the incorrectness was a result of missing information, due to dissociation, and not of elaborating the truth. We may say these stories are quite simple and single layered in their meaning.

Some of the best and richest examples of this type of communication are to be found in the book edited by Valerie Sinason (1994), where the point about the accuracy of the accounts is very clearly made.

Conversely, the symbolic type of infanticidal attachment produces 'nameless dread' (Bion, 1967), because the reason for the fear, namely, the infanticidal intention of the parent was covert, hidden, and symbolized – the dread is detached from its 'name', from its cause. Jo was terrified of a King in the City of the Dead, not of Dad. Lidz's patient, if the analysis is correct, went to extraordinary lengths in trying to appease her infanticidal mother, who loved Virginia Woolf. None of the infanticidal ideation or wishes was directly expressed. Subsequently, all the terror is expressed by the child (and later, the adult) in that same covert, hidden, symbolic way, which protects everyone from knowing about the murderousness.

Jane, on the other hand, was afraid of being forced actually to kill her pets and eat parts of their bodies. Her stories were like a trail of breadcrumbs leading us to the truth: whispered, but not coded.

It is perhaps like comparing the sense of horror that is induced in us while watching a David Lynch film in contrast to the one we feel while watching a war film. The former is chilling through its sinister suggestion; the latter is simply gory. Both can be highly traumatizing.

Infanticidal attachment was a term waiting to be coined. And the fact that it is so naturally absorbed and further elaborated is a sombre reminder of how little we know, and how much is still waiting to be understood in the field of trauma.

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# Introduction

*Adah Sachs*

Lily, 13, was the sweetest girl you can imagine. Big blue eyes, a lovely, soft smile, and a gentle voice. She was admitted following a massive overdose, as well as repeated episodes of head banging. At the time of her admission her forehead was so hugely swollen that she looked quite deformed. She appeared insightful regarding some school problems she had and was generally charming and warm, showing every sign of being a normal "troubled adolescent". That was rather at odds with the level of her self-harm and with our knowledge of severe abuse in her history. Lily, I might add, had maintained that "nothing bad had ever happened to her".

On her second session, Lily came wearing her hair in pigtails and holding her teddy, which made her look about 6 or 7 years old. Still at the door, she asked me sweetly if I'd look after her teddy for her. I asked if she felt that he needed help, too, and she said that we were all making a mistake: he was the one "in danger"; she was fine. At that, she sat on the floor, carefully placing the teddy on the patient's chair. After a moment of silence, she said she was very worried about him; he would die if he wasn't watched. I asked what did she fear may happen to him. To my

shock, her sweet little face suddenly became white and contorted, and in a monstrous, croaking voice that sounded to me like it came straight from *The Exorcist*, she roared, "*I–I–I–I* will kill him!"

Now who is "I", and where does it live: in the teddy, which she had put on the patient's chair? In her harmed body? In the contorted faces of her abusers, who were suddenly visible on her own face? Or perhaps in that Lily she had told me about, the one whom "nothing bad had ever happened to"?

For Lily was actually many "Lily's", who were largely unaware of each other. Most of them were very distressed in different ways, but one of them was a bright and lovely girl, with some minor difficulties at school, who was completely baffled by her strangely swollen forehead and had no idea why she was in a hospital at all.

One night, with great consternation and rather shakily, a white-faced Lily told the ward nurses that she had murdered her sister. She was then sick and couldn't go back to sleep for a long time. The incident was recorded as "hallucination". But was it? She had never hallucinated before and did not again, to my knowledge, after that night. In a session she had with me some days later, she again alluded to that murder, adding her sister's name.

I was haunted by questions: Was it a phantasy? What does such phantasy mean? Did it express her secret wish to be rid of her sister? But her record showed that she was an only child. Did her mother know about these thoughts? Did the family therapist understand any more? Could it—could it possibly be true? Did I have a duty to report it? To whom? What would happen if it were true, and I treated it as a symbolic expression? Should I become Sherlock Holmes and try to investigate? What would happen to the therapeutic relationships? To the mother? To the girl? What would happen to me? Could I be prosecuted for withholding information about a serious crime? For disclosing confidential material? For wasting police time? For being stupid?

One of the most uncomfortable aspects of offering therapy to people with dissociative identity disorder (DID) is that, sooner or later, most of them begin to talk about horrendous crimes. Crimes that were committed against them, crimes that they have witnessed, or crimes that they have been made to commit or have



deliberately committed themselves. The crimes that they describe are always shocking. They sound unlikely, mad, impossible. Almost always they are unproven, and there are so many bits missing in these stories that one can hardly think how they can ever be proven—or, for that matter, proven wrong.

Dissociative identity disorder (formerly known as multiple personality disorder), is a baffling, confusing and seemingly bizarre condition. Although DID is a formal *DSM–IV* diagnosis, it is very controversial, and many professionals hold the view that it is extremely rare, doesn't exist at all, or is factitious (pretended). I suspect that the most important reason for the reluctance to recognize DID is not its confusing appearance, which to many professionals is actually rather fascinating. I believe that the reluctance stems from the disturbing link between DID and the most extreme and sadistic forms of crime, especially when faced with the continued involvement that many survivors still have with a world that none of us wishes to believe in or to share (Coleman, chapter 1; Healey, chapter 2; Cross & "Louise", chapter 5; Silverstone, chapter 12; Cook, chapter 13).

There is, on the whole, a fair interest in the "mechanism" of dissociation, which is quite fascinating. Much less interest is usually found in the background to DID. Similarly, there is much more openness among therapists to techniques of "grounding" the traumatized person than there is to listening and bearing witness to a traumatic history. One may say that this is rather at odds with the normal therapeutic stance, which is that listening to and understanding the history of a patient are prerequisites to any helpful therapeutic process. I would like to highlight here the rather obvious fact that therapists, while aiming to help, are aided by—and hampered by—their own emotional and mental scope, not least by their capacity to hear evil.

Furthermore, therapists, on the whole, are interested in and are trained to delve deeply into the internal processes of the psyche. Our consulting room is deemed best used as a place for thinking, feeling, and reflecting, and what we normally hope for is an internal development or transformation. Being called upon to respond to serious, sometimes ongoing crimes is not usually our area of interest, training, skill, or competence. It forces our attention

outwards rather than inwards. We become worried about our own responsibility for what was—or is—being done to, or by, our patient. We feel unsure whether what we hear is an internal, psychological process or whether it is in the external reality of the person (Sinason, chapter 7; Mollon, chapter 8). We get caught up in trying to figure out "what really happened" and in doubts about the truthfulness of the narratives that we hear. We feel guilty and anxious when we don't believe the person's story—and perhaps even more guilty and anxious when we do believe it, as this may mean that we should be doing something of which we aren't sure. Not to mention the anxieties about being simply wrong, misled, taken in. Of all the forensic stories that one may hear in the consulting room, the ones coming from people with DID are probably the most unbelievable, the most shockingly grotesque, and the least corroborated. It is not surprising that these accounts are met with a great deal of suspicion and often outright hostility; and the field of extreme trauma is marred by fierce political debates, aggressive legal battles (e.g. regarding false memories), and bitter professional disagreements, as if in resonance with the violent nature of the clinical material.

Whether one is a therapist, a police officer, a clergyman, a GP, or a lawyer, listening to accounts of people with DID is confusing, owing to the multiplicity of speakers and all the contradictions that arise from that. A person may relate an event, while another alter of that same person completely denies it, has a different version of what happened, or is shocked at the fact that you ask questions about a subject that she or he had never told you about and is a secret. One is forever left questioning: Does all this really happen (Coleman, chapter 1; Sinason, chapter 7)? What (and who, and if, and why) do I really believe? Does what I believe matter (Galton, chapter 9)? Is the person speaking responsible for the crimes that have, allegedly, been committed by other alters, and what are the implications of the answer (Farmer, Middleton, & Devereux, chapter 6)? What are the limits of confidentiality when an alter reports a crime, whether in the past, the present, or the future (Anderson, chapter 11; Cook, chapter 13)?

Perhaps even more than the minefield created by multiplicity and dissociation, DID is hard to engage with because it is very



upsetting, frightening, and unnerving. The traumatic content of the stories is upsetting and frightening. The unproven claims about terrible crimes are unnerving. There is an overall sense of a big pitfall that one is constantly on the verge of, while grappling with difficult clinical, ethical, moral, and legal questions, not to mention the spiritual concern that many people feel about such a close brush with evil.

One can't help but wish for the problem to "go away", or be proven to be a mistake, a misunderstanding, hallucination, or lie. But it seems that rather than going away, our growing (if still rather limited) knowledge of extreme abuse and its sequels is pointing to the contrary. The results of the Extreme Abuse Surveys (Becker, Karriker, Overkamp, & Rutz, chapter 3) give a stark picture of the types of abuse that people with DID (and others) have reported.

Many authors discuss trauma and abuse as the cause of dissociative disorders: to name but a few, the *DSM–IV–TR* (APA, 2000), Ross (2000, 2004), Sinason (1994, 1998, 2002), Mollon (1996, 1998), van der Kolk, McFarlane, and Weisaeth (1996), and van der Hart, Nijenhuis, and Steele (2006). The most relevant point for this book is that none of these authors refers to trauma in general, such as may occur as a result of natural disasters, poverty, or hunger. They refer specifically to trauma that is deliberately and systematically inflicted by people on whom the victim is dependent, with the aim of creating intense suffering and intense fear and, subsequently, utter submission to the will of the perpetrators (Sachs, chapter 10; Sinason, chapter 14; Lacter, chapter 15). The perpetrators may be religious groups, paedophiles, political entities or simply a family ("Aahbee", chapter 4), as well as any combination of them. They all intend to achieve an invisible slavery that makes the victims unable to resist the wishes of the perpetrators, including participation in further perpetration: indeed, another unnerving aspect of working with survivors of these types of abuse is the realization that, often, they are also the perpetrators of the awful crimes that they describe.

I'll return to my young patient, Lily.

Sadly, at the time that I attempted to treat her, I knew very little about this subject, and I was of very little help to her. I did not

ask more about her sister, nor did I think that there might be other alters, inside Lily, who knew about things that she didn't know. Through several years of psychiatric admission, most of which were spent in intensive care, locked units, Lily has never been assessed for having a dissociative disorder of any kind. She had an array of other diagnoses and a poor treatment outcome. My own resistance to entertaining the possibility of a real, bizarre crime—a resistance that was totally supported by my entire professional environment—did not help her to explain. Her tormented world remained intact, unreachable, untouched by any understanding. And she was not the only one.

It is for the sake of reaching the many other Lilys out there that we need to think deeper.

* * *

The chapters in this book reflect the thoughts of a range of professionals who have worked with this group, as well as those of two people who have DID, about the forensic aspect of their experience.

Joan Coleman addresses the question that is always asked about organized abuse: "So why don't the police get them?" Her chapter is about the great difficulties of bringing cases of alleged satanist ritual abuse to court. She describes the low credibility of accounts regarding any satanist activity, as well as the further complication of having to rely on witnesses whose accounts are subject to change as their alters or personalities change.

Chris Healey, in an interview, takes us through his own vexing experience, questions, and quandaries in the process of investigating four allegations of ritual abuse that were made to the police by people with DID.

Thorsten Becker, Wanda Karriker, Bettina Overkamp, and Carol Rutz report the preliminary results of the largest survey to date of extreme abuse—the Extreme Abuse Surveys—reflecting a sample of over 2,000 survivors and professionals from 40 countries. From the responses to the survey's detailed questions, which cover many areas, the authors have extricated for this book the ones relating to forensic issues.

"Aahbee" writes about the development of her own DID in the traumatic environment of severe domestic abuse. She shares



her insights into this process, which are based on her professional understanding as well as her personal therapeutic journey.

Sue Cross and "Louise", in a counsellor-and-survivor joint account, show the complex multidimensional maze of learning "what really happened" to "Louise", who spent three years in prison.

James Farmer, Warwick Middleton, and John Devereux write about the complex position of the law regarding *agency* and *responsibility* in cases of crimes that were committed by persons with DID. The principles on which responsibility is allocated, or is deemed "diminished", are discussed in a number of cases that have come to court in the United States, Australia, and New Zealand.

Valerie Sinason talks about the internal and external reality of murder in the life of a person with DID, in a rare case where a body was found and a conviction took place. In this surprising account, Sinason shows how the "internal" and the "external" are not mutually exclusive, and that the search for the truth is even more complex than may first meet the eye.

Phil Mollon's chapter is about the difficulties in offering psychoanalytic psychotherapy in cases where the horrendous internal reality is inextricably linked with the patient's external reality.

Graeme Galton explores the clinical implications of the psychotherapist maintaining a strictly neutral stance on the question of believing—or not—the DID patient's memories of extreme abuse and the effect that this stance is likely to have on the patient. He considers the meaning of believing not just the psychic reality of the patient's account, but also the historical truth of what the patient is saying.

Adah Sachs offers a theoretical link between extreme abuse and DID, using a new attachment theory classification, *infanticidal attachment*, and considers the idea that the very presence of DID may serve as forensic evidence.

Alison Anderson shares her sense of professional isolation and clinical concerns regarding a patient with DID whom she treats in general practice.

John Silverstone considers trauma evidence in the body, through the eye of an osteopath. He describes his findings when examining people with DID and their distinctive kind of

presentation, differentiating old, new, and repeated injuries, as well as "scars" that are left in the body tissues as a result of intense emotional trauma.

Sue Cook grapples with some of the ethical and practical difficulties of counselling a person who is repeatedly assaulted—and perhaps who is assaulting—while in therapy.

Valerie Sinason, in her second chapter, looks at the phenomenon of mind control as one of the ways in which DID is deliberately produced. Sinason discusses mind control in its wider social context, from the normal to the sinister.

Ellen Lacter offers a description of twelve different types of mind control, from the simplest and conscious to the most complex and unconscious. She then discusses methods for "undoing" the control over the person's mind in an attempt to restore the capacity for thinking freely.

* * *

Dissociative identity disorder is considered to be very difficult to treat. In looking at the forensic side of this disorder, I hope to highlight what, to my mind, makes it so difficult: the terror, the secrets, and the defensive (or protective) chasm between the traumatized person and all those who have not been tortured. I believe that reaching across this chasm is the true work of integration.

This is the aim of this book.

Sachs, A. and Galton, G. (ed.) (2008). Forensic Aspects of Dissociative Identity Disorder. London, Karnac.

CHAPTER TEN

# Infanticidal attachment: the link between dissociative identity disorder and crime

*Adah Sachs*

The *DSM–IV–TR* (APA, 2000) states that individuals with dissociative identity disorder (DID) frequently report having experienced severe physical and sexual abuse, especially during childhood.[1] Many authors have attempted to explain this link between abuse and dissociation. Schore (1994, 2003), Davies and Frawley (1994), van der Kolk, McFarlane, and Weisaeth (1996), Wilkinson (2006), and others have written extensively on the neurobiological process that leads from extreme trauma to dissociation, as a bodily "shutting-down" response. Ross (2000) describes a deliberate creation of DID through government-sponsored mind-control programs. Van der Hart, Nijenhuis, and Steele (2006) coin and describe *structural dissociation* as the result of chronic, especially (but not only) early, traumatization. Liotti (1999), Southgate (1996), Sinason (2002), and others have written about the link between trauma and dissociation from an attachment perspective, focusing on disorganized attachment as the almost inevitable sequel of severe relational trauma.

In this chapter, I would like to add to the attachment-based discussion regarding extreme relational trauma in infancy and its link to DID. I shall focus on the special role that *infanticidal*

*attachment* (Kahr, 2007) plays in the most severe forms of dissociative disorders. And as infanticide—the practice of killing infants—is among the worst of crimes, I would emphasize the forensic aspects of the trauma in the lives of people with DID, and the special significance of this element.

## *Infanticidal attachment*

> "Francine still believes that Daddy was trying to kill her, and if she'd been a good girl she would have stopped breathing and died. . . ."
>
> "i just have to lie really really quiet and still and see if am dead later."
>
> "Aahbee" (chapter 4)

The words "infanticidal attachment" are very evocative, which suggests that they are describing something that we can recognize. I would like to place this "something" in the context of the known attachment types.

Attachment, the term coined by John Bowlby (1958), is an innate structure in humans and animals that makes the young seek the proximity of a specific caregiver (the attachment-figure), for the purpose of safety and thus survival. I would now look at the different identified forms or types of this structure as occupying points along a continuum of effectiveness in achieving the purpose of safety.

### *Attachment types*

*Secure attachment* provides a stable, organized structure, allowing for separation, exploration, and play and serving as a basis for the formation of future relationships. It thus supports short- as well as long-term survival.

More painful, but still functional structures are present with *insecure attachment*. There are two types—avoidant and ambiva-



lent—and these represent specific deficiencies in the relationship with the attachment-figure and are likely to lead to varying degrees of difficulties in forming future intimate relationships (e.g. with partner, children). However, these insecurely attached babies were consistently able to reach the attachment-figure, although they had to go about it in a roundabout, painful way. Attachment behaviour of the kind that the parent could tolerate did prove effective, consistently producing the proximity, safety, and comfort needed. The attachment style that resulted was thus organized and stable, if not happy.

With *disorganized attachment* we move to the sphere of trauma. The baby never knows what would bring comfort or safety, as this is unpredictable. In the case of neglect, for example, the baby gets no comfort at all for lengthy periods, no matter what attachment behaviour is expressed. In the case of abuse, the confusion and terror are greater, as the attachment-figure, towards which the child turns in distress, is also the one causing the hurt. In the case of a mentally ill, depressed, or dissociative parent, there are so many variables affecting the parent's capacity to respond helpfully that no consistent way of reaching comfort can possibly be found, and the child is in a constant, frantic search for the parental closeness. Disorganized attachment, while reaching for safety, may also become a hindrance to it, by linking the infant to a figure that may be dangerous and by exposing him or her to further trauma.

Disorganized attachment is, statistically, the single most important predisposing factor for dissociative traits in adult life, from developing dissociative disorders to a high propensity for PTSD. It also predicts a much higher likelihood for psychiatric distress or for criminal activity (Hesse & Main, 2000).

So far there have been a few suggestions for subdividing the disorganized attachment classification.

Liotti (1999, 2006) talks about three motivational systems that could replace the painful experience of the disorganized attachment system being activated. He calls them the *agonistic, sexual, and caregiving* systems and explains that each of them provides a way of being close to the longed-for figure in a less painfully vulnerable, dependent way. The use of these systems in defensive replacement of the attachment system is expressed in three types of controlling

strategies: punitive, sexualized, and caregiving. We may consider these controlling strategies as three more subtypes of disorganized attachment, as they fulfil the same role (immediate reduction of distress by achieving proximity to the attachment figure).

The category *cannot classify* in the Adult Attachment Interview (AAI) was suggested by Hesse (1996). This category is thought to be a more severe and pervasive form of the *disorganized* category, where the "disorganization" appears throughout the interview, and not just at specific, difficult points of it. One may speculate that this result may belong to people with DID.

In every case of disorganized attachment, the actual relationship between the attachment-figure and the infant is traumatic and traumatizing. Severe neglect, mental illness, and physical or sexual abuse cause unspeakable damage to the infant, *but they do not necessarily intend to cause damage*. These parents may well love and attempt to protect the baby when and where they can, despite the damage that they inflict at other times. One may say that these parents "take out on the baby" their own uncontainable emotions of aggression, despair, sexual arousal, or fear, unable to care, in these moments, for the baby's feelings or needs. It is as though the baby becomes, temporarily, invisible to the parent, not a real person.

Now let us consider the additional harm where *there is an intention, a wish, or actual attempts* to mutilate or kill the child. The child, in these cases, is not invisible: he or she is specifically targeted by the attachment-figure as a "chosen sacrifice" or as an object of hate, in fantasy or in practice. This, I suggest, is where *infanticidal attachment* will result. On our continuum of functionality, it is the most dysfunctional, as it increases, rather than reduces, the risk to the child's well-being or even life.

A child with an *infanticidal attachment type* (Kahr, 2007) feels reassured by, and thus strives for, the proximity of a murderous caregiver. This leaves the child completely exposed to further damage which emanates from the attachment-figure. As well as impacting on the child's safety, this also creates a particular kind of attachment-behaviour, which aims, as does all attachment-behaviour, to engage the caregiver. This type of attachment behaviour becomes apparent in the process of therapy of infanticidally attached people and represents a serious challenge to the therapy.



Infanticidal caregivers, however, vary in the quality and type as well as the intensity of their murderous feelings. I would therefore like to draw a distinction between two types of infanticidal states of mind, the *symbolic* and the *concrete*. Subsequently, I would distinguish *symbolic infanticidal attachment* from *concrete infanticidal attachment*. I suspect that only those infants who were exposed to the *concrete* type of infanticidal caregiving would develop DID, with all its distinctive features.

The spectrum of attachment types, in decreasing order of safety, can be summarized as follows:

SECURE

INSECURE

Insecure avoidant / Insecure ambivalent

DISORGANIZED

"Replacement": Agonistic / Sexualized / Caregiving [Liotti]

Cannot classify [Hesse]

Infanticidal attachment (IA) [Kahr]

Symbolic IA / Concrete IA [Sachs]

### *Symbolic and concrete infanticidal attachment*

While it appears that a large percentage of people with schizophrenia, as well as other mental disorders, have suffered parental infanticidal ideation or intentions (Kahr, 1994, 2007; Ross, 2004), I would like to emphasize the predominantly symbolic form that characterized these death threats. The symbolic form in which parental murderousness gets expressed shapes, as it always does, the attachment-behaviour of the baby and may lead to the highly symbolic language of schizophrenia (as well as some other forms of mental illness). The history of people with DID, on the other hand, seems to invariably include early exposure to parental concrete acts of murder or torture, which the infant endures, witnesses, or is forced to commit. This, I would argue, is a necessary condition for developing the concrete language of DID.

The parallels between the type of parental expression of murderousness and the attachment-language in the child (symbolic leads to symbolic, concrete leads to concrete) should hardly be surprising to us: attachment-behaviour—the "reaching-out" language of the baby—is always modulated by the language of the attachment-figure, as it aims to engage with the attachment-figure.[2]

While *symbolic infanticidal attachment* can occur due to a variety of tragic circumstances (Green, 1986; Hollins & Sinason, 2000; Sachs, 1997), I suggest that the *concrete type* will only occur where there are concrete, actual, intentional, and repeated torture and death threats at the hands of an attachment-figure. The diagnosis of DID, therefore, may have to be seen as a marker for forensic concern, as it is likely to indicate extreme childhood abuse, though not the identity of the abuser(s).

Attachment needs, however, cannot be "switched-off". An infant cannot forego having an attachment-figure, whatever the qualities of that figure may be. Furthermore, an infant's attachment-style will, inevitably, mimic the person to whom the infant is attached. If that person wants the baby dead or mutilated, the baby will become attached in that particular way: "Mum loves me when I'm screaming in pain. Dad will be with me if I'm good and dead." The baby's feeling of comfort will thus be linked to death, hate, or sadistic thrill in the same way that it is linked to being distant if their parent is AAI *dismissive* type. The sight of torture will be linked to the feeling of safety or even love, in the same way that the sound of a mother's voice singing a lullaby is linked to it.

I suggest that the term *infanticidal attachment*, symbolic or concrete, would correctly fit the attachment-style of babies whose parents are not just unable to contain their aggression or despair, but who actively want or need to see them dead or mutilated, whether they imply that wish or act on it.

It goes without saying that parents who feel compelled to see their children tortured or dead have an extremely traumatic history themselves. And it is the inevitability of further trauma, generation after generation, that makes it so critically important to offer therapy to persons of any age who present with this type of attachment-style.



## Clinical examples

A child who is attached to an infanticidal caregiver experiences reduction of stress when he or she is in the proximity of a person who aims to torture or kill them. This attachment further exposes the child to danger, with no way of abating it. It is thus dangerous, as well as traumatizing. I would now like to draw a distinction between infanticidal ideation or intentions that are symbolically implied and those that are concretely acted upon. The severity of either can vary, but, to my mind, there is a qualitative, not just quantitative, difference between them.

The following are short examples that may serve to illustrate the difference between symbolic and concrete parental murderousness:

> *Christina*, a young woman with schizophrenia, said she was named after Christ because she had to die for the sins of others. She knew that she really was Christ, because she could walk through walls; in fact, she was compelled to walk through walls, explaining that if she was only allowed to do so, "peace will come to earth, and all the sins will be forgotten." Naturally, hospital staff were not in favour of this behaviour, as she had already broken her nose and a knee-cap in these attempts.
>
> Christina was conceived when her mother had an affair with a married man. The man didn't want to leave his wife, and Christina's mother, who was Catholic, could not have an abortion. She married another man, whom she didn't love, and had a very unhappy marriage. Christina felt she really should have died, "walked through the wall" of her mother's womb, and then her mother's sin would have been "forgotten". Instead, they all lived very unhappily together.
>
> The infanticidal ideation that the mother may well have entertained had never been acted on but was implied in a hundred ways—for one, by telling this story to Christina as soon as she reached puberty, as a warning. She never had any other children, saying that "more children would kill her". Mother and Christina were very close and "had their own [symbolic] language", having this big secret to keep.

Christina's language was equally symbolic: she was Christ, because she was to die for the sin of her mother, and she had to walk through walls—that is, not have a physical body—in order to bring peace to earth. In the therapy, much of the work was to do with me having to find the meaning of each symbol, in answer to her desperate plea for being liberated from the deadly secret.

*Emma*, by contrast, had a completely different language and a different trauma history. Aged 15, she was an extremely ill patient whose self-harm behaviour was particularly dangerous. We knew that she had been badly abused as a young child, but she never revealed any details of the abuse, the identity of the abusers, or, in particular, the way in which they used to get hold of her each time. Emma communicated mostly through drawings, and a few written words. She hardly talked. In her art therapy sessions, she repeatedly produced images of many *arms* reaching to grab a little person who was chained to a table, and of a *key*. The art therapist and myself tried for months to follow her line of communication, expecting the *arms* images to be the *key* to the riddle of the people who harmed her. In other words, we understood the images of the key to have the symbolic meaning of *key*—that is, a *clue*. But we were wrong. Emma kept producing the same images, and to all our explorations of hidden clues she answered a definite "No".

The breakthrough happened one day when, despairing of ever "getting it", I asked Emma "was there a real key there?" She looked at me with relief and nodded "yes". Emma herself, under threats, had given the abusers a key for the back door of the house. It was not a symbol, but a straightforward, concrete description of the way the abuse could take place.

*Jo*, a terribly thin and grubby young man, used to tell me extremely lengthy stories involving his visits to ancient Egypt, where he was the king's hieroglyphics writer and lived in the City of the Dead. He was a professional translator of eight languages, when he wasn't in psychiatric admissions, and an



interpreter of dreams for the ward when he was in hospital. He always told me that I'll get nowhere without "learning the secrets first". The secrets, of course, were not about the Egyptian Royal Court but about the home that he grow up in, "the City of the Dead", where his father, the king, didn't want any children (the Pharaoh who put to death all the Israelites' first-born?). Father was 15 years younger than mother and had always maintained that he, father, "needed her more than anyone".

Here, too, the symbolic language of hiding the truth that was used by the whole family could be seen in Jo's highly symbolic, schizophrenic language.

*The "young Virginia Woolf"* (Lidz, 1973, quoted in Kahr, 2007) could serve as another example of symbolic infanticidal attachment. She was a schizophrenic patient of Lidz, and I have named her "the young Virginia Woolf" because her mother, who adored the famous author, regularly likened her daughter to her in talent and in personality. The girl, tragically, ended up committing suicide. We may suspect that the nature of her attachment to her mother was infanticidal, which may have been the reason for her tragic death. The quality of the infanticidal attachment was symbolic: for all we know, the mother had never attempted to kill the girl or hurt her. On the contrary, she rather idealized her daughter as being of a rare literary talent and sophistication. One had to know the life (and death) story of Virginia Woolf to see the significance and intensity of the mother's message to the girl: "I'll love you best when you're dead."

*Jane*, aged 15, by contrast, told me a lot of stories about the pets that had died in their house, and how upset she was when the man in the pet shop, to whom she went for advice, tried to comfort her by saying that "these things just happened". She went on to tell me the details of how the dog bit her because he was scared, because the pet rat had bitten him, and that the pet rat was missing some toes and was bleeding.

Jane was brought to hospital in her parents' arms, literally dying. Her bodyweight was at 50% of normal, a level of starvation from which recovery is rare in medical literature. The obvious question—why did the parents wait so long before seeking help—was not answered, but it is hard to miss the infanticidal intention of such a lack of action. She was not psychotic, and, I'd add, not symbolic. She was a survivor of ritual abuse, in a family where children were made to cut, kill, and eat body parts of animals from an early age, as part of their "training". Her stories about the dead and mutilated animals were not, as I first suspected, a symbolic description of her own self-hatred and death-wish. She did not want to die. She wanted someone to notice what was *actually* happening at home; hence her upset about her unsatisfactory "consultation" with the man in the pet shop. What she told me was a concrete description of actual events, and her refusal to eat was her revulsion at being forced to ingest the body parts of her pets. Her story had a partial corroboration.

## *Discussion*

I suggest that what differentiates these cases from one another is that in the "concrete infanticidal attachment" group (Emma and Jane) the infanticidal ideation was not covert, not implied, not hidden, not symbolized. It was acted upon, as though there was nothing to hide or to cover. What is grossly forensic, and thus normally hidden, was simply allocated to another, "not-me" part of the self (both in the parent and in the infant), and therefore did not need to find a complex way to be "lived with" or integrated.

Christina, "the young Virginia Woolf", and Jo, on the other hand, came from families who symbolized their murderous feelings and expressed them in a way that made them almost unnoticed. The three young people that I have described similarly expressed their fears and anguish in symbolic, complex ways that made them appear rather mad, but did not expose (even to themselves) the murderousness of their attachment-figures.



It is my experience that people with DID are remarkably literal. When they draw a baby they mean a baby, not a representation of a needy part of the self; when they say a knife they mean a knife, not a representation of danger or sexuality. When they say "I cannot talk to you about these things" it is because they were "trained" or brainwashed not to be able to betray secrets, which made them literally not able to do so, rather than embarrassed to discuss a shameful topic. Often, when their accounts seemed totally implausible to me, I have tried to find an alternative explanation that could make sense of what they have said. Almost invariably, I have subsequently learned that the account was literal and accurate, if not complete. And the missing information was due to dissociation, either spontaneous or induced, and not to elaboration of the truth. We may say that these stories are quite simple and single-layered in their meaning: Jane was afraid of being forced to actually kill her pets and eat parts of their bodies, and this is what she tried to express. Her stories about frightened, dead, and mutilated animals, as well as her severe anorexia, were like a trail of breadcrumbs leading to the truth: whispered, but not symbolized.

Conversely, the symbolic type of infanticidal attachment produces "nameless dread" (Bion, 1967). Because the reason for the fear—namely, the infanticidal intention of the caregiver—was covert, hidden, symbolized, the dread was detached from its "name", from its cause. Jo was terrified of a king in the City of the Dead, not of Dad. Lidz's patient, if the analysis is correct, went to the *n*th degree in trying to appease her infanticidal mother, who loved Virginia Woolf. None of the infanticidal ideation or wishes was directly expressed. Subsequently, all the terror got expressed by the child (and later, the adult) in that same covert, hidden, symbolic way, which protected everyone from knowing about the parental murderousness.

Making the division between the symbolic and the concrete may help our understanding of dissociation on the attachment map, but it has another, far more uncomfortable aspect. It states a difference between the tragic damage done to a child through their attachment to a person with infanticidal ideation (symbolic type), to the criminal damage done to a child through their attachment to

a person or a group who openly act in a murderous way (concrete type). For the therapist, this represents a new level of challenge, as the forensic becomes a centrepiece in the therapeutic process.

It is important to stress that while I have stated that there must have been an actual, intended, and murderous abuse in the background of anyone with DID, and that the abuser(s) must be the victim's attachment-figure(s), this does not necessarily help to identify the perpetrators. In many such cases, the abusive attachment-figure is a group, rather than an individual. Such a group has a whole hierarchy of people involved in abusing children, while "training" them to become part of the group. Furthermore, when one is in the grip of extreme terror or pain, the people who inflict it or stop it can become new attachment-figures, even at a later age. Identifying this type of attachment thus tells us that something awful was done to a person; but it is still a far cry from knowing what was done, how, or by whom. And it is even a further cry from being able to stop it, or to bring about healing.

A brief word about healing, the ultimate aim of all our attempts to understand. Becker and Karriker (private communication, 2007), as part of the Extreme Abuse Surveys, explored the views of survivors on the helpfulness of 53 healing methods. The preliminary results of the survey show that the three methods that were marked "great help" most frequently were individual psychotherapy, personal prayer, and supportive friends. From an attachment perspective, it is notable that all three involve closeness, and someone listening. Poignantly, it seems as though what helps to heal the damage of a murderous attachment is a benign and deep relatedness.

## Notes

1. This finding is further elaborated in the writing of Davies and Frawley (1994), Mollon (1996, 1998), van der Kolk, McFarlane, and Weisaeth (1996), van der Hart, Nijenhuis, and Steele (2006), Ross (2000, 2004), Schore (1994, 2003), Sinason (1994, 1998, 2002), and others. Quantitative studies are offered by Ross (2004), who links DID to "a history of *particularly severe* childhood trauma" (emphasis added), demonstrating the very high proportion of such trauma in this group in a large number of independent studies. Becker, Karriker, Overkamp, and Rutz (chapter 3) report preliminary results that reflect a sample of over 2,000 survivors and professionals from 40 countries. The authors show a very high correlation between DID and a list of abuse types, all of which are extreme.

2. Hollins and Sinason (2000) point out the risk of disorganized attachment and death-wishes in some people with learning disabilities, who could sense the wishes of their attachment-figure for them to have been aborted.

CHAPTER THREE

# Intergenerational transmission of massive trauma: the Holocaust

*Adah Sachs*

My baby was born ill and lacerated
And tiny as the palm of my hand.
And when he cried, grandpa told me to nurse him,
my little baby,
only his lips weren't sick.
My little baby was born ill and wounded:
I've always known, something
is sick
inside me, someone
dead.

—*Anon.*, poem by a second-generation Holocaust survivor, 1985

Ruben, fifty-four, is a famous chef and a "wild character". He is obese, a heavy smoker, and a reckless driver. Despite his high earnings, he is often in debt. He is twice divorced.

Gabriel, aged fifty-five, still lives with his parents. He is single, and has a very promiscuous lifestyle "on principle" (to use his own words).

Yellin, J. & Bedouk-Epstein, O. (ed) (2013). Terror Within and Without: Attachment and Disintegration: Clinical Work on the Edge. London, Karnac.

Daphna, fifty-two, is an unusually beautiful woman. She is a consultant at a teaching hospital, specialising in HIV and AIDS. She is a single mum.

David, a bright man of fifty-five, is chronically unsuccessful at his work. He is single.

Lea and Josh, forty-eight, are married and have three children. They both suffer from depression, and largely depend on the help of their ageing parents to support their family.

Naomi, aged forty-eight, is a senior scientist, and had gained her PhD at the age of twenty-eight. She is happily married, has three children and a beautiful home. She and her family spend a lot of the time living abroad.

Josepha, fifty, had lost her four-month-old baby in a car crash, due to her own reckless driving (Kogan, 1995).

Isaac, fifty, had shot and wounded his father, during the latter's attempt to save him from suicide (Kogan, 1995).

Kim, aged thirty-eight, is a successful photographer. She loves her work and her lifestyle, which involves frequent travel to exotic locations. She is highly sociable, charming, and warm. She is single, and states that she "could never settle down".

* * *

These little snippets appear totally unrelated. Indeed, these people are very different from one another. Some are high-flyers and some unsuccessful; some have families and children and some never managed a relationship; some travel a lot and some have never left home. Some suffer depression and have even attempted suicide; one was responsible for the death of her baby; and some of them lead rather happy and creative lives. The one visible link between them is that they are all quite close in age: they are all part of a group known as "the second generation of Holocaust survivors". One of them, the thirty-eight-year-old Kim, is from the "third generation". It was her grandmother who was a survivor.

The name, "second generation Holocaust survivors", suggests that these people are a distinct group, and that the Holocaust plays a significant role in their lives; in fact, it suggests that they themselves are some sort of survivors. But is that really so? They were not even born during World War II, and have certainly not endured any of its horrors.



They all grew up in free countries, in at least moderate material comfort, and most of them still have two caring parents. Yet the name "second generation" arose somehow, and stuck. As though there *was* something distinct and different about this group; as though they do, somehow, carry their parents' trauma; as though the parental trauma has somehow been transmitted to their offspring.

In this chapter, I would like to look closely at the notion of "trauma transmission". I will ask, and try to answer, two related questions. Does trauma really get "transmitted"? And if so, how, exactly, does that happen?

Intuitively, it seems quite plausible that growing up with traumatised parents may be traumatising for their children. But is this the same actual trauma being "transmitted", or the consequences of a painful upbringing?

In some cases, like, for example, violent families, there may be an apparently obvious "transmission pathway", through the repetition of the same kind of violent behaviour that the now adult child suffered, being directed towards his or her own children. Each generation, in turn, thus experiences the same type of trauma. I would like to suggest, however, that even in those families where obviously dysfunctional behaviour is inflicted down the generations, the most traumatising element is not the violent behaviour itself but something else, which is even more powerful than that behaviour, and yet may be completely invisible.

The offspring of Holocaust survivors, at any rate, have had a completely different experience to that of their parents. For one, they have not lived through the Holocaust. Furthermore, their parents, the survivors, are on the whole highly protective and caring parents, who rarely manifest abusive behaviour towards their children. They are, generally, a well-adjusted population. Most of them have families, homes, jobs; they go on holidays and do not seem to act in strange ways. In their homes, most of them avoid even mentioning the Holocaust. It is not easy to see what exactly may cause trauma in their offspring. And yet, organisations that, forty years ago, offered support and therapy to Holocaust survivors, are now finding their hands full with the second and even third generations of these survivors. The poem quoted at the beginning of this paper was not written by a survivor, but by a daughter of one; and she writes about her sense of damage to her own baby,

a "third generation survivor". The trauma seems to continue to unfold, somehow, generation after generation.

Many researchers have tried to compare the "second generation" group to controls, regarding their levels of happiness, capacity for intimacy, sexuality, procreation, ambition and achievement, delinquency, psychiatric disturbance, individuation, depression, and attachment to parents. The results were mixed: some studies show no significant difference, while others show significant impairments among the second generation.

There was one area, however, in which every single study of the many that I have examined, namely Barocas and Barocas (1980); Brom, Kfir and Dasberg (1994); Danieli (1981); Gross (1988); Guy (1995); Hadar (1988); Karr (1973); Klein (1971); Mazor and Tal (1966); Shefet (1994); Solkoff (1981); Solomon, Kotler and Mikulincer (1988), and Zwerling (1982), arrived at exactly the same finding: the second generation group differed significantly from controls by being more attached to their parents and less able adequately to negotiate the process of *separation-individuation*.

I am using the term "separation–individuation" in the way Mahler (1968) defines it: the process by which both mother and baby gradually emerge from their initial "oneness", and the transformation of their relationship from *immersion* to *relatedness*. During this process, the baby becomes aware of his own Self as distinct and separate from that of the mother.

It appears that this process of emerging from immersion into relatedness is universally impaired in Holocaust survivors' families.

These findings have three important implications.

The first is that people who are born to Holocaust survivors do form a distinct group, with a specific common denominator. The second is that the common denominator is some sort of an attachment disturbance, which does not allow the second generation to separate and "be themselves". The third is that, because parents and children in these families remain in a state of "oneness", to a large degree any disturbance in the parents could be directly experienced by their children, who have not completely separated. As Bergmann has put it:

> The Holocaust trauma is probably transmitted with devastating effect to the child precisely because the parents could not assist in the process of separation. (1982, p. 265)



Now let me change the angle of our exploration, and look at the question of trauma transmission from the perspective of the parents, the survivors of massive trauma.

## *Massive trauma*

It is impossible and meaningless to measure trauma against trauma. It is impossible to compare suffering with suffering. How can one total anguish be any larger or smaller than another? Yet the expression "massive trauma" assumes some yardstick, which renders some kinds of trauma bigger, more devastating than others. I suggest that the best yardstick for the enormity of the trauma lies in our own incapacity to bear witness to it; or in the level of dissociation that listening to it inflicts on the witnesses.

Normally, we understand someone else's pain through our own feelings of empathy: "How would I feel if I found that I had cancer, or if my partner had died?" We flinch when we see a violent scene on television because we imagine it happening to ourselves; we cry with the bereaved, because we are able to imagine our own loved ones taken from us; and, sometimes, we "can't watch" certain things, when they surpass the limit of our capacity or willingness for empathy. To my mind, the differentiating factor between what is called "massive trauma" and any other traumatic experience, is that the former is beyond the limit of *anyone's* ability or willingness to feel empathy for, or to be "able to watch": anyone, including the victims themselves. This leaves the survivors utterly alone, as well as injured. As Freud wrote in *Civilization and Its Discontents* (1930a): "We may shrink in terror at the thought of certain situations: that of the galley-slaves in antiquity ... [or] of the Jews awaiting a pogrom. *It is impossible for us to feel ourselves into the position of these people*" (p. 89, italics mine).

Forty years after these words and a Holocaust later, Niederland (1968), having interviewed hundreds of concentration camp survivors, states:

> In examining a great many survivors of Nazi persecution I have again and again become aware of our consistent incapacity to imagine, much less to evaluate, the nature of the experience. (p. 61)

The "incapacity" that Niederland talks about seems to affect anyone who comes into contact with survivors, including the most empathic health professionals.

In one of his many examples of this phenomenon, Niederland describes a meticulous twelve page hospital report about a Holocaust survivor patient, complete with:

> ... all the details about his childhood illnesses, the condition of his grandfather, grandmother, and the patient's early and later masturbation; but, about his five years in Auschwitz ... [remaining] the only survivor of a family of 91 people, there is one line—*I repeat, one line* ... specifically, the one line says, "This man was in Auschwitz for five years". (ibid., p. 61, italics sic)

This patient had witnessed "... his brothers, sisters transformed into lumps of flesh and blood. One of his children was lying before him, transformed into such a lump" (ibid.). Yet the hospital report neglected even to mention these events. Niederland attributes this neglect to what he calls "the incapacity to imagine" such experiences; an incapacity that induces a sort of blindness, denial, rejection, or simply disbelief, in people coming in contact with survivors of massive trauma. In today's language, we could say that such trauma evokes dissociation in the countertransference.

### *Dissociation*

Most of my work at present is with severely traumatised people who have dissociative disorders. People who, from early infancy, suffered prolonged neglect, cruelty, and often the most unimaginable forms of sadistic abuse, usually at the hands of their attachment figure. And because they were only children or even babies, they were utterly helpless.

Utter helplessness is a key element in the devastating results of trauma. Krystal (1968) calls it "surrender to inevitable danger" (p. 113). Herman (1992) adds that the likelihood of damage increases through "exposure to extreme violence or witnessing grotesque death ... the salient characteristic ... is its power to inspire helplessness and terror" (p. 34). Niederland details the damaging elements:

> 1. The constant pervasive threats and reality of torture and death. 2. Extreme deprivation and suffering. 3. The necessity of ... suppression of any aggressive or altruistic reaction. 4. The immersion in death in its most ghastly and grotesque forms as a ... factor of daily experience. 5. A permanent psychological mark—*death imprint*—in subjects exposed to such massive traumatization. (Krystal & Niederland, 1971, p. 7)



Our inability fully to engage with accounts of massive trauma can only be matched by the inability of the victims themselves. Indeed, the distance that we experience in attempting to listen to accounts of massive trauma is a reflection of the same psychic process which occurs in the person who is subjected to such traumatic experience.

In the most devastating or terrifying moments, when deadly claws are about to sink into one's body, or into a loved one, with nothing that could stop them, all thoughts stop. The basic world of instincts takes over. Those who can, fight. Those who cannot fight, try flight. And the ones who are helplessly trapped, unable to fight or escape, freeze. What appears from the outside to be a freeze reaction or numb compliance is, in fact, dissociation. We might say that dissociation is a sort of extraordinary flight reaction: when a person can do nothing to save themselves or their loved ones, when both fight and flight are impossible, the mind, or parts of it, splits off from the body, and escapes without it. The body, with any parts of the self that could not escape, remains in place to take the inevitable; but parts of one's self remain "safe" by "disowning" any connection to the trauma, as if the terrible thing had not happened, or had not happened to "me". Like the little girl whom John Southgate (1996) talked about many years ago, here at the Bowlby conference, the little girl who explained her drawing to him: "This is me sitting in the ceiling, watching Daddy hurting little girl".

But massive trauma never passes without consequences, and it is only "as if" one can remain unscathed. The little girl who was sexually abused by her father did not remain safely in the ceiling. She was scarred for life. And what I call "scars" is but a euphemism for years and years of dysfunctional life and crippling suffering. As Bettelheim (1990) states: "Despite all outer appearances to the contrary, it is not possible for these victims of past events to have normal lives in the present" (p. 214).

Moreover, the dissociation itself, while being a rather ingenious way to flee the unbearable while it was happening, has debilitating effects on the person's life later on.

Studying survivors' families, I have interviewed a number of survivors and their children. One of my interviewees, Mrs. A., was twelve years old at the beginning of the war, and was on the run and in hiding for five years. When she started talking, it took me a long while to realise the gruesomeness of the events that she was describing. In a perfectly unaffected voice and with an almost expressionless face she related, in precise order, the names of towns she had fled; exact dates; method of transport; the names of participants in each escape attempt; the death toll; methods of executions; the cost of food. In the same unaffected voice she reported the names of people she never saw again, including her father and her mother. Her most terrifying and hopeless moments were made to sound so boring that I had to struggle to maintain my concentration. "It seems totally unreal, you know", she said, after talking, monotonously and without a break, for over an hour. "It is really like the life of someone else; like it happened on another planet".

Clearly, both Mrs. A. and I were quite dissociated from the content of what she was talking about. It was striking how the facts were perfectly remembered by her (unlike repressed material, which is forgotten), but as if they were "someone else's life". And while she was talking, I was able to take detailed notes of these facts, but felt terribly bored. Like her, I, too, was disconnected from what these facts meant.

But while the witnesses (such as myself) can all "turn their gaze away" or dissociate from the horrors, the victims can only do so at a great cost: whole parts of themselves, which are burning in pain and terror, become out of reach. They do not get help; they never get better; they cannot be soothed and they never find out that the war is over. Their tormented existence continues, as Mrs. A. said, "as if on another planet". Only occasionally the horrors become visible: through nightmares, flashbacks, chronic illness, depression and, as we will see later, through their children.

But, for the moment, let us stay with the survivors, and continue to explore the long-term costs of surviving massive trauma.

## *Identification with the aggressor*

In 1933 Ferenczi stated that the predominant defence available to children who are helpless in the hands of abusing adults is *identification with the aggressor*. This defence mechanism is achieved through introjecting the qualities of the aggressor into oneself.



We know that violence and abuse have the most devastating effects when inflicted in childhood or babyhood, particularly if inflicted by the attachment figure. It is generally agreed that the same events would have less damaging consequences if they were inflicted by strangers, or experienced at a later age. This may seem intuitively obvious, but the reason for it is important: while adults may be affected by people, children internalise or *introject* them, as part of normal child development. This is particularly so regarding their attachment figure.

In normal circumstances, introjecting the qualities of the attachment figure helps the child to become independent, caring, and able to look after him—or herself, as the attachment figure had done previously. But if the qualities of the attachment figure are not protective, but are violent, sadistic, and murderous, a child would introject them just the same, and even more so: when the attachment figure is terrifying, introjecting it also serves as a *defence mechanism* against its frightening qualities. Anna Freud demonstrated this well when she quoted a girl who explained to her little brother, who was frightened of dogs: "If you be a doggie, the dog won't bite you" (Sandler & A. Freud, 1985).

Adults, by contrast, are generally less affected by extreme events compared to children, because their identity is already formed. That is to say, they experience events, bad or good, as external to themselves, rather than introjecting them.

However, "In massive psychic trauma, the ego regresses, and we find that childhood susceptibility to trauma returns" (Krystal, 1968, p. 26). This is a very important assertion, as it explains how even adults can be transformed, not just affected, by massive trauma: under sufficient terror, adults, too, can return to a childlike state where new introjects can occur. It is a stark reminder that there are no hard borders between a child and an adult, a victim, an aggressor, or a saint. We are all susceptible. We can all be harmed.

I would like to elaborate on this point, as in my view it is critically important.

## *Infanticidal attachment*

If we consider that the attachment figure is the person who, so to speak, holds the key to safety and survival—such as a mother to a newborn—we can see that in an extreme, relationship based trauma, the people who have the power to inflict or stop the torture can become new, horrendous attachment figures. And with a new attachment figure comes

a new attachment behaviour, one that will keep the person safe at the side of the attachment figure. This behaviour may mimic that of the aggressor, identifying with him, or aim to appease the aggressor by being compliant with his or her wishes. (It is worth noting that some forms of mental illness, in particular schizophrenia, may also be seen as a mixture of these reactions to trauma (Kahr, 2007; Ross, 2007).

The traumatic damage that occurs in massive trauma is, thus, damage to the attachment system of the victim, whether a child or an adult. That is so because, in extreme terror, attachment needs are at their most extreme, and therefore they are re-exposed to remoulding, and to being damaged.

The process of traumatisation is thus manifold, and a vicious cycle: extreme terror elicits extreme neediness which brings, in turn, attachment behaviour, aimed at bringing the frightened person closer to the attachment figure and creating a feeling of safety. When the attachment figure does not rescue the victim, and no relief can be found, the victim eventually falls into one of the three defence types that have been described here, or some mixture of them. He or she may *dissociate* from the real situation into an imaginary safety, like John Southgate's little girl in the ceiling. Or, like Anna Freud's little boy who "becomes" the frightening dog, the victim *introjects the perpetrator*. The third way is to *appease* the perpetrator, striving to do what the perpetrator wants: be almost dead, dead, tortured. In the first case, the survivor loses the integrity of the self, by profound splitting. In the two latter cases, new, deadly introjects form a new sense of identity, and new images of safety: the comforting image of the aggressor, or the comforting image of being dead. Niederland called this "a permanent psychological mark—*a death imprint*—in subjects exposed to such massive traumatisation" (1968, p. 7).

While introjecting qualities of the perpetrator reduces the terror, it has a cost, too. Survivors are left with a strong sense of having been contaminated by evil. The feeling of contamination causes additional suffering, in the form of survivors' guilt, depression, and chronic illness.

For some survivors, however, the sense of contamination and the sense of a broken, dissociative self have brought about what seemed to be the complete opposite. Their lives became a constant, frantic attempt at creating a brand new, "clean" life, full of new, intense attachments. For many of them, the deepest way of finding a new life was by producing new life, by having children.



### *The second generation child: a new attachment figure*

For the survivors, having children was like magic. It was a completely new, non-malevolent attachment; it was a proof that, despite all the evil that they had been through, they were whole, and able to produce life; it carried the hope (or illusion?) that new life can replace the dead.

Most Holocaust survivors were, therefore, extremely dedicated and caring parents. Their babies were felt to be their cure, their hope, their lifesavers. Yet the effects of trauma did not disappear in the light of the new life. Encapsulated and dissociated, the trauma remained uncured, unchanged, untouched. And what is more, it was passed on to the next generation, through the natural door of the attachment system.

While most of these parents would have given their lives away to protect their offspring, they could not protect them from the messages of their traumatic introjects, and from the death threats that were carried and implied by them: "There is murder and terror and grief carried inside myself, forever ready to burst, and any sharp move that you make, may cause the bursting". "If I burst, you'll be contaminated too". "You are contaminated already, because you are mine" (Sachs, 1997, p. 36.)

The survivors of the Holocaust continued to carry the terrifying introjects of the perpetrators and their murderous wishes, in a dissociated way. And they needed their children for their healing, for their psychological survival.

The children, naturally depending on their parents (their attachment figures) for their own survival, had to develop attachment behaviour that would ensure they kept the parents alive, and the perpetrator inside the parents mollified. These children had to be always at the ready to soothe, to imitate the aggressor, to comply, to distract, or simply to duck whenever the aggressor appeared. Breaking away from the parents meant denying the parents their attachment figure, thus threatening their lives. As the child's main purpose in life was to heal the parents, failing to do that meant the child had no right to life. A member of a second generation therapy group expressed this very poignantly:

> ... "For years, I was a china doll. Always nice, neat, pretty, well dressed and well-tended. Eating what she is given. Not loving, not angry, not feeling ..." *The doll belonged to her [her mother]*, and she

> held on to it with both hands. So everyone knew that I was hers and she wasn't alone. (Wardi, 1992, p. 75)

That feeling, that "the doll is for mother" is the ultimate expression of individuation impairment. It says that the child is not even fully alive in the present, because it is only mother's doll; and that a form of killing has, already, taken place.

The second generation children did not have the safety which is needed for *individuation*. They had to stay very closely observant of their parents' smallest mood changes and needs, and fit in with those in the best way, for the sake of survival. This is disorganised attachment.

Furthermore, these children had to rely on the love of an attachment figure who had a murderous aggressor internalised. This is *infanticidal (disorganised) attachment* (Kahr, 2007; Sachs, 2007, 2008, 2010).

At the start of this chapter, I questioned the notion of "trauma transmission". I have asked whether the signs of trauma in the second generation were the actual parental trauma being somehow "transmitted", and noted that the parents could not possibly reproduce any of their Holocaust experiences. Furthermore, these parents were, on the whole, very caring and non-abusive towards their children. It was therefore hard to see how any trauma could be passed on to their children, or what could be the substance that might have affected the second generation.

I now suggest that the traumatic substance that was "transmitted" to the second generation was the dissociated, deadly introjects of their parents. The dissociative traits and the terrifying introjects constituted permanent changes to survivors' attachment systems, which were partly rebuilt around the survivors' abusers. For the survivors' offspring, these were now the qualities of their own attachment figure, which were invariably damaging. Without any abusive behaviour. And despite all love.

I would like to demonstrate some of these dynamics through the following case.

### *Ruben*

Ruben is fifty-four years old, and was born in London. Both his parents have blue numbers on their arms: Auschwitz survivors. His mother had had a child "there", a boy who did not survive. His father was previously married, but Ruben is not sure if he had children. He was



not called by his dead brother's name, but the meaning of his name is "behold, a son", which he thinks is in memory of that child. His mother had had several miscarriages before he was born. She is very small and frail, and has a crooked back. His father is also very thin. When Ruben was a child, they owned a small toyshop: he remembers them "going to work, hand in hand, like Hansel and Gretel—two little children going to fairyland". He knows nothing of their experiences "there", except that there was hunger, and that they both lost all of their families.

Ruben is a wild, fun, larger-than-life character. He is a star chef in a famous restaurant, with hundreds of people who call him their friend. He is also obese, a heavy smoker, a reckless driver, and he never goes to sleep before the small hours, or before he has had lots of alcohol in good company.

His earliest memory is of sitting in front of the table, with a plate of "disgusting, old, cold food" in front of him, and his mother sighing, "Eat, eat, you must be strong and big". He also remembers coming home from school, his tiny parents ready to leave for "Fairyland" (his name for the toyshop), giving him last orders: "The pots are on the stove. Eat everything. Everything". And he ate—with disgust and anger, yet unable to refuse them. "It kills her when you don't eat her food. And she is a terrible cook. I sometimes think she does it deliberately, to teach us not to be spoiled—we may not survive the next famine if we were!"

Despite the joking manner in which he speaks of his parents' "fear of the next famine", he himself grossly overeats. The obvious thought is that he has introjected his parents' fears of starvation, and eats to protect himself against such risk; but there is more to it.

His frequent referral to his parents as "Hansel and Gretel" suggests a rather sinister association to food. The two children were chased away from their home by an evil stepmother only to fall into the more evil hands of the witch in the candy house, who kept them in a cage and fed them in order for them to grow fat enough so that she could cook and eat them.

Food, in Ruben's experience, was not an expression of parental love and care, nor was it nice. It was "cold, old and disgusting", and he had to eat it because, "It kills her if you don't eat".

He calls his parents Hansel and Gretel because he sees them as vulnerable and childlike, and they were nearly "cooked in the oven", in Auschwitz.

But Ruben, too, was a frightened child in the forest, with only these frightened little "Hansel and Gretel" parents to protect him—that is, if they could. If you recall, he had had a brother, who was killed, unprotected by his mother. His attachment behaviour, therefore, had to ensure that his mother was alive, and strong enough to be able to come to his rescue. The most obvious power that he had in order to achieve these aims was to eat. And his excessive eating may now be understood as a frantic, desperate attachment behaviour.

But he has other sides to him, too: the reckless driving, the heavy smoking, the wild lifestyle. It may look quite surprising that, being so concerned about his parents' fears, he nevertheless lives so dangerously, which, he says, worries them terribly. Is he expressing some sense of independence, rebelliousness, individuation or "true self" after all? Having interviewed his father, I tend to think not.

The way Ruben's father spoke about his big, well-fed, and fearless son, so different from the fragile, sickly parents, was almost smug. And I could almost hear a sound of admiration and pride in his complaints about Ruben's careless behaviour.

Furthermore, the constant fear for Ruben's life allowed his parents to talk about their grief and preoccupation with the death of a son, and thus to express their pain, otherwise mute, about Ruben's dead brother.

Shefet (1994) had called the second generation's attempts to make their parents happy "the impossible task" (p. 23). To elaborate on this, I would say that, in order to help their parents survive, these children had to fulfil many tasks and avoid many pitfalls. They had to become experts at making their parents happy, and at letting their parents grieve; at being very "alive", and at being like a dead person; at being one with the parents, being different from them, being very successful, depressed, ill, and in danger, and, most important, being all of that forever.

We can see Ruben frantically attempting all these tasks. In the words of Suttie and Suttie (1932), "The helpless infant would do everything within its powers to preserve itself, i.e. to maintain its close association with the mother" (p. 209). Whatever that might take.

## *Summary*

Survivors of massive trauma, of all ages, have dissociated, deadly introjects, which either represent (in children) or replace (in adults) parts of their original attachment figures. In other words, as a result of their



trauma they develop an *infanticidal attachment* pattern. These introjects are subsequently expressed towards their own children, and are perceived as death threats. Introjects and expressions vary, according to the specific trauma that the survivor has undergone, but they are always deadly, as they were modelled in the image of a murderous perpetrator.

The children, subsequently, dedicate their lives to appeasing the aggressor, whom they cannot escape, as the aggressor lives in the same body as their attachment figure. They develop what Winnicott (1960) called a "false self", a self which is whatever the parents need them to be, a "doll"; and their individuation becomes severely impaired. A vicious cycle is set in motion, as the impairment in individuation exposes the children even more to the parental introjects and death threats, and the attachment of the second generation becomes disorganised, or, often, infanticidal.

Tragically, the damage of atrocities goes far beyond the duration of the traumatic experience. Because what gets damaged is the attachment system of the survivors, it continues to affect their children, generation after generation.

I would like to end with a brief word about healing, which is the ultimate aim of all our attempts to understand.

In 2007, four creative clinicians (Becker, T., Karriker, W., Overkamp, B. & Rutz, C. 2008) conducted a major survey on extreme abuse, in which they explored the views of some 2,000 survivors on various questions, including the relative helpfulness of fifty-two healing methods. The results of the survey show that the three healing methods which were marked "great help" most frequently were individual psychotherapy, personal prayer, and supportive friends. From an attachment perspective, it is notable that all three involve closeness, and someone listening. It is as though what helps to heal the damage of a murderous attachment is a new, benign, and deep relatedness.

If we cannot stop atrocities from happening in the first place, may we be willing to listen to the survivors. Through our ability to hear evil, we may enable its victims to draw on the resource of our shared humanity.

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Chapter 5

# As thick as thieves, or the ritual abuse family

## An attachment perspective on a forensic relationship

*Adah Sachs*

### Introduction

In this chapter, I would like to look at Ritual Abuse (RA)-produced dissociative identity disorder (DID) in the context of family life, rather than the context of an individual predicament or a societal problem. And that is because, in my view, the family aspect of RA-produced DID is one of the most powerful elements in creating it, maintaining it and, potentially, in healing from it.

Theoretically, I will place RA-produced DID at the most dysfunctional end of attachment styles. Subsequently, I will outline the implications of this view for the therapy that we offer to survivors of RA.

### The RA family and DID

In 2007, four inspired clinicians ran the largest survey to date on extreme abuse, which recorded the responses of over 2,000 survivors and professionals. It was named the EAS (Becker et al. 2008). In that survey, 84% of people who had a diagnosis of DID reported some form of extreme abuse: various forms of torture, multiple rape, incest, forced abortion, forced perpetration of torture and murder and others. Obviously, all of these are serious crimes. In the cases of RA families, however, these are not seen as 'wrong': they take place regularly between family members, as part of the ongoing family relationship and belief system. We may call it *a forensic family relationship*: a family relationship that is based on committing serious crimes against each other.

Remarkably, however, these families are very tightly knit. The expression 'as thick as thieves' is particularly apt, describing the particularly strong bonds as well as the forensic content of the relationship.

The person who comes to therapy usually starts by stating that, more than anything, she or he wants to be free of these family ties. But this appears to be the hardest thing to do. Something pulls them back, time

Sinason, V. (ed.) (2011) Attachment, Trauma and Multiplicity, second edition. Hove, Brunner-Routledge.

after time, right into the arms of the people who would hurt them, or force them to hurt others.

This distressing 'pull to return' to the abusive group or family has been explained in different ways: as 'programming', as an expression of terrorised subordination, or as a vicious circle, in which DID and RA support each other:

1 The DID is created and then maintained through RA (continual abuse and torture).
2 The existence of DID then allows further crimes to be committed, by
   a alters who are cult-loyal
   b alters who are too young, weak or frightened to resist family demands for compliance or perpetration
   c alters who are sadistic
   d alters who can't remember any torture, and thus feel safe and trusting in the family
   e alters who remember, but can't talk.
3 The trauma caused by continual involvement in these crimes necessitates further use of dissociation, thus enhances the DID.

This chapter will suggest an additional explanation for the 'pull to return' phenomenon: that people who are unable to free themselves from a relationship that is based on extreme abuse should be understood, using the language of attachment theory, as occupying a new classification, which I'll call *Concrete Infanticidal Attachment Type*.

The following is a clinical example of such a family relationship.

### Bella

At the end of her long working day, wishing she could just go home and put her feet up, Bella, aged 35, drove down to her grandmother's house. It was her uncle's 70th birthday, and she was expected to be there. She was the youngest niece, and she was going to hand him his present. Bella never liked her uncle or her grandmother: 'they somehow scare me, I don't know why'. She hated her grandmother's house: 'it is a weird place. Not exactly dark, but very big, formal and unpleasant. You can't laugh there'. But a family occasion prevailed, and she went. It was a big event, and, still on the drive, she could hear music and see the white vans of the caterers. Looking at the vans, she suddenly felt a cold wave of sickness and terror, and an almost unbearable urge to turn back and go home. But the next moment the feeling passed, and she knew that she was going to the party. She thought of how much she looked forward to meeting her little nephews and nieces. They would all be there, no doubt, she thought. Inexplicably, the thought of them only made her feel worse.



She remembers parking her car near the large house, next to one of the stone lions that guarded the gate. She remembers getting out of the car, picking up the birthday card and the present that were on the back seat. She remembers walking up the gravel path to the front door, and reaching her hand to the doorbell.

Sometime later, she was in her car, driving in the dark. She had no idea where she was. Her body felt numb; she could see large stains on her dress, and she smelt sweat and smoke and something else. Her mobile phone was ringing.

It was her husband, worried, as it was so late. Rather cheerfully, she said that she was on her way home, and reminded him that she had to go to the birthday party. 'How was it?' he asked. 'Oh, fine; you know them, a bit stiff and tedious', she said. 'It really is late – don't wait for me, darling, I'll just have a bath and a cold drink when I get home, and I'll sleep downstairs, I know you have an early start tomorrow.'

The next day, Bella wasn't there at the start of her session. Instead, I met Little Bellina. She was in a lot of pain, but had no idea why. She was in a party, she said, and she played with the pets and the other children in the garden, and uncle gave her some presents, and played hide-and-seek with her. 'He always wins, he always finds me!' she said in childish disappointment. Then she added that she was most scared of the dogs, and she hid when they came.

Then Sylvie said she just loved her uncle. She gave him his present, and a kiss, because she loved him so much – she'd always been his favourite, since childhood, and used to go and stay in his house on school holidays.

Rebecca couldn't speak. She looked at me imploringly, until I asked 'were you hurt?' and she nodded, yes.

Alice, shaking, then sat on the floor by my feet and silently offered me her wrists to handcuff.

Evan drew a picture of a large, white van, and whispered that he didn't want to go inside it.

Someone I didn't recognise started to retch in the corner of the room, crawling on all fours.

Bella suddenly looked at me, very puzzled. 'I can't remember a thing about that party last night. I got an e-mail from my uncle this morning, thanking me for his lovely present, so I must have given it to him. He's always polite.'

Obviously, that party was not a benign, if somewhat tedious family occasion. The accounts of the different alters reveal a very different story: Bella was very apprehensive about attending, and, disturbingly, the knowledge that her beloved little nephews would be at the party had made her feel worse, rather than better. Her last memory was reaching for the doorbell; then she switched – perhaps into Sylvie who loves her uncle, or into Little Bellina, who played hide-and-seek with him and with the other

children, and disappeared when the dogs joined the party. At some point Evan was pushed into the white van. Alice's wrists got tied. And Rebecca, always mute, was hurt.

And what about Bella? Bella knows that some terrible things happen on these family occasions. She has some memories of herself being hurt, and flashbacks of extreme abuse done to faceless children. Her greatest dread is that she herself, or one of her alters, has also perpetrated these acts. Although she loves her husband, she has frequent episodes of sex with other people, and she can't bear the idea of having children. And for days, before each family occasion, she is in a state of terror. What brought her to therapy was the tormenting questions 'I don't know how it is that I'm always back there'.

## Infanticidal attachment

Attachment, the term coined by John Bowlby (1958), is an innate structure in humans and animals, which makes the young seek the physical proximity and the full engagement of a specific caregiver, the attachment-figure, for the purpose of safety and survival.

While attachment is an innate structure, the ways in which people use and express it are learned. As each infant needs to seek the proximity and engagement of their own attachment figure, they need to learn the most effective behaviour to make their own mother stay close. The particular style of reaching that each baby learns becomes their life-long attachment style.

Normally, we look at the hierarchy of attachment styles in the order of their effect on one's psychological well-being. This chapter, though, considers their hierarchy regarding aiding survival:

### *Attachment types in decreasing order of aiding survival*

**Secure**
**Insecure**
Insecure Avoidant/Insecure Ambivalent
**Disorganized**
'Cannot Classify' (Hesse 1996)
Agonistic/Erotizing/Care-giving (Liotti 2006)
Infanticidal Attachment (IA) (Kahr 2007)
Symbolic IA (Sachs 2007)
Concrete IA (Sachs 2007)

In *Disorganized Attachment* there are no markers for the baby by which to know how to reach safety, as the attachment figure's responses are unpredictable. In cases of neglect, for example, the baby gets no comfort at all for



lengthy periods, no matter what attachment behaviour is expressed. Parents who are mentally ill, depressed or dissociative are so variable in their capacity to respond helpfully that no consistent way of reaching comfort can possibly be found.

People with disorganized attachment are thus in constant, frantic search for order within the chaos. We may view the various presentations of people with disorganized attachment as representing their never-ending attempts to engage their attachment figure. For a fuller discussion of these presentations (see Sachs 2007, 2008).

Kahr, in *Infanticidal Attachment* (2007), describes the attachment behaviour that would best engage an attachment figure who has death wishes towards the infant. These death wishes may be unconscious, and tragic, rather than malevolent: it is when the parent, who otherwise loves the child, also has deeply conflicting and upsetting feelings of expecting or hoping for the child's death.

These have been observed in families of holocaust survivors (Sachs 1997), of children who were born disabled (Hollins and Sinason 2000), of depressed, suicidal or schizophrenic parents (Kahr 2007; Green 1986).

This kind of infanticidal ideation in the parent *does not intend to cause damage*. The harm is done through the child's attempt to fit in with the parental death fantasy, which leads to what I have termed *Symbolic Infanticidal Attachment* (Sachs 2007, 2008).

But in some cases, such as the RA family, the harm to the child *is* intended: He or she is the chosen sacrifice, the actual object of sadism or hate. In the relationship with the attachment figure there are repeated, concrete and intentional torture and death-threats to the child. The deepest and most powerful engagement with these parents is in the midst of abuse. I've suggested the term *Concrete Infanticidal Attachment* for this group (Sachs 2007, 2008).

On the continuum of functionality, *Concrete Infanticidal Attachment* is the most dysfunctional: practically, it increases, rather than reduces, the risk to the child's safety or even life. Emotionally, it ties together hate and love. Such an infant feels a reduction of distress at the moment the abuse starts, and his or her sense of safety is thus linked to death, hate or sadistic thrill as though it were the mother's voice singing a lullaby.

## As thick as thieves

The expression 'as thick as thieves' points to the strong links between people who are engaged in criminal activity together. The attachment connection is readily seen: the danger that faces all the thieves together, should one of them give the others away; the identification of all 'outsiders' as 'the enemy'; the need to seek security with each other as the only possible attachment figures.

In a family where normal behaviour patterns involve 'thieving', that is, criminal acts, the bonds of dependency are stronger than in families where the outside world is more-or-less in harmony with their values. This is not to say that they love each other more; rather, that they have to rely on each other with greater intensity. The adults have to rely on the children's ability to keep a secret. The children have to rely on the adults to not actually kill them. Everyone needs to rely on everyone else to stay 'in' with the group, cult or family, so that nobody loses their attachment figure.

The ubiquitous practice of incest in RA families, and the common reality of not being raised by one's real parents further enhances a sense of a 'tribal' bond of attachment. On the scale of usefulness for survival, *Concrete Infanticidal Attachment* is the lowest; subsequently, one is permanently and frantically seeking to be near the attachment figure, which is the extended RA family. Paradoxically, escaping the abusers goes against the most basic survival instinct, which we call attachment.

The ability to separate, the wish to explore reality and the world, the capacity to build a solid sense of self and independence all require a state of safety, where attachment needs and attachment behaviour are not called upon too frequently. In other words, as close as possible to a secure attachment. It is only in the gaps between the moments of attachment cries that we can look out, to see the world, and look inside, to see ourselves.

## Implications for therapy

Therapy for survivors of extreme abuse is notoriously difficult, for both therapists and survivors. The difficulty is further compounded by the lack of theoretical thinking to support the clinical work. This often leaves professionals in a defensive position regarding their clinical choices.

Based on the idea that the main damage to RA survivors is the corruption of the attachment system into a concretely infanticidal one, my suggestion is that the therapy should aim to foster the development of a 'secondary attachment style' that would be higher on the scale of usefulness for survival.

Given that attachment styles are enduring structures, which are based on the relationship with the attachment figure, the only possible chance at changing it would be through the creation of a new attachment figure, who may evoke a new attachment behaviour and style.

But in order to 'qualify' as an attachment figure, not just a friendly, positive presence, one has to be the attuned rescuer, at the time of the greatest distress.

Unfortunately, abusers are very well placed for becoming attachment figures: the person who inflicts torture, simply by stopping the hurt, becomes the person who helps. Obviously, the therapist cannot resort to



perpetration of abuse; and the therapy relationship can never mimic the level of need and life-and-death dependency of the victim of torture towards an abuser.

The only way by which the therapist can, ethically, become a new attachment figure is by offering help at the moments of real danger. And it appears that, indeed, most therapists in this field tend to do exactly that, instinctively. But they then feel very uncomfortable being so far out of the usual therapy boundaries, with no theoretical framework with which to explain these choices.

I suggest that the therapeutic aim of helping to create a new attachment style, which can only be reached through becoming, for the duration of the therapy, an attachment figure, is the theoretical reason for offering as far-reaching support as any therapist can personally manage.

The problems of practicing within this approach are the subject of further discussion elsewhere. The following is a small example.

### 'Wait with Me'

Carla was at home. It was Good Friday, and she was feeling very agitated and quite unwell. We were talking on the phone, as we did every Friday afternoon, but then she said to me, in a rather formal tone, 'Excuse me, I can't go on talking now, I'm in a bit of a hurry. Would you please call me tomorrow?' and hung up the phone. Concerned, I called her mobile phone. The same polite, impersonal voice said: 'I have explained, haven't I, that I really do need to go now'. 'Could you tell me where you are going?', I asked. 'Ah – no, not really', came the answer.

I could hear the noises of driving, and said (rather clumsily, I'm embarrassed to admit), 'I can hear the car, are you going somewhere nice?', to which she replied, 'I don't know'.

I could hear her getting out of the car.

'Where are you now?' I asked. 'Ah – at the train station', she said. 'I'm just sitting down, if you must know'. 'Waiting for a train?', I asked. 'I don't know', she said. 'Just waiting'.

'Could you just go back?' I asked, desperately. 'I'm afraid that something bad may happen, if you stay there. You can drive back home, now, and no one would get hurt!'

'Oh, no, I can't do that', she said, in a measured voice. 'I must be here, at the station. Waiting'.

'Well', I said, my heart sinking, 'if you are waiting there, would you like me to wait with you?'

There was silence. Finally, in a whisper, she said, 'Yes, if you like'.

We waited together. Some minutes later, I could hear a train coming into the station. An older woman's voice said, 'Hello, Irma', and the line went dead.

I felt sick. It was like I was watching someone taken to the gallows. And there was nothing more I could do.

I couldn't stop Carla from going to the station, where she was to be met by someone who took her for an Easter ceremony. But Irma, an alter who had never talked to anyone before, had let me wait with her, and took some comfort from not waiting alone. From that day, she had a friend.

In subsequent months, she became the main agent of change in her internal system. She took risks in speaking to me, to the police, to her GP; and, some years later, she was the first one who dared *not* to go to a ceremony. Because in that terrible pre-abuse half-hour, I was with her; and, knowing full well that there was not going to be a happy end to this waiting, I waited with her. That shared wait was the birth of a new attachment pattern, and the start of her healing.

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# Boundary Modifications in the Treatment of People with Dissociative Disorders: A Pilot Study

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*This article examines the prevalence and types of modifications to professional boundaries that occur in the treatment of people with dissociative disorders (DDs) and considers some of the implications of the findings. The study is based on the replies of 163 professionals to a 20-question survey. The survey compared the boundaries that each practitioner kept with patients/clients (P/Cs) who suffered DDs to their boundary practice with all of their other P/Cs (non-DDs). Boundaries were deemed modified when professionals treated their DDs P/Cs differently than their other P/Cs. Professionals' general boundaries were not examined. The results showed a marked tendency for the modification of professional boundaries when treating people with DDs. These results appeared to be independent of country or profession but were more pronounced among the more experienced professionals. Areas of greatest modifications were identified. The prevalence of these modifications points to their potential importance in understanding some features of DDs.*

*KEYWORDS* *dissociative disorders, professional boundaries, boundary modifications*

The field of mental health, which inherently deals with people's vulnerabilities, places great importance on professional boundaries. The subfield of trauma and dissociation, with its constant brushing against the forensic, is particularly sensitive to this issue, and views regarding the ethical, legal, and clinical merits of various practices vary greatly and are often polarized.

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Differences in culture, country, profession, training organization, registering body, and trends further complicate questions regarding boundaries.

The idea for this study came from numerous colleagues and supervisees whom I have heard confess, "This case, I don't even take to supervision." The clinicians in question were fully trained, experienced, registered professionals. The cases they referred to were of patients/clients (P/Cs) with dissociative disorders (DDs). The reason for these confessed statements was that in the cases in question these clinicians had acted in ways that differed from their normal practice in regard to boundaries, and they felt anxious about the potential of finding themselves in violation of their professional guidelines. Yet they considered that the changes to their normal boundaries were necessary and that they could not have carried out their *duty of care* toward their P/Cs while maintaining their normal professional boundaries. A case in point is one on which I have recently been consulted in which a clinician was facing allegations of misconduct by the health service for continuing to see privately, but for no charge, a DDs patient who had been discharged from the service.

It has been my subjective impression that such conflicts and risk taking are not rare in the treatment of P/Cs with DDs. This pilot study examines whether evidence can be found to support this subjective impression. It also measures the prevalence and type of modifications to professional boundaries in the treatment of people with DDs and observes some of the characteristics of the professionals who reported them.

## DEFINITIONS

In this article, the term *professional boundaries* is broadly used to describe the normal standard of contact that professionals observe with their P/Cs. The article does not attempt a view regarding what this standard should be. The term *boundary modifications* refers to any differences between the professional boundaries that professionals observe with their DDs P/Cs compared with their practice with any other P/Cs. This study measures these modifications regarding 20 specific questions. Boundary crossing, boundary breaking, and boundary violations are not examined.

## THE CENTRAL PRINCIPLE

The complexity and wide variation of views regarding the correctness and suitability of different boundary practices makes it difficult to agree upon a baseline against which professional boundaries could be measured. The *central principle* of this study was thus to compare the normal boundaries of each professional with the boundaries of that same professional when he or she works with DDs P/Cs. Professionals who kept, crossed, or violated boundaries with both P/Cs groups (DDs and non-DDs) in the same manner were deemed, for the purpose of this study, to show no boundary modifications. With this principle in mind, differences in views, values, principles, and practices between the wide variety of professionals could be largely bypassed, as each professional was only compared to himself or herself in his or her work across the two P/Cs groups.



It should be emphasized that the thorny questions of what constitutes keeping, crossing, breaking, or violating clinical boundaries (and indeed the numerous definitions of *boundaries*) are not the subject of this article, and the study does not attempt a view on this, nor does it examine controversies regarding these concepts. (For a sample of the extensive writing on boundaries controversies across several professions, see Chu, 2011; Doel et al., 2010; Gabbard & Nadelson, 1995; Galton, 2006; Guthheil & Gabbard, 1998; Poole & Cook, 2011; Pope & Keith-Spiegle, 2008).

## METHOD

### The Participants

To participate in this study, one had to work or to have worked with both DDs and non-DDs populations (at least one case from each group), be a registered professional or a registered trainee-professional, and be invited to the study as a member of a participating professional organization. As participants were asked to potentially place themselves at risk by reporting professional boundary violations (with either P/Cs group), the survey was designed to be strictly anonymous in order to minimize response bias. To further ensure confidentiality, no details on the participants were required other than their membership in the invited professional organizations and their professional registration status. Background questions were optional. Participants were notified that the material gathered might be published.

To ensure the suitability and genuineness of the respondents, participation was offered only to members of specific professional groups. These groups were chosen to provide a wide range of professional attitudes and a wide geographical spread. Participation in the study was proposed to the appropriate committee, board of directors, or chairperson of seven professional bodies (see below). Following approval, these organizations invited their own members through their normal channels of communication (e.g., members' online bulletin, password protected) to take part in the survey. Online access to the survey was granted by a group-designated password. Each person could reply once. People who belonged to more than one group could only reply once, at their discretion. Only completed surveys were used in the study. Approximately 400 responses were received, of which 163 were usable.

Responses were collected in five groups, as follows: United Kingdom: The Bowlby Centre; Association of Christian Counsellors; Institute for the Arts in Therapy and Education ($n = 30$); Israel: Trauma and Dissociation Israel, an association of trauma therapists ($n = 15$); Europe: Association of German-Speaking Trauma Therapists ($n = 14$); International: International Society for the Study of Trauma and Dissociation (ISSTD) membership ($n = 56$); and International: dissociative identity disorder specialists, individually invited ($n = 48$); total $N = 163$.

## The Instrument

The study aimed to establish whether there are notable differences between the boundaries that professionals keep in their work with the two groups (DDs and non-DDs) of P/Cs. The instrument used was a 20-question survey that explored clinicians' actual practice (not views or values) with both groups. A number of experienced colleagues reviewed the initial list. The final list (see Appendix) was constructed to reflect areas that are frequently discussed in boundaries discourse (e.g., contact between sessions), as well as a few that are more unusual (e.g., looking after your P/C's children or pets). An optional section, not used in the scoring, explored background parameters: profession, country of practice, percentage of DDs P/Cs in one's practice, and additional comments.

## Scoring

According to the central principle of this study, the scoring did not evaluate the strictness of the boundaries of each professional but the differences between the practices that each professional applied to the two groups (DDs vs. non-DDs). Each of the survey questions (see Appendix) had five possible answers, which in the scoring process received numerical values from 0 to 3. Each question was answered twice: once for the DDs group and once for the non-DDs group. The numerical discrepancy between the two answers to the same question was scored and is the subject of this study. The score for DDs P/Cs is referred to as A and that for non-DDs P/Cs as B. The difference between them (A minus B) is the C score. When the answers to A and B were the same, the C score for that question was 0. A positive C score (+C) means A > B; a negative C score (–C) means A < B.

# RESULTS

The 20 C scores for each respondent were aggregated to give a total C score per respondent. Out of the 163 respondents, 138 (85%) had a positive total



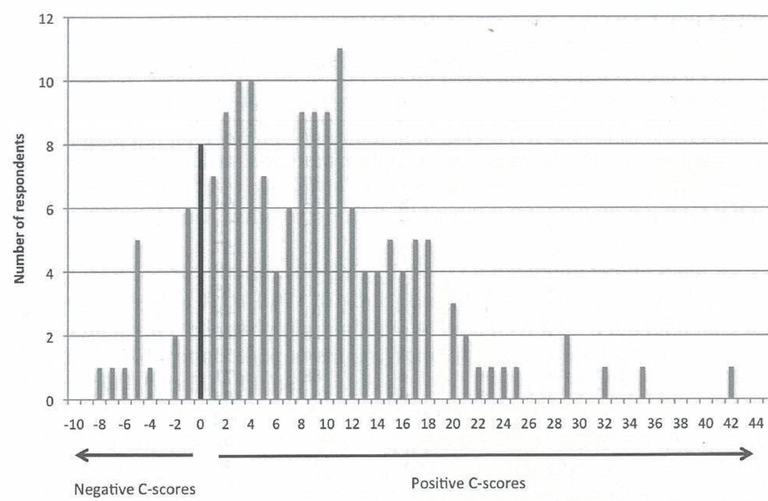


**FIGURE 1** Distribution of C scores by respondent.

C score (i.e., the total of their answers for the DDs group was higher than the total of their answers for their non-DDs cases). Their scores ranged from 1 to 42 out of 60 possible points. Seventeen (10%) of the respondents had a negative total C score (i.e., answers for the non-DDs group were higher than those for the DDs group). Their scores ranged from 1 to 8 points out of 60 possible. Only 8 (5%) respondents reported total C = 0 (i.e., no overall difference in practice with the two groups; see Figure 1).

Out of 3,260 C scores (20 questions × 163 respondents), approximately two thirds were C = 0 (the same answer for both the DDs and non-DDs groups). The last third, however, were consistently weighted toward the DDs group (the answer for the DDs group greater than the answer for the non-DDs by at least one step, e.g., from "rarely" to "sometimes"). Positive C scores were reported 1,061 times out of 3,260 (32%); negative C scores were reported 133 times (4%). The ratio of +C answers to –C answers was 8:1. These ratios varied for each question but never reversed: For each question, instances of positive C were always markedly higher than instances of negative C (see Table 1).

## Some Differentiations

Given the relatively small sample size ($N = 163$), further division into subgroups may have provided misleading results. There were, however, a few subgroups that appeared potentially interesting and worthy of reporting.

**TABLE 1** Distribution of C Scores by Question

| Question No. | Number of responses per C score | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | −3 | −2 | −1 | **All −ve** | 0 | **All +ve** | +1 | +2 | +3 |
| 1 | 0 | 0 | 8 | **8** | 51 | **104** | 54 | 43 | 7 |
| 2 | 0 | 0 | 3 | **3** | 111 | **49** | 31 | 13 | 5 |
| 3 | 0 | 0 | 1 | **1** | 139 | **23** | 14 | 6 | 3 |
| 4 | 0 | 2 | 4 | **6** | 93 | **64** | 37 | 23 | 4 |
| 5 | 0 | 0 | 7 | **7** | 83 | **73** | 47 | 24 | 2 |
| 6 | 0 | 3 | 5 | **8** | 118 | **37** | 23 | 13 | 1 |
| 7 | 0 | 0 | 2 | **2** | 122 | **39** | 25 | 11 | 3 |
| 8 | 0 | 3 | 5 | **8** | 120 | **35** | 23 | 12 | 0 |
| 9 | 1 | 4 | 9 | **14** | 101 | **48** | 35 | 13 | 0 |
| 10 | 0 | 0 | 9 | **9** | 128 | **26** | 20 | 6 | 0 |
| 11 | 0 | 0 | 4 | **4** | 106 | **53** | 25 | 20 | 8 |
| 12 | 0 | 0 | 4 | **4** | 88 | **71** | 46 | 21 | 4 |
| 13 | 0 | 1 | 5 | **6** | 104 | **53** | 33 | 18 | 2 |
| 14 | 0 | 1 | 7 | **8** | 103 | **52** | 41 | 9 | 2 |
| 15 | 0 | 0 | 6 | **6** | 95 | **62** | 34 | 22 | 6 |
| 16 | 0 | 0 | 18 | **18** | 111 | **34** | 28 | 3 | 3 |
| 17 | 0 | 0 | 11 | **11** | 116 | **36** | 23 | 10 | 3 |
| 18 | 0 | 0 | 1 | **1** | 105 | **57** | 39 | 16 | 2 |
| 19 | 0 | 0 | 4 | **4** | 84 | **75** | 54 | 17 | 4 |
| 20 | 0 | 2 | 3 | **5** | 88 | **70** | 45 | 21 | 4 |
| Total | 1 | 16 | 116 | **133** | 2,066 | **1,061** | 677 | 321 | 63 |

*By country.* The sample provided a wide geographical cover. As well as the country-specific groups (United Kingdom, German-speaking Europe, and Israel), the international spread included Canada, most states in the United States, eight European countries, and a small sample from Australia, New Zealand, and Africa. The average C scores by country were very similar: German-speaking Europe, 6.1; Israel, 6.5; United Kingdom, 7.2; international ISSTD membership, 7.7. Only minor geographical or national differences were noted in this study.

*By profession.* Across the most frequently reported professions in this study, psychiatrists and medical doctors showed the highest average +C scores (14 and 12.8, respectively) and art therapists and psychologists the lowest (4.4 and 4.3, respectively). Counselors, psychotherapists, and social workers were almost identical, in the middle range (9.5, 9.2, and 8.8, respectively).

Considering the variations in these results, several factors are noted as potential explanations. The majority of psychologists in this study were from the United States. Two of them commented that they were required by insurers to be available out-of-hours to *all* of their P/Cs when asked. If such is the requirement of all U.S. psychologists, then their scores may be artificially determined (by funding providers rather than their own clinical choices). Indeed, the psychologists' distribution picture showed elevated bottom-scores for both A and B groups (= fewer than average "never" answers for *all* P/Cs). In regard to the art therapists, 50% of them in this study were also trainees. The C score result may thus reflect their level of experience (see the next section) rather than their profession.



The psychiatrist and medical doctor groups had the highest average C scores in this study. Notably all of them scored the highest on Question 19 (placing oneself at risk personally or professionally in work with his or her DDs P/Cs). Their overall high C scores thus seemed to occur despite a high sense of risk rather than as a reflection of a relaxed attitude toward boundaries.

*By level of experience with DDs.* One background question was "What is the percentage of DDs P/Cs in your practice?" Respondents who answered "over 50%" showed markedly higher C scores than their colleagues for most questions. Worryingly their average C score to Question 20, "Reached a point of burnout," was 30% higher.

Of the practitioners with less experience, two trainee art therapists who had negative C scores (= answers for the DDs group lower than for the non-DDs group) reported in their comments that the therapy with their DDs P/Cs had broken down. What is interesting is that both believed that it had to do with their boundaries being too loose. In the absence of a larger sample one can only wonder whether these comments and the low C scores reflect the fact that trainees who are under evaluation for qualifying, as well as the least experienced, are potentially the most anxious about boundary modifications.

*By severity of cases.* This study did not evaluate the severity of cases. However, the group of practitioners who specialized in the treatment of dissociative identity disorder (and was thus likely to represent professionals who work with the most severe cases) showed the highest +C scores on 15 out of the 20 questions and the highest overall average +C score (11, compared with 7.7 for the ISSTD general membership).

*By index questions.* Although the replies to all of the survey questions were weighted toward boundary modifications with the DDs group, there were five questions for which less than 55% of respondents maintained their normal boundaries with their DDs P/Cs. These questions indicate areas in which practice with DDs P/Cs has in fact departed from the practice with other groups and may require new guidelines (see Table 2).

## DISCUSSION

This pilot study was carried out on a small scale and limited to a descriptive analysis of the results. The findings, nevertheless, do appear to present a picture. They show an almost universal tendency, reported by 85% of practitioners in the survey, for professionals to modify some of their normal boundaries when working with DDs P/Cs (compared with 10% of respondents who reported modifying their boundaries with non-DDs P/Cs).

**TABLE 2** C Scores for the Index Questions

| Have you ever . . . | Distribution of C scores: Negative C scores | 0 | Positive C scores |
|---|---|---|---|
| 1. Conducted significant work with your P/C outside your normal working hours? | 4% | 31% | 65% |
| 5. Conducted sessions on the phone, or in any other place other than your usual office? | 5% | 50% | 45% |
| 12. Kept contact (e.g., on the phone) with your P/C while you were on holiday? | 2% | 54% | 44% |
| 19. Risked yourself professionally or personally? | 3% | 51% | 46% |
| 20. Reached a point of burnout? | 3% | 52% | 45% |

*Notes:* P/C = patient/client.

The wide prevalence of boundary modifications reported by professionals in their work with DDs, especially among the more experienced and more qualified practitioners, challenges the notion that such modifications are aberrations or deviations from normal practice. In particular, the five index questions point to areas in which practitioners' boundaries get modified 50% of the time, thus changing the meaning of what is "normal" in practice with DDs.

Most commonly in this study boundary modifications were found to be linked with practitioners' availability: offering time outside normal working hours, outside the office, and during practitioners' holidays. It is noteworthy that these boundary modifications not only are at odds with the respondents' normal practice but are also greatly inconvenient and were often accompanied by the additional stresses of secrecy and risk taking (Questions 18 and 19) and a high burnout rate (Question 20). Clearly these types of modifications cannot be seen as self-serving, and they beg the question why.

My hypothesis is that these frequent boundary modifications may reflect a feature in people with DDs that actually requires different boundaries in several areas and that most professionals, especially the more experienced ones, tend to recognize and respond to this need. This hypothesis may explain the findings of frequent boundary modifications in work with this group despite the high cost to practitioners. It may also explain the relative consistency of this phenomenon despite the many variations among the professionals.

### Limitations of This Study and Suggestions for Further Research

This pilot study focused only on actual practice differences and did not explore practitioners' insights into or reasoning regarding the discrepancies in their practice with the two groups. A follow-up study of professionals' views regarding their boundaries with the two groups is warranted.



The absence of respondents' profile information may have also obscured important information. A larger scale study could provide a more complex, accurate, and reliable picture.

If, as the hypothesis suggests, people with DDs require changes in boundaries, evidence for this may be found through a treatment outcome study. Such a study would need to define parameters for measuring treatment outcome (and the timescale involved) and compare these parameters in P/Cs whose treatment used different types of boundaries.

The results of this study also point to a need for theoretical principles (as opposed to empirical reasons) that could explain, and perhaps guide, any boundary modifications in the work with people with DDs.

It is my view that given the prevalence of boundary modification in the work with DDs P/Cs and in the light of the risks and stresses that are associated with unclear boundaries, an in-depth study of this phenomenon should be a matter of priority to the field of DDs.

## CONCLUSIONS

Difficulties in maintaining professional boundaries are usually regarded as a sign of lack of experience, confidence, rigor, or sophistication in one's training or practice. The main findings of this pilot study, however, form a different picture in the case of working with DDs P/Cs. With these P/Cs, boundaries are reported to be modified very frequently, at a high cost to practitioners, and more so by the more qualified and experienced professionals. These findings suggest that boundary modifications in working with DDs do not reflect incompetence and, given their wide prevalence, cannot even be seen as a deviation from normal practice.

Based on the findings of this study I hypothesize that boundary modifications in work with DDs may reflect a feature of people with DDs to which experienced professionals respond by modifying their normal boundaries. Further empirical outcome research as well as theoretical exploration is needed in order to elucidate this feature and its implications for improved practice with this group.

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# APPENDIX

## The Survey Questions

Please answer each question once for each category (DDs and non-DDs). Answer N/A only if the question is meaningless for you for *both* groups (e.g., Question 2 if you are a medic).

**In your professional capacity, have you ever done any of the following (tick one in each category):**

1. Conducted significant work with your patient/client (P/C) outside your working hours?
   **DDs P/Cs**
   N/A never rarely sometimes often
   **Non-DDs P/Cs**
   N/A never rarely sometimes often
2. Accompanied your P/C to a doctor or to hospital?
3. Taken your P/C with you on holiday?
4. Invited your P/C to stay at your home for the night, for their safety?
5. Conducted sessions on the phone, or in any place other than your usual office?
6. Visited your P/C at their home?
7. Breached your P/C's confidentiality in any way (as defined by your professional body's guidelines)?
8. Withheld information from relevant professionals at your P/C's request?
9. Accompanied your P/C at a police interview or to court?
10. Met members of your P/C's family or friends?
11. Looked after your P/C's child, other relatives or pets?
12. Kept contact (e.g., on the phone) with your P/C while you were on holiday?
13. Given your P/C presents or money?



14. Had physical contact (nonsexual, nonmedical) with your P/C?
15. Advocated for your P/C?
16. Declined to charge for your work or parts of it?
17. Decided to end the work with your P/C unilaterally or abruptly?
18. Kept any of your interactions with your P/C a secret?
19. Risked yourself personally or professionally?
20. Reached a point of burnout?

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*Notes:* DDs = dissociative disorders.

# Still Being Hurt: The Vicious Cycle of Dissociative Disorders, Attachment, and Ongoing Abuse*

Adah Sachs

## Introduction

One of the most disheartening discoveries that a therapist can make in working with people with dissociative disorders is that their invariably traumatic childhood histories are, sometimes, not confined to their past. For some people with dissociative disorders, severe abuse continues into their adult life, into the present, into the gaps between their therapy sessions; and it appears extremely resistant to change, despite the person's and the therapist's best efforts.

In this paper, I will describe the relationship between dissociative disorders, on-going abuse and attachment as a vicious cycle, in which each of these three elements perpetuates the cycle. People who are thus caught up may find it extremely difficult to break free from a lifetime of abuse and to get better.

## Rona

On her birthday, Rona arrived to her session late, and completely drunk. This had never happened before: she came in reeking of alcohol, giggling, and humming a song. With her step unsteady and her speech slurred, she explained to me: "I met some people at the station, and we had a looooovely time together. I'm sure you can understand!" At which point she winked at me, like we shared a little secret together.

Rona, a woman with dissociative identity disorder (DID), is a fifty-year-old professional. She is tall, slim, always immaculately dressed, and perfectly spoken. My face must have betrayed how taken aback I was, for suddenly she looked down,

*A version of this paper was given as a key-note talk at the TAG national conference, June 2012.





and when she looked up again there was no trace of the drunk Rona, other than the smell. Instead, I saw a serious, tight-lipped woman, who shook her head disapprovingly and said in a cut-glass, elderly voice: "Alice should not have spoken this way. Rona had met her brother and cousins at the station. They all wished to congratulate her on her birthday. Naturally, they spent some time together". Lea, a teenage alter, then whispered to me, "the old bitch got us drunk. Rona's brother took us to the men's loos at the back of the pub. I didn't look". Liam, a teenage boy alter of Rona, was very drunk and clearly enjoying himself. He said he loooooved playing with his big cousins—they are so naughty! "They always hide in toilets and lock the door, and it is so funny when other men want to use the loos but can't get in". Another alter, Maria, sobbing, said she'd been raped by a group of men she'd never met before. She'd tried to call the police, she said, but her mobile phone was stolen. The older woman was back for a minute, hissed "oh stop this nonsense!" and then Rona was there, looking pale. She said she'd had a birthday card from her brother the day before; and she does not know what happened after that. She now felt sick and sore, and was wondering about the alcohol smell in the room. Her face suddenly ashen, she looked up at me: "do you think . . .?" she started.

Rona had an extremely traumatic childhood, and she now has a diagnosis of DID. She has a large number of alters, of all ages and both genders. Some of these alters felt that the birthday card from Rona's brother, that included an invitation to lunch, was a lovely treat, and were happy to accept the invitation. The alters who hated and feared him were "not around" as Rona, willingly, went to meet him at a pub near my practice. This meeting had ended up in the men's toilets, with Rona having sex—or being raped, depending on the point of view—by her brother and her cousins.

It is important to note that the older woman, who is an alter modelled after Rona's grandmother, treated the incident with respect and dignity: "naturally, they spent some time together". In her eyes, there was nothing unnatural or wrong about what happened, and the alter "Alice" was simply rude. In her words, "Alice should not have spoken in this way".

Rona, however, feels very differently. She calls her grandmother "a witch"; and her alters described witnessing "the witch" cruelly abusing children, animals, adults, and sometimes Rona herself. As for her brother, the very notion that she might have a sexual relationship with him is completely abhorrent to her.

Yet on every family occasion, every holiday or birthday, Rona ends up meeting with these family members. By the injuries on her body she can later tell that she had been hurt; and her greatest dread is that she herself might, unbeknown to her, through some of her alters, have done "bad things" to the younger children in the family.

It may seem hard to understand the power that brings Rona, a successful fifty-year-old, into these repeated situations. Especially as her scary grandmother had been dead for thirty years.

This was exactly the question which brought Rona into therapy.

### Abuse and dissociation: a cycle

We can readily see two elements of the vicious cycle operating: abuse and dissociation.

Dissociation, the experience that some of our history, feelings, thoughts, or body parts do not belong to us, is instrumental in surviving the physical pain of severe abuse, as well as the psychological horror of it. It is the greatest tool that the mind has for coping with the unbearable. But it is also a very dangerous tool: it undermines the person's ability to learn from his or her experiences, as these experiences are not available. As a result, the capacity to recognise danger and to act for safety is seriously impaired. This perpetuates a vicious cycle: the continuous exposure to abuse increases the need for the dissociation, as a defence; and the dissociation allows for more abuse to happen, as the person is not aware and does not fully realise what really goes on in his or her life (Figure 1).

### Perpetration of abuse

From accounts of people with dissociative disorders (DDs) who were able to recall abusing others, it appears that memories of perpetration are the most traumatic of all of their experiences, and the hardest to heal from. Not surprisingly, these experiences are the most heavily dissociated, and often do not get reached in therapy.

In families where abuse is multigenerational, subjugation and perpetration of abuse are both part of people's lives from the youngest age, and cannot be avoided. As therapy aims to help people process their traumatic history, rather

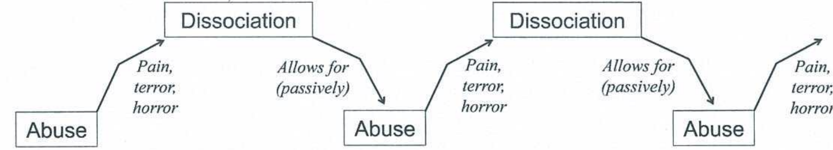


Figure 1.





than hide it, therapists must consider that a blanket condemnation of all perpetration may tar their own suffering and victimised patient with the same brush, as the person who has suffered may have also caused harm to others.

Accounts of perpetration reveal moments of sadistic frenzy that a tormented person was suddenly overwhelmed with; being forced to hurt others under threats of being hurt; abuse perpetrated in an altered state; perpetration that the person realises that he or she has committed (through obvious evidence), but is amnesic to; and, in DID, perpetration carried out by specific alters, unbeknown to the main person.

Typically, such recall is extremely distressing for the person, and requires from the therapist, in the first place, a great deal of willingness to listen and to acknowledge their traumatic nature (Miller, 2012). Where such willingness is lacking in the therapist, recalls of perpetration experiences would simply get pushed deeper into the shadows of dissociation, where they could not be thought about or grieved for, where no thinking or remorse is possible, and no healing can reach.

It is notable that in DID, alters who are perpetrators are indeed the last ones to emerge. Child-alters, who are not burdened by the same level of crushing guilt and by the horror of realising what they had done are usually the quickest to reach out for the therapist, longing for protection and kindness. Adult or elderly alters who may recall harming others may not appear in therapy for many years, or ever. Indeed, the traumatic reality of perpetration is often the main force that keeps the dissociation intact.

Furthermore, as long as one's perpetration remains dissociated, further harm to others may continue to be committed by the person, setting in motion new cycles of trauma and dissociation (Figure 2).

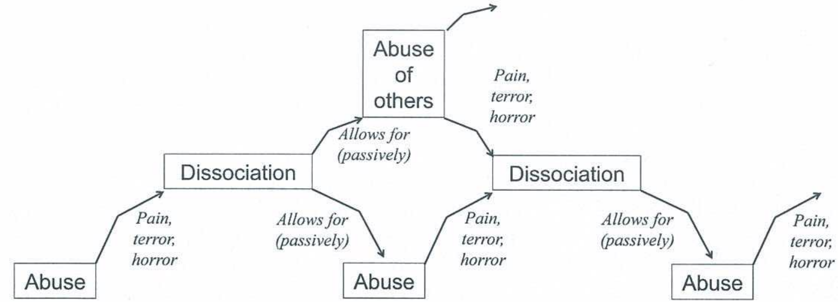


Figure 2.

### John

John is serving a prison sentence for a succession of rapes. His eyes fill with tears when he talks about that. He is a very meek man, and he is sure that he could not have possibly been aggressive towards anyone. He has had several courses of therapy over the years, mainly "anger management" CBT, but as he is completely unaware of these dissociated events, the therapy could not address them.

### Attachment

I would like to suggest that attachment is the third, and perhaps the most powerful element perpetuating the vicious cycle of abuse in dissociative disorders. This idea is supported by the fact that most of the known cases of ongoing abuse involve abuse by close family members, that is, attachment figures (Courtois, 2010; Freyd, 1996; Herman, 1992; Middleton, in press).

The term attachment is used in this paper specifically as coined by Bowlby (1958), to signify a survival instinct (not an emotional longing): the young of every species instinctively holds on, follows, and acts in ways that engage the adult's attention, to maintain their close contact. It is important to note that the task of the young is not to choose an attachment figure, but to engage it. The survival of the young depends on their ability to draw the closest attentiveness from the parent that he or she has.

Some parents respond most readily to cries; some to sweetness; some respond best if baby is quiet. As the proximity and the full engagement of a protective adult is a matter of life and death, the baby learns very quickly how best to reach it, how best to engage their own parent. The particular ways of reaching that each baby learns becomes their blue-print of relating, their enduring, usually life-long attachment pattern (often referred to as attachment style or attachment type).

Disorganised attachment is said to occur where the attachment figure's responses are random and unpredictable: where, for the same behaviour, the child may get a hug or a beating, or perhaps no response at all (as in neglect). The child is thus left in a constant, frantic, chaotic search for effective ways to engage the attachment figure.

It is my view, however, that disorganised attachment is not truly disorganised, because the parental reactions are not really random. They follow the parent's mental states and preoccupations, however dysfunctional these may be, and the baby or child does learn to find the internal logic of these reactions.

The following diagram shows sub-groups within disorganised attachment in the general context of attachment theory. Each sub-group, like all other attachment patterns, aims to engage a particular kind of parent or care-giver. The sub-groups are arranged in decreasing order of their usefulness for survival (for full discussion of these categories, see Sachs, 2007, 2008) (Figure 3).





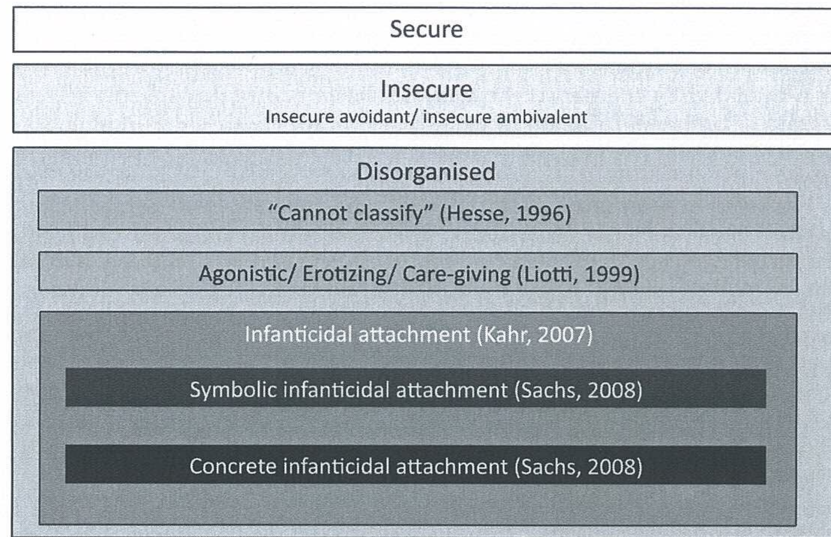


Figure 3.

Hesse (1996) noted that in conducting the adult attachment interview, some people, who were most similar to the category of disorganised attachment group, did not exactly fit the criteria for it in that the lapses in their narratives were too extensive. He suggested a new classification that he very modestly named "cannot classify".

Liotti (1999) delineated three ways in which people with disorganised attachment may reach a semblance of attachment relationship: through an erotising pattern, where the intensity of erotic relationship is used as a replacement for the need for closeness; an agonistic pattern, where an aggressive grip is used in order to stay close; and through a care-giving pattern, where caring for others is used for reaching closeness.

Kahr (2007) explained that an infanticidal attachment pattern aims to engage an attachment figure who is deeply and constantly preoccupied with death. The language of this attachment pattern thus involves constant brushing against danger, illness or death, as these would be of most interest to such an attachment figure. Kahr includes self-harm, suicidality, frequent illness, various forms of self-destructive behaviour, some personality disorders, and even schizophrenia among the expressions of infanticidal attachment.

I suggest that this attachment pattern should be named, more accurately, symbolic infanticidal attachment (Sachs, 2007, 2008, 2011). That is because in this pattern of relationship the harm to the child is neither directly caused nor is it intended by the parent. Instead, the harm occurs through the child's attempts to represent, for the parent, that which for the parent is most engaging, that is, death (Green, 1986; Hollins and Sinason, 2000; Kahr, 2007; Sachs, in press).

However, in some cases the infanticidal preoccupation is not symbolic, but is acted upon concretely and directly. The actual relationship of the child with the attachment figure, in these cases, includes repeated acts of abuse, torture, and overt death-threats to the child. Most importantly, the deepest and most powerful engagement between the child and the attachment figure occurs during abusive acts. For this group, I've suggested the term concrete infanticidal attachment (Sachs, 2007, 2008, 2011).

Because the attachment figures of these children engage most deeply while hurting the child, these infants feel a reduction of distress, the relief of feeling safe in the embrace of loving arms, at the moment in which the abuse starts. The heightened engagement of the abuser at these moments is the signal of safety, the mark of being truly connected to their attachment figure. Such a child's sense of safety is thus linked to pain, hate, sexual arousal or sadistic thrill as though it were mother's voice singing a lullaby. When distressed, this child will actively seek being hurt by the attachment figure, as this is the only way to engage it fully, and thus feel safe.

On the continuum of functionality, concrete infanticidal attachment is the most dysfunctional, as it increases, rather than reduces, the risk to the child's safety or even life. As this attachment pattern does the opposite of what it is meant to do (that is, aiding survival), I suggest it should be classified as an attachment disorder.

As every new hurt causes fresh distress, the child will seek the engagement of the attachment figure with renewed intensity, perpetuating a second vicious cycle (Figure 4).

## Abuse, crime, and isolation

This cycle gains additional velocity from the fact that the abuse element of it is a crime. Children who grow up with crime as an integral part of their lives are taught to be quiet, and never tell. Not only does this increases their physical risk, but it also creates a psychological isolation, as though they live in a separate world to the one that the non-abused occupy; and the isolation, in turn, further increases the dependency on the attachment figure.





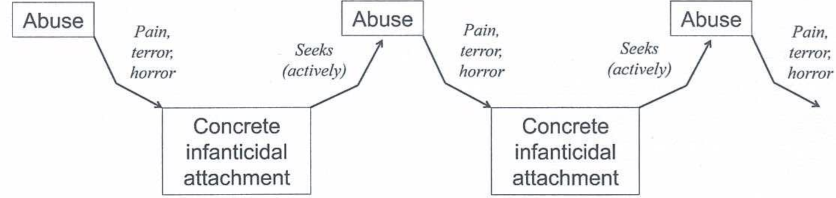


Figure 4.

Isolation from the rest of society is characteristic of families and groups whose beliefs and values are in strong dissonance to the rest of society (typical examples, as related in therapy, include the assertions that incest is love; pain is purifying; telling is a sin). Acts which are committed under these convictions (most notably, all child abuse) are not seen as bad or wrong. They take place regularly between family or group members, as part of their ongoing relationship, values or belief systems, and the fact that these acts are illegal in the wider society only serves to increase the alienation from it.

## Dissociative disorders, attachment, and on-going abuse: the full cycle

I would like to suggest that people who are subject to ongoing abuse which they are unable to end, despite years of therapy and all other support, are caught up in an infinity-shape cycle (Figure 5).

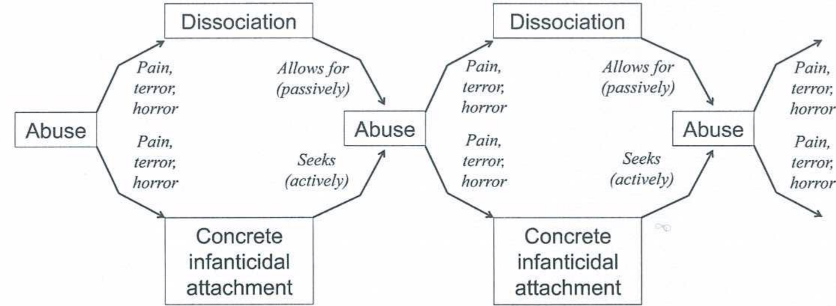


Figure 5.

The effects of abuse, in these cases, manifest simultaneously in two different ways:

- The traumatic experience becomes dissociated (through any of the dissociative pathways—amnesia, derealisation, depersonalisation, or dissociation of identity). The person loses the awareness of their link to the trauma; and being protected from the knowledge of it, is unable to guard against a repetition of it.
- At the same time, the extreme distress which is caused by the trauma activates the attachment instinct, with an instant reaching towards the perceived safety of the attachment figure. In order to fully engage the attachment figure, the person actively and urgently seeks an abusive contact, in such a form as will please and engage their attachment figure. The role that the person has been brought up to fulfil will dictate their actual behaviour when highly distressed, making them act as victim or as perpetrator of abuse.

The relational (rather than purely internal) element of this dynamic allows for abuse to be inflicted on others, as well as on oneself, and thereby can start new, endless cycles of abuse, dissociation, and disordered attachment (Figure 6).

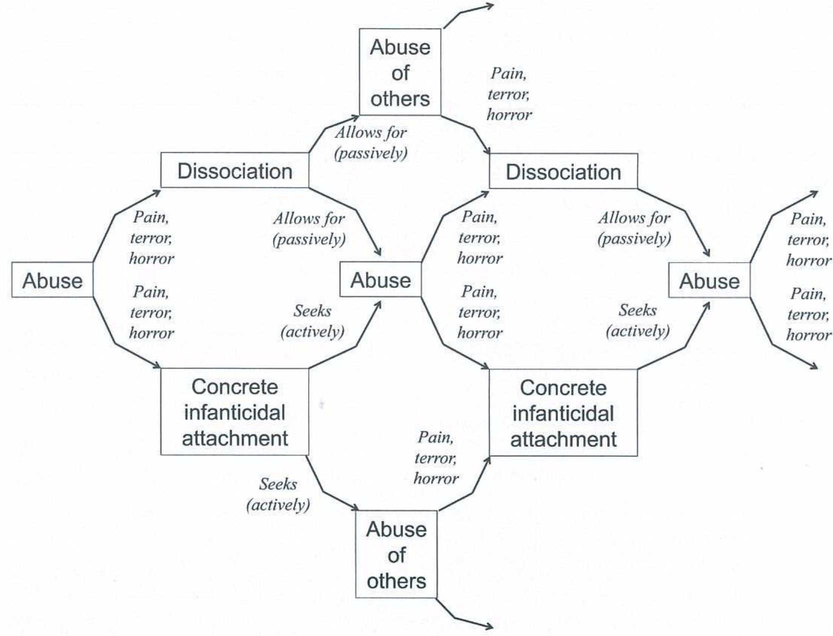


Figure 6.





## Conclusion

In some cases, abuse that had started in infancy or childhood remains ongoing into adulthood, and does not give way to the persons' expressed wishes to be free of it, nor to years of therapy.

This paper suggests a model which can explain the great difficulty in breaking free from a lifetime of abuse. The model describes this phenomenon as a double, infinity-shape vicious cycle, where severe abuse activates both a dissociative (passive) reaction and an attachment (active) reaction, both of which lead the person back into abuse.

The paper also suggests that the roles of victim and perpetrator are both manifestations of exposure to severe abuse, and are by no means "opposites". Both victim and perpetrator reach for their attachment figures, as well as for the oblivion of dissociation, in order to cope with their trauma: the pain, horror, and the experience of their loss of humanity. Through dissociation, both victim and perpetrator can passively disown and survive the abuse. And through reaching for their infanticidal attachment figures, both victim and perpetrator actively seek to engage in further abusive acts.

In the light of this model, it appears that, in order to facilitate change in cases of ongoing abuse we must address, simultaneously, all three elements of the cycle: the reality of the abuse itself, the dissociated parts of the person, and, perhaps most importantly, the disordered attachment.

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# COMMENTARIES

## Commentary on "Parent–Child Incest That Extends Into Adulthood: A Survey of International Press Reports, 2007–2011" and "Ongoing Incestuous Abuse During Adulthood" (Middleton)

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Like other pioneers who have highlighted hitherto "invisible" problems, Warwick Middleton makes visible the problem of incestuous childhood abuse that does not end when childhood ends, or does not end at all.

Middleton's (2013a) extensive research reveals a large number of such cases, corroborated by criminal convictions. The sparseness of clinical writing on the subject, he argues, reflects not its rarity but the "invisibility" of the incestuously abused.

In detailed interviews with 10 of these women (Middleton, 2013b), all 10 reported extreme levels of violence and brutality in their home lives, mostly but not exclusively by the father. All reported severe sexual abuse (including, in most cases, bearing children) by the father but also by others; they also reported witnessing the sexual abuse of other family members, including, in some cases, of the father himself.

All of the women in the sample suffered some form of a dissociative disorder (DD).

Middleton concludes that what perpetuates the incestuous abuse is threefold: *fear,* instilled through years of subjugation to violence and brutality, renders the victim unable to resist; *manipulation of the victim's sexuality,* achieved through exposure to sexual acts from infancy, makes her responsive to incest; and the realization of her own responsiveness then causes

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a crippling sense of *shame,* self-hatred, and worthlessness, which further undermines her ability to resist her father even in adulthood.

I would like to suggest additional aspects in the analysis of the data presented in this seminal work.

### THE CONTEXT OF INCEST

Middleton focuses on father–daughter incest. All of his interviewees, however, reported abuse that was not limited to fathers but was committed by grandfathers, uncles, mothers, siblings, church members, and friends. Furthermore, most of the interviewees reported that other family members were also sexually abused, and 30% reported witnessing their father being sexually abused by grandfather—that is, incest perpetrated on the male perpetrator. In all of these cases, the incest was not "a secret": It was practiced openly (within the family), almost as though it were "normal."

This may suggest that a critical element in perpetuating the abuse is its *context.* A family context of multigenerationally accepted incest (as well as violence, sadism, and other perversions [e.g., reported bestiality]) means that the victims were reared on these "values" and deem them generally "right." The perpetrators in such a context were also likely to believe that their actions were "normal," hence their lack of attempt to hide their actions from other family members.

It is worth researching a possible correlation between ongoing incest and a larger (family, group, ring, cult) context, compared with cases of single abuser and single victim (e.g., father–daughter).

### ATTACHMENT

Middleton focuses on the manipulation of sexuality, that is, the deliberate stimulation of sexual responsiveness in a child, as the vehicle for the intense bond between abused and abuser that makes the incest relationship repeat endlessly.

I would like to suggest that, even more than their sexuality, the most manipulated aspect in abused children is their *attachment patterns.* That is because the attachment system becomes most activated when one is in a state of survival fear (Bowlby, 1958). Indeed, in all of the cases reported, violence, cruelty, and terror played a major part in the victim's life and in her relationship with the abuser(s), both during and outside of the sexual acts.

A terrified child instinctively reaches for his or her attachment figure, using behavior that will summon and engage the attachment figure (Bowlby, 1958; Main, 1995). In a violent and highly sexualized family (Davies & Frawley, 1994) the attachment figure is bound to respond to sexual or violent signals; infants or children in such families are thus liable to develop a

sexualized and/or violent attachment behavior, that is, act as a victim or a perpetrator of abuse when frightened.

Liotti (1999) described these patterns as subtypes of disorganized attachment. Others (Kahr, 2007; Sachs, 2007, 2008, 2011, 2013) have further emphasized the murderous, *infanticidal* element in the preoccupation of the attachment figure, that the child is compelled to satisfy through repeatedly brushing near death in order to engage the attachment figure.

## ONGOING ABUSE AND DDs

The 10 women in Middleton's (2013b) in-depth study all suffered some form of DD, and Middleton suspects that such is the case in many of the other cases reported (Middleton, 2013a), as well as in his own clinical experience. However, he does not explain the relationship between DDs and the ongoing nature of the abusive relationship.

## THE CYCLE

I would like to suggest that the relationship between DDs and ongoing incestuous abuse is *cyclical*.

A child who grows up with severe abuse is at high risk of developing a DD, so as to disown his or her abuse experiences. And a child in a social context in which cruelty and incest are not only deemed normal but are the most powerful way to engage the attachment figure will develop an abnormal attachment language. Both dissociation and infanticidal attachment increase the child's vulnerability to further abuse, thus perpetuating the cycle (see Figure 1).

Furthermore, the child's alienation from society (resulting from shame and fear) increases the danger in his or her life and thus, paradoxically, his or her reliance on the attachment figure.

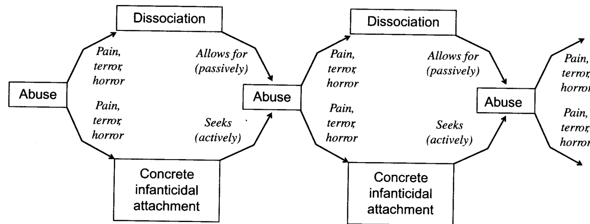


**FIGURE 1** Abuse, dissociation and infanticidal attachment: The full cycle.



In a clinical setting, this cyclical model should alert experts to the possibility of unreported ongoing abuse when people with DDs do not get better or when their attachment behavior suggests an infanticidal attachment pattern (Sachs, 2013).

## CONCLUSION

The problem of ongoing incestuous abuse is extremely disturbing from social, clinical, and ordinary human perspectives. Like domestic child abuse 30 years ago, ongoing incestuous abuse needs attention drawn to it in order to facilitate its being seen, understood, and, hopefully, helped.

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