DISSOCIATIVE IDENTITIES IN CHILDHOOD:

An exploration of how children with dissociative identities may present in psychotherapy. Are there implications for psychoanalytic technique?

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ABSTRACT

Children who have experienced early relational trauma in the realms of neglect and abuse may go on to develop a range of dissociative states of being as a consequence or as a defence. Child psychotherapists are frequently referred children struggling with such a legacy, yet for historical reasons dissociation is notably absent from the psychoanalytic literature and not a formal part of our professional training. This thesis aims to illuminate how dissociative children may present in psychotherapy sessions and to assess whether there are indications that traditional psychoanalytic child psychotherapy technique may need adjusting if treatment is to be most effective. Current theory regarding the aetiology of dissociative pathology is presented including the significant contributions from attachment and neuroscience research, and the slender view offered by psychoanalytic theory is elucidated. Case histories of two of the three participant children are presented with specific reference to attachment and trauma. Process recording notes from the psychotherapy of all three dissociative children are subjected to thematic analysis to arrive at two sets of patient and therapist related themes which are then recursively discussed in fine detail to determine what evidence the material provides. The conclusion is drawn that whilst dissociative children present with some distinct difficulties, these do not dominate the therapeutic endeavour and are largely similar to the presentation of traumatised and attachment disordered patients with whom child psychotherapists are very familiar. Furthermore it is suggested that whilst child psychotherapists treating dissociative children should consider psychoeducuative, organising and validating interventions, their core psychoanalytic skills of withstanding and analysing hostile and perverse transference material, together with their experience in creatively bringing all parts of the self to the child's conscious awareness are central to helping dissociative children recover.

‘La théorie, c’est bon, mais ça n’empêche pas d’exister’- Theory is good, but it does not prevent things from existing

Charcot cited by Freud in his obituary 1893

DECLARATION

I declare that while registered as a research degree student at UEL, I have not been a registered or enrolled student for another award of this university or of any other academic or professional institution. I declare that this thesis is my own work.

CONTENTS

FORMAT

There are several formatting procedures employed for clarity which it may help the reader to be familiar with before embarking on the main text:

1. Participants' distinct personified dissociative identities are distinguished from the host or given name personality by italicising, for instance *Priti* for Kayleigh's personified dissociative state named 'Priti' or *Little Frankie* for Frank's infantilised dissociative personality.

2. When referring to a group of extracts coded for the same feature the code abbreviation in bold font may be used where the sense is clear from the previous text. For instance 'therefore the entire **F** set was excluded as occurring insufficiently to merit further analysis'.

3. Coded items of patient or therapist features are identified by the first letter of the participant's name, the number of the session from which they are extracted and the order number of the item within the session. For instance if referring to an incident of 'varying capacities' which was the fifth extract coded in Frank's third session, this would be represented F 3:5. Where it is not obvious from the context these may be preceded by the code abbreviation in bold followed by a dash, in this instance **Va** - F 3:5.

4. Brief citations from process recording notes are given in italic font within the main text body followed by the reference form above parentheses. For instance, *'Robbie's switching was dramatic from moaning to fury to a few moments of contrived sweetness* (R 8:5)'.

5. Vignettes of material from process recording notes of 40+ words are given in italic font in a paragraph identified by the full name of the participant, session and item number.

ABBREVIATIONS

AAI Adult Attachment Interview
ADHD Attention Deficit Hyperactivity Disorder
ANP Apparently Normal Part of the Personality
APA American Psychiatric Society
ASC Autistic Spectrum Condition
CAMHS Child and Adolescent Mental Health Service
CT Countertransference
DA Disorganised Attachment
DID Dissociative Identity Disorder
EP Emotional Part of the Personality
GT Grounded Theory
H/S Hindsight
IAPT Improving Access to Psychological Therapies
IMPACT Improving Mood with Psychoanalytic and Cognitive Behavioural Therapy
IPA International Psychoanalytic Association
ISSTD International Society for the Study of Trauma and Dissociation
IWM Internal Working Model
NHS National Health Service
OSDD Other Specified Dissociative Disorder
RCT Randomised Controlled Trial
TA Thematic Analysis
WMA World Medical Association

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Most importantly I would like to express gratitude to the unnamed dissociative children and young people who are not participants in this investigation but from whom I have learned a great deal during our work together. I salute your survival.

DEDICATION

This thesis is dedicated to Frank, Kayleigh and Robbie, children of determined spirit forged in adversity. My thanks to all three and to their families and guardians for their permission to share our work together in the hope of helping others.

Chapter 1: INTRODUCTION

Frank and Robbie were both profoundly irritating. In particular their infantilised personas, complete with baby-voice, toddler gait, nursery preoccupations and over-intimate dependence had adults around them metaphorically running for the hills. Unlike reports of overly-affectionate therapist responses to engaging child alters (Shusta-Hochberg, 2004) the two boys' otherwise thoughtful teachers and patient carers would go to great lengths to avoid working with them and created robust almost punitive behavioural programmes in unsuccessful attempts to impel them towards 'age appropriate' behaviour. The manager of 12 year old Frank's residential school would regularly call me in between sessions seeking advice on how to get him to 'stop being so babyish' whilst frustrating encounters with 9 year old Robbie were repeatedly brought to the work discussion group I ran for the teaching staff at his special school. It was the similarity of these two children, not just in their presentation but also in the powerful effect they had on those around them that piqued my initial interest and suggested the investigation. Their infantile personas, ostensibly directed at engaging others to attend to baby-type needs, seemed to have the opposite effect. The original research design and ethical clearance included not only systematically analysing process recording notes from the two boys' psychotherapy sessions, but also interviewing their teachers, carers and Robbie's parents, in the hope of gathering some first hand information.

However, the project reached a hiatus when I moved employment to take up a senior post in specialist CAMHS service. The process recordings were complete and both boys' therapy was able to continue to completion through special funding (Frank) and goodwill (Robbie) but the demands of a new post led to a two-year suspension of the research. When I returned to a consideration of interviewing the adults involved with the boys both had moved to new facilities, as had several of the carers and teachers and it was judged that retrospective interviewing was likely to be much less illuminating than the parallel interviewing initially anticipated. In addition my NHS experience had brought me into contact with children presenting with a broader range of mental health problems, leading to two important personal 'discoveries':

1.1 Dissociative disorders exist!

In the first place, through meeting dissociative young people in my own consulting room and through working with colleagues who had expertise in recognising, understanding and treating such patients, it became undeniable to me that Dissociative Identity Disorder (DID) and Other Specified Dissociative Disorder (OSDD) (American Psychiatric Association (APA), 2013) really exist as pathological conditions in children and young people. Of course dissociation itself is not new and neither is its presence in the psychological experience of children, from Estelle[1] forward (Despine, 1840), but formal recognition of dissociative pathology in children and young people as an identified condition with a distinctive aetiology and treatment needs *is* relatively new to the modern medical era from the 1970s forward, first making it into the diagnostic manual in 1980 (APA, 1980). Within the psychoanalytic field Freud's discovery of the mechanism of repression as the major axis of response to internal mental conflict held ascendancy from his much debated abandonment of the seduction theory in 1897 (Freud 1896, 1987) right through to when Ellenberger's reintroduction of Pierre Janet's by then almost forgotten work eventually put dissociation back on the map of dynamic psychiatry (Ellenberger, 1970 pp.331-372, Janet, 1889). For myself, it was only when engaged in the treatment of these children that I was firmly faced with the reality of young people who authentically and persistently relate to the world as a group of distinct states or identities rather than as one person, and who have varied capabilities and amnesias between these alternative states.

There is not room within this thesis to debate the fascinating assertions and counter-arguments regarding the validity and prevalence of DID in the general and child population (see Merskey, 1992, Spanos, 1996) nor to present the very finely tuned research debunking aspersions of iatrogenic or malingering aetiology, (Reinders et al., 2006, Brand et al., 2009 amongst others), nor to speculate about why the professional community might need to marginalise, deny or dissociate dissociation (Dell, 1988; Marks, 2014) 'That would spare us all the pain of having to consider it might be true' (Sinason, 2002 p.13). Within my own professional practice a growing body of clinical

[1] Louise-Estelle Hardy was just 11 when she was successfully treated for impairing 'double consicousness' by Despine in 1836 using traditional hypnotic procedures; she became famous as 'la petite résurrecte' throughout France and Janet drew on the work in his own theorising (1889). Some 8 decades later Ellenberger (1970) once again brought Despine's work with her back to more widespread awareness.

experience with traumatised children made the existence of bona fide dissociative conditions incontrovertible. Experienced clinicians concur that dissociative phenomena have different quality to the psychotic states of mind typical of the prodromal symptoms of Schizophrenia; dissociative states / voices tend to be experienced as located internally rather than externally, having a 'first person' experience, and generally impair functionality only temporarily. In addition DID and OSDD symptoms usually pertain to 'rational' rather than bizarre delusions that can be relatively easily traced to an internal landscape in which trauma is a prominent feature, whereas the aetiology of schizophrenia appears to have a significant element of genetically mediated biological vulnerability (Mollon, 2002 p.181-2). Dissociative presentation is also notably distinct from the high expressed dramatics of young people with incipient personality disorders, so that as the consultant child psychiatrist who had assessed Kayleigh asserted rather unscientifically to a sceptical colleague on making the diagnosis of DID: *'You know it when you see it!'*.

As I developed a more thorough understanding of how children may experience internal voices, dissociative states and alternate identities so this transformed how I could formulate both Frank and Robbie's presentations as an infantile version of themselves. It was already clear that Frank had several other self-stable and self-organised states (after Putnam, 1988) as well as the infantile *Little Frankie*, and that Robbie's interactions were primarily determined by a discrete number of rapidly shifting mood states which included a whiney-child mood, a blithe-child mood and a persecuting 'Mr. Angry'. Viewing their symptomatology through a new 'dissociation-aware' clinical lens was illuminating but also stimulated a fresh round of questions about which features might commonly occur when working in psychotherapy with such patients. In addition I had by now struggled with several dissociative young people and children in traditional psychotherapy and was about to embark on weekly sessions with fifteen year old Kayleigh, who was formally diagnosed with DID but much more able and motivated to engage in talking treatment than either Frank or Robbie. What could the material from all three tell us about the kind of dissociative phenomena that make their way into the consulting room to help or hinder the therapeutic endeavour?

1.2 Traditional child psychotherapy is not always helpful

My second 'discovery' was that unmodified psychoanalytic psychotherapy as applied by this particular clinician did not seem to produce much healing. Before I had read very much at all from the comparatively small professional literature on working with DID, and before I had had the benefit of incisive supervision for my dissociative child patients from Dr. Valerie Sinason, I had already 'discovered' that to help these young people who presented with shifting identity states, some aspects of a traditional approach observably raised anxieties and increased dissociative features. In her instructive paper 'The Technique of Early Analysis' (Klein ,1932) Klein emphasises the imperative that immediate and 'deep-going' interpretations of both the transference situation and the primal sexual phantasies are essential and gives compelling examples of her clinical work with neurotic children where as a result 'the child's play (became) more and more free and its representational content increasingly rich and revealing' (ibid. p33). Klein's experience that attending directly to the anxieties presented by at once relating them to both her self and to the original phantasy constructions of the child prevented a child from breaking off a play thread or running out of the room were the exact opposite of mine. Interpretation *on its own* did not result in Frank or Robbie becoming better related to reality nor to the emergence of a stronger unitary ego in the way that Klein observed to be a result of the her analytic work; on the contrary both become more anxious and employed dissociative manoeuvres more frequently, causing multiple breaks in play and in any embryonic connection with myself.

It appeared that I needed to adjust my approach if I were to begin to engage these children let alone to help them heal. I felt both excited and disquieted by this, both energised and apprehensively guilty by the push sideways from established Kleinian wisdom as I had learned to practise it. Poised as I was on the brink of a fresh treatment journey with Kayleigh, the opportunity arose to investigate my own practice and to explore whether the material might offer something in answer to a question about whether there are indications that child psychotherapists might need to consider specific alterations to our traditional techniques when working with dissociative children and young people.

So the research investigation and the foundational orientation of the central thematic analysis has this second new phenomenon, of altered technique, built in to the question being asked of it. I was looking to understand what was new to me in the consulting room when faced with the task of trying to help a powerfully dissociating young person move on with their life to enjoy pleasurable relationships and contribute to society as fully as their potential would allow. What adaptations to my traditional psychoanalytic child psychotherapy technique was the presentation with dissociative pathology prompting me to make in the attempt to help my patients? Whilst the stimulus for this question was arguably *inductive* - a 'grass roots' deep-in-the-clinical-work awareness of distinctive symptomology and an altered therapeutic approach – the application of the thematic analysis methodology would necessarily be *deductive*, directing my interest from the start towards moments where I recorded this occurring.

Thus this investigation is focused on two questions: first as to how dissociative experience and behaviour appear in the psychotherapy sessions of these children and second if adjustments to traditional Kleinian child psychotherapy technique may be indicated. An understanding of the aetiology of the dissociative disorders is central to this endeavour - how, why and when do children dissociate and what might predispose certain children to this particular psychological pathway? The following chapter examines this topic in some detail.

1.3 Outline of chapters

This paper is divided into a series of chapters to set the scene, present the findings and finally to evaluate these and discuss the implications of the investigation. Apart from a few notable exceptions dissociation has not been a concept widely used by mainstream psychoanalytic theorists; Chapter 2 therefore presents a brief description of the dominant aetiological models from other fields, including attachment theory, neuroscience, and Silberg's work on dissociation in children, followed by an analysis of the modern day psychoanalytic position, standing on the shoulders of Breuer, Fairbairn and Ferenczi, appreciating contributions from Bion, Rosenfeld, M. Sinason and Garland, and bringing us up to date via Bromberg, Stern, Kluft and V. Sinason. Despite an extended field of study encompassing three participants, the methodology draws directly on single case study analysis so that Chapter 3: "How 'I' became 'us' ", offers detailed case histories for Kayleigh and Frank with particular reference to the early

care-giving and trauma implicated in Chapter 2. Rationales behind the necessary methodological decisions are explicated in Chapter 4, including a detailed discussion of the specific ethical considerations pertaining to dissociative patients and the diverse outworking of these with the child participants of the study. The findings are then presented across the following three chapters with Chapter 5 given over to the initial collection and refining of the codes undertaken in the first four phases of the thematic analysis, work which illuminates the experience of applying the method to the kind of raw data gathered. The method generated a huge amount of data comprising two sub-sets of eight patient themes and five therapist themes which are then recursively reviewed in Chapters 6 and 7 respectively. In these primarily analytic chapters, fine attention is paid to both convergence and divergence between the participants, links are made with the relevant theory and potential connections with other themes within and across the sub-sets are identified. In Chapter 8 a thematic map is offered as an informed speculation on the relationships between the themes, together with an evaluation of the investigation and a discussion of what the implications may be for psychoanalytic child practitioners hoping to help dissociative young people in the modern age.

Chapter 2: THEORISING THE AETIOLOGY OF DISSOCIATIVE DISORDERS

Acknowledgement of impairing dissociative experience as a bona fide mental health condition, present and distinct, and consequent research aimed at understanding the aetiology of such conditions began afresh from the mid-1970s forward. Whilst both the literature and research pertaining to dissociative children and young people is comparatively sparse, aetiological models are steadily evolving in response to emerging research evidence, not least the contribution from neurobiology. Unsurprisingly there is still much debate, particularly over the issue of when pathological dissociation takes hold in relation to the development of the brain and mind, yet also increasingly substantial consensus in relation to the centrality of severe trauma alongside the key role of disorganised attachment.

Midgley's 2002 paper identifies that the study of child dissociation has been prompted by theory and research relating to how adults become dissociative, a 'top-down' investigative field familiar to psychoanalytic enquiry, beginning with dissociative pathology and tracing this back to the start. By contrast the theoretical models that are generated from studying infants and young children are based on the nature of developmental processes and how these are affected by the 'vicissitudes of life', (Freud, 1933) especially the quality of early caregiving. There are two directions of travel here which are reflected in the models articulated and discussed below - first the well theorised 'top-down' structural dissociation model, and then important contributions to an emerging 'bottom-up' developmental model including those from attachment and neuroscience specialists. Following this I set out how key psychoanalytic thinkers conceptualise dissociative processes both historically and currently and the implications this has for effective therapy.

2.1 The Structural Dissociation Model

The model of structural dissociation has gained a great deal of ground within the clinical field and is clearly popular with service users for whom it resonates with the lived experience of a divided self. Structural Dissociation is not a priori a developmental model but instead its chief proponents Steele, Van der Hart and Nijenhuis build explicitly on the key constructs of Janet (1889) to determine that the 'dissociative process is a stable integrative failure in which the personality is divided into two or more psychobiological systems' (Steele et al 2009, p.241). They assert the existence of a first-person perspective, a phenomenal 'self-in-the-world' experience for all truly dissociative parts (Nijenhuis and Van der Hart, 2011 p.426-9) and understand these to be functional - or attempting to be functional - subsystems of mental and behavioural contents issuing in both psychoform and somatoform symptoms of equal clinical significance (ibid. p.439). They adopt Myer's identification in his shell-shocked WW1 patients of an *emotional personality* (EP) that repeatedly relives trauma and an *apparently normal personality* (ANP) dedicated to avoiding traumatic memories in the service of daily functioning (Myers 1940), refining these to *emotional part of the personality* and *apparently normal part of the personality* in order to emphasise their position that these biopsychological systems are indeed part of the whole, not separate entities. They conceive these dissociative parts as constructed to incorporate evolutionarily derived action systems constellated at a subcortical neural level and ascribe the ANPs as built on 'energy management' action systems - finding food, staying warm and so on, and the EPs as primarily executing the defence action systems responding to perceived threats to the body's integrity, hypothesising a 'natural fault' line between the two (Steele et al, 2009 p.243). Some natural parallels can be found in the psychoanalytic literature with this model, not least Winnicott's use of the notion of a 'caretaker self' (Winnicott, 1960) which is so similar in function to an ANP, and Garland's assertion that the psychological effects of an external world trauma are largely determined by how they 'fuse' with person-specific fault lines of psychic reality, 'stir(ring) up without fail the unresolved pains and conflicts of childhood' (Garland, 2002 p.4) and seemingly 'provid(ing) confirmation of the most persecutory of unconscious phantasies about one's objects, event the world itself' (ibid. p.12). For Garland the fault lines are those forged on the internal landscape in the early formative stages of psychological development, and it is along these lines that personality disintegrates under the weight of a later traumatic event.

Although Steele et al assert that their model integrates attachment theory and take some care in their more recent publications to delineate several developmental pathways that might render individuals more vulnerable to dissociation (Steele et al 2009 p.245), the fundamental premise is of an established and organised personality structure that becomes subject to fragmentation rather than one which has never made it to unity in the first place. Whilst allowing that children are 'vitally dependent on their attachment figures for initial regulation of inborn action tendancies….Disrupted attachment in traumatised children appears to be a significant cause of chronic dissociation' (ibid. p.245), their focus is primarily on integrative failure. Structural dissociation theorists assert that, under the pressure of trauma, integrative failure can occur even for securely attached children who necessarily have immature brain structures, as immaturity confers additional susceptibility to the compromising effects of extremely stressful events in an internal context of limited balancing experiences.

In addition the authors argue that their model allows clear diagnosis within the hierarchy of dissociative disorders dependent on the number of ANP's and EP's in evidence for an individual. However from my own experience with dissociative children and young people such a schema risks being overly 'neat' and forcing a framework onto clinical presentations which do not easily fit such categories. It is not always clear that a personified dissociative state or 'system of psychobiological states' (ibid p.239) is exclusively either an EP 'fixed in the traumatic experience' (ibid p.242) or an ANP 'striving for normal life' (ibid p.243).[2]

In my view whilst this model attempts helpful clarity regarding definitions and diagnoses within the field, it is less informative concerning what factors in the individual's environment create the dissociative 'fault lines' along which pathological dissociative separations and divisions then occur (see Silberg, 2013 p.16). Structural dissociation may be most apt in describing the psychological condition of individuals who are struggling with the mental sequelae of trauma experienced as adults, for

[2] For instance Frank's personified dissociative state Ben+Ben, an 8 year old boy and his eponymously named spaniel, could be understood both as deriving from a need to accompany himself with an unthreatening friend during periods of abandonment or boredom (EP), yet was also his least disturbed most attachment-normal version of himself, allowing him to relate to himself and myself as his therapist in a non-perverse and fairly straightforward playful way, suggesting a 'business as usual' function (ANP). It seems possible, indeed likely, that dissociative states may be bent to additional purposes as the child's attachment environment changes over time

instance post combat stress symptomology, but does not easily give the fullest picture of what may have occurred within the minds of our child patients**.**

2.2 Building a developmental Theory

2.2.1 Dissociative conditions as state-change disorders

Putnam's concept of *discrete behavioural states* is widely cited by following theorists as an initial staging post in unravelling the aetiology of DID. Outlined in the very first edition of *Dissociation*, the professional journal of the then newly formed Institute for the Study of Dissociation (Putnam, 1988) and elucidated fully in one of the few publications of that time dedicated specifically to child dissociation (Putnam, 1997) he built on the findings of Wolff's explication of infant states of consciousness (Wolff, 1987). Putnam emphasised that these states are discrete and self-stabilising constellations of physiology and behaviours and described non-linear changes that occur at switching between these states, so that affect, access to memory, intelligence, sense of self etc. shift rapidly from one state to the next. These discrete states are are observable from shortly after birth and are initially relatively few in number**.**

Putnam continues that in the course of normal development a caregiver gradually helps the infant modulate these so that together with increasing experience and uncompromised neurobiological development, a proliferation of subtler states emerge which can be adjusted to biopsychosocial contextual demands and can be recovered following disruptions. A thoughtful attuned carer is required to finesse the physio-psychological state of the infant towards more functional integration and eventual self-regulation. In a healthy adult Putnam asserts that it may be almost impossible to identify the shifts as these become finely tuned and almost seamless, certainly unconscious; however in the dissociative disorders, and most keenly in DID, Putnam postulates a 'return to type' in which consciousness becomes once more organised into discrete states centred on specific affects, modes of cognition, memories and behaviours. In the traumatised child discrete behavioural states become predominantly fear-based, increasingly segregated and inflexible. As for the infant, transitions or

'switches' are often abrupt and discontinuous, hence Putnam's description of DID as a 'state-change' disorder.

Putnam refers to research to evidence the close correlation between DID (then MPD) and severe trauma and hypothesises that the trauma must occur relatively early in order to interrupt the normal state modulation process, it is a developmental disorder. He is also quick to comprehend the adaptive potential of dissociation for a traumatised child:

> By binding these variables to discrete circumscribed dissociative states, the child protects him or herself against being overwhelmed by a flood of painful affects and memories during times when he is not being traumatised,…This enables the child to function successfully in other areas of his life.
>
> (Putnam, 1988 p.26)

The inference here is that if defence is not the primary purpose for the child, it is certainly a secondary gain.

2.2.2 Dissociative disorders and disorganised attachment

A key contribution here is the work of Giovanni Liotti, who has, for over two decades, conceptualised and re-conceptualised how a dissociative mind is generated and has been instrumental in designing a host of focused research projects aimed at evidencing the relationship between parental environment, disorganised attachment and dissociation. Liotti theorises a developmental aetiology in which inadequate relational environments set up precursors or substrates for dissociative self states and argues that these are *from the first* dissociative in nature (Liotti 2006, italics mine). One of the first organising tasks of the infant mind is to construct representations of the self and the care-giving others - Bowlby's Internal Working Models ('IWM's Bowlby, 1973) which comprise expectations about how both can be predicted to behave within the attachment system. These IWMs are initially held in the infant's implicit memory and do not require language or consciousness, thought they will later, if all goes to plan, be consciously attributed to an attachment need and become part of the expressed narrative of the self. Where the parental environment provides sufficiently consistent responses to the infant's needs, even where these are not attuned responses, these become integrated into a coherent attachment pattern for the young child, and a secure, insecure avoidant or insecure resistant attachment pattern develops.

However a disorganised or disorientated attachment pattern (DA), as identified somewhat later by Main and Solomon (1990) via the Strange Situation Procedure, is a different order of beast altogether, understood as resulting from multiple contradictory IWMs. Liotti's contention is that not only are typical DA behaviours equivalent to those that predict dissociative disorders, but that DA is in itself a dissociative process incurring as it does a disruption of the normally integrated workings of memory and consciousness. From research using the Adult Attachment Interview (AAI) and close observation of interactions between young children who show DA with their caregivers, Main and Hesse suggest that when the parent(s) are either frightening or perceived as frightened the infant is caught up in an insoluble attachment dilemma which they painfully describe as 'fright without solution' (Main and Hesse, 1990).

Liotti explains this in terms of the infant's inborn motivational systems, an attachment system which prompts behaviours aimed to make the child stay close to their caregiver, and a defence system prompting behaviour aimed to make the child avoid (or possibly fight off) an environmental threat. Frightened or frightening caregivers simultaneously activate both systems at once, giving the infant or young child contradictory information about how to interact and IWMs that cannot be integrated into an organised representation of the self and the other.

The correlation between DA and dissociative pathology in later childhood or adulthood is well evidenced (Ogawa at al, 1997; Lyons-Ruth 2003; Liotti 2004), and, intuitively, clinicians who routinely work with children who have experienced chronic abuse in their family of origin are likely to find this unsurprising. It seems to make sense that the 'double whammy' of inadequate parenting plus abusive parenting equals serious mental health sequelae including the dissociative disorders as a drastic psychological 'solution' to overwhelming negative experiences. However emerging research suggests a more complex relationship: for instance the Minnesota Longitudinal Study, which has followed a non-clinical cohort of 168 young people from infancy, found that DA at 12-24 months is in fact more predictive of a higher score on dissociative scales in early adulthood than is known abuse (Ogawa et al, 1997). Liotti argues that this adds evidence to his view that infant DA is *necessarily* a dissociative condition, involving simultaneous incompatible multiple representations of reality and states of trance-like altered consciousness in even very young infants (Liotti 2006 p.58).

Characteristically Fonagy adds some fine-tuning here, taking up the issue of precisely how the relational environments that create DA take effect to produce dissociative adults (Fonagy, 2002). For Fonagy it is the intersubjective mentalisation, which he argues lies at the heart of positive mother-infant exchanges to build a secure attachment, that is implicated (Fonagy et al., 1991). Fonagy proposes that infants are biologically prepared to make use of the observations and responses of a reflective parent to develop their own ability to understand that the other and the self have thinking minds which determine how each behaves - 'metacognitive capacity' (Fonagy 2002 pp.75-6). This capacity is key to a coherent sense of self since without it the psychological meaning of experiences cannot be integrated. However this process necessarily involves being in intimate contact with the care-giver's own mind in an exchange which psychoanalysts would describe in terms of projective identification. Fonagy argues that where the mind of the parent is hostile, abusive or neglectfully unresponsive the infant may 'defensively disrupt' (Fonagy 2002 p.79) their capacity to mentalise because it is too frightening or too contradictory to be engaged with the contents of that mind. He asserts that unmentalised experience is *per se* dissociated experience, bodily events not connected with thoughts and feelings which then exist 'in limbo'. Whilst substantial defensive deactivation of mentalisation may protect an infant in the short term it deprives them of the very process they need to develop a sense of their own mind and self, instead creating inaccurate and inflexible schemata of thoughts and feelings that may be experienced as multiple voices.

2.2.3 The neurobiology of dissociation

Neuroscience research informs our understanding of how dissociation is generated and sustained across the levels of the neurons, the neuro-hormones, the structure of infant and adult brains and indeed the entire nervous system. Central to the field are Alan Schore's evidenced explanations of the enduring effects of early relational trauma on right-brain development (Schore, 2009) and Bruce Perry's work on how acute adaptive states, such as dissociation, become maladaptive established structures within the brain. (Perry 1995, 2009). Reassuringly the findings support the attachment theorists' perspective, indeed both draw from and build on each other in terms of conceptualising and describing the significance of the earliest dyadic relationship for the infant's construction of an organised and functional self, able to adapt flexibly to future stresses

or trauma. Perry's conclusion about how brain structures are constructed could equally have been written by Bowlby, Winnicott or Main: 'While experience may alter the behaviour of an adult, experience literally provides the organising framework for an infant and child.' (Perry 2009 p.245).

The human animal has two immediate brain-body responses to perceived threats: *hyperarousal* which readies the individual for an active 'fight or flight' response and *dissociation*, which allows a passive 'freeze, fainting or feigning death' response. Initially then, when alarmed, the sympathetic nervous system is activated to mediate bodily changes such as increased heart rate, blood pressure and respiration in order to mobilise energy and promote a 'tight engagement' (Schore 2009 p.112) with the environment that should, in an adult, allow a better apperception of the threat and directed use of somatic resources. This capacity is present in the infant from birth, but as the infant can neither independently fight or flee, and is motivated by the preemptive influence of the attachment imperative, this will be expressed in attempts to elicit the caregiver's attention and responses, primarily, as a neonate, by crying.

There is a second possible response to environmental stress which is mediated instead by the parasympathetic nervous system, and promotes a disengagement from the environment, a 'shut-down' and energy conservation. This is a hypo-aroused *dissociative* reaction. The adaptive potential of such a response in an adult survival situation is hypothesised as 'buying time to appraise the threat' (Perry 1995 p.279) and involves neurological changes analogous to those identified in animals that utilise 'playing dead' as a defensive strategy. In an older child this might be expressed as numbing, compliance or avoidance, but for a stressed infant or young child it is observed, for instance in the Strange Situation Procedure, as 'behavioural stilling…a dazed facial appearance…accompanied by a stilling of all body movement, and sometimes a freezing of limbs which had been in motion' (Main and Solomon, 1986). The infant alarm distress scale can reliably calibrate the nature and degree of such withdrawal by measuring variables such as absent facial expression, eye contact, vocalisation, relating and total motor immobility (Guedeney and Fermanian, 2001). The distinct neurobiology of this hypoaroused dissociative response includes the release of endogenous opiates which in older children and adults are known to alter perceptions of time, place and pain and causes a lowering of heart rate, blood pressure and so on

even though adrenaline levels have increased. Schore emphasises that, despite the infant's observed hypo-aroused behaviour, the dissociative response is indicative of extreme emotional arousal and a profound detachment from an unbearable situation, and includes a dissipation of consciousness (Schore 2009 p.113).

Just as the attachment theorists conclude, the neuroscience evidence discovers that neglectful caregiving has a dual role in the genesis of habitual or default dissociative responses in children and young people. To attain secure attachment the infant requires the contingently responsive attunement of his or her primary caregiver in order to both amplify states of positive arousal and regulate negative arousal, the very same interactions which build and organise the rapidly growing right-brain of the infant to become able to regulate stress for him or herself. By contrast unresponsive, frightened or frightening caregiving mitigates against this and is *in itself* experienced as stressful - relational trauma. For the neglected infant there is likely to be a repeated dissociation-building cycle in which an ordinary bodily need causes arousal and an attempt to engage the parent, an ill-attuned response which then incurs additional trauma and consequent infant hyper-arousal which when sustained in the context of inadequate parental response results in initial forays into hypo-aroused dissociative shut-down. However, as this state is mediated by very primitive 'reptilian' dorsal vagal complex, the learning and development needed to grow the higher brain capacities to self-regulate is not possible, there are 'encoding failures' in both autobiographical and implicit memory.

Perry aptly describes this as a 'cascade of dysfunction' (Perry 2009 p.242) in which initial spontaneous neurological responses become rigid and automatic physiological and behavioural traits. His concept of the 'use-dependent' development of the brain explains how a dissociative neural system becomes all too readily internalised and subsequently activated by low stressors as 'experience creates a template' (Perry 1995 p.275) and the brain becomes 'reset' as if the individual is under persistent threat (Perry 2009 p.244).

2.2.4 Silberg's Affect Avoidance Model of Dissociation

Joyanna Silberg is perhaps one of the most experienced and widely published clinicians working specifically with dissociative children and author of two comprehensive

accounts of how she works effectively with this traumatised group (Silberg, 1998, 2013).

Silberg's formulation of how dissociation begins offers the distinctive contribution that children who become habitually dissociative have developed a phobia of emotional engagement and respond to emotions *of all kinds* by the evasion dissociation confers. Silberg argues that the failures in care-giving which lead to the internalising of competing and contradictory IWMs are experienced by the infant as a world of entirely negative affect scripts representing shame, grief, terror, humiliation and so on so that any and all emotional arousal becomes stressful and something to cut off (dissociate) from (Silberg, 2013, p.15). As in our description of the attachment and neurobiological models this turning away from interaction may be short term adaptive - the child is not engaged with an inadequate or abusive caregiver and not stressed by incompatible perceptions - but long term maladaptive. These children quickly come to rely on a closed repertoire of learned behaviours impermeable to the affect cues which should finesse appropriate responses to emotional stimuli and can become internally represented as voices, imaginary friends or alternative identities.

> For the dissociative child, the navigational system is turned off and autopilot programs, resounding to only partial information, control behaviour…Treating dissociation involves unravelling those hidden islands of segregated affect and experience and integrating them into a cohesive experience of self.
>
> Silberg 2013 p.21

2.3 The contribution from psychoanalysis

2.3.1 Breuer and Freud

Dissociation was present at the very beginning of psychoanalysis both clinically and theoretically. Breuer's case of Anna O. plainly describes a young woman suffering from a dissociative disorder:

> She used to hallucinate in the middle of a conversation, run off, start climbing up a tree etc. If one caught hold of her, she would very quickly take up her interrupted sentence without knowing about what had happened in the interval.
>
> Breuer and Freud, 1893 p.84

So that unsurprisingly Breuer concludes '…it is hard to avoid…saying that the patient was split into two personalities of which one was mentally normal and the other insane'

(ibid. p.101). At this early stage Freud's own thinking is clearly influenced by Anna's presentation and treatment and includes the dynamic process of dissociation:

> We have become convinced that the splitting of consciousness which is so striking in the well known classical cases under the form of 'double conscience'… is present to a rudimentary degree in every hysteria, and that a tendency to such dissociation, and with it the emergence of normal states of consciousness … is the basic phenomenon of this neurosis. In this we concur with Binet and the two Janets'
>
> Breuer and Freud 1983 p.12

Unfortunately however Freud's interest in his signature formulation of repression as the major psychic defence with the necessary concomitant conception of the mind as stratified horizontally (the consciousness overlaying the unconscious) appears to have rapidly foreclosed on the possibility of allowing a defensive mechanism of dissociation full consideration alongside repression.[3] In addition whilst Freud began with an acceptance of the reality of sexual trauma in the life of his patients and understood this to be severely pathogenic:

> …these infantile sexual scenes…include all the abuses known to debauched and impotent persons,….(and have)…grotesque and yet tragic consequences (which) reveal themselves as stamped upon the later development of the individual and of his neurosis, in countless permanent effects which deserve to be traced in the greatest detail.
>
> Freud, 1896 pp.214-215

Yet less than a year later, in apparent change of heart that has famously received a great deal of analysis and counter-analysis of its own over the years, Freud abandoned this challenging perspective and asserted instead that the sexually abusive and other traumatic material produced by his analysands arose not primarily as a reaction to unbearable life events that could not be assimilated, but from internal wishes and fantasies arising from infantile sexuality that were incompatible with other internal impulses and imperatives.

Together these 'inaugural category mistakes' (O'Neill, 2009 p.307) appear to have directed Freud's subsequent theory even when treating patients such as Rat Man (Freud, 1909b) whose pathology could perhaps have prompted an explicit re-appraising of the concept of dissociation. The Rat Man describes his own condition as a *'disintegration of the personality'* (ibid. p57, italics in original) and successful treatment is delineated in terms of 'a re-integration of his personality' (ibid. p. 58). However whilst later

[3] Howell, 2005 and Mollon, 2012 both offer an extended discussion of Freud's contribution to the field.

writers somewhat tentatively conceptualise Rat Man's pathology as dissociative, (Gregg, 2012; Alayarian, 2011), Freud conceptualises the intrapsychic dynamics as topographically layered rather than vertically split, with repression rather than dissociation as the key mechanism at play. Dissociation is not mentioned throughout. In theorising about Rat Man and in generalising his findings to the aetiology of obsessional neuroses, Freud explains the internal conflict as one between the conscious and the unconscious, not between multiple selves: obsessional ideas are 'transformed self-reproaches which have re-emerged from repression' (ibid. p.101). Freud contrasts the symptoms of hysteria, which attempt to manage an intrapsychic conflict by 'killing two birds with one stone', with obsessional neurosis in which the conflicting impulses are satisfied sequentially (Freud, 1909b p. 73). Powerful affects are 'displaced' onto the wrong causes (ibid. p.78).

However in terms of Rat Man's lived experience what emerges from the narrative is not what we would usually recognise as a dissociative disorder but rather as an obsessive compulsive disorder. He appears as someone with a relatively unified sense of self caught in the grip of powerful opposing emotions that cause him to behave in contradictory ways. Although Rat Man expresses a sense that he has two selves, a moral and an immoral one (ibid. p.58), he describes no amnesia for current experiences, no fugue, no wholesale depersonalisation. His mind is powerfully pulled in two directions, so that he 'changes his mind' frequently in efforts to satisfy opposing internal imperatives, but we do not read of him switching into alternate states of consciousness. Whether Freud's treatment of Rat Man was indeed a missed opportunity for the study of dissociation or not, history confirms that the concept remained exiled from the European psychoanalytic mainstream for nearly a century.

2.3.2 Ferenczi

From Breuer forward psychoanalysts who openly considered dissociation as a major psychodynamic process and countenanced the veracity of reported sexual trauma, tended to be viewed as controversial or maverick by their contemporaries. Ferenczi and Fairbairn are chief amongst these. Having been deeply clinically involved with some of the most disturbed patients of the era, Ferenczi's 'Confusion of Tongues' paper explicitly criticises a psychoanalytic approach that privileges internal dynamics and

excludes the reality of trauma: “An insufficiently deep exploration of the exogenous factor leads to the danger of resorting prematurely to explanations - often too facile explanations - in terms of ‘disposition’ and ‘constitution’ ” (Ferenczi 1949 p.225) He makes an unequivocal assertion of the reality of childhood sexual abuse:

> I obtained above all new corroborative evidence for my supposition that the trauma, especially the sexual trauma, as the pathogenic factor cannot be valued highly enough. Even children of very respectable, sincerely puritanical families, fall victim to real violence or rape much more often than one had dared to suppose.
>
> Ferenczi 1949 p. 226

and clearly asserts a traumatogenic aetiology of dissociative pathology:

> Detailed examination of the phenomena during an analytic trance teaches us that there is neither shock nor fright without some trace of splitting of personality….If the shocks increase in number during the development of the child, the number and the various kinds of splits in the personality increase too, and soon it becomes extremely difficult to maintain contact without confusion with all the fragments each of which behaves as a separate personality yet does not know of even the existence of the others.
>
> Ferenczi 1949 p.229

Ferenczi’s work is peppered with clinical observations and technical advice that therapists working with dissociative patients would recognise. He identifies a split off care-taker part of the self ‘in the form of a helpful, loving, often motherly, minder (that) commiserates with the tormented remainder of the self, nurses him and decides for him;’ (Ferenczi, 1931 p.237) which equates easily to an ANP of the structural dissociation model, and he describes the abused child’s attempt, by dissociative splitting, to maintain the ‘situation of tenderness’ with the abusive parent in terms that prefigure the concept of children facing an approach-avoidance attachment dilemma (Ferenczi, 1949 p.228). His discoveries about the most effective therapeutic attitude with dissociative patients are equally relevant today; he argues for the power of taking a robustly honest and humble stance, being prepared to take criticism as the therapist and to apologise for misunderstandings since ‘it is this confidence that establishes the contrast between the present and the unbearable traumatogenic past’ (ibid. p.226). Ferenczi clearly also has experience of patients becoming unreachable when they are ‘gone off into (a) trance and (become) a child indeed who no longer reacts to intellectual explanations, only perhaps to maternal friendliness’ (ibid. p. 227) perhaps in clinical awareness of the perspective Perry would evidence over seventy years later that interventions with the traumatised are best be pitched to the level of the brain that received the trauma (Perry, 2009).

2.3.3 Fairbairn

Ferenczi presented the 'Confusions' paper in 1932 against Freud's express advice and paid a heavy price for his public dissent, dying just a year later with a ruined reputation whilst the paper had to wait another 17 years for publication. Fairbairn fared better, perhaps posing less of a threat in both the timing of his publications a few years after Freud's death and in his isolated geographical location at Edinburgh, but his contribution still only found a home in the 'middle' (later 'independent') school rather than across the board. Fairbairn recognised dissociation as a key clinical phenomenon and incorporated it into a developed theory of endopsychic structure that departed significantly from the orthodox Freudian position (Mollon, 2012 p.18, Van der Hart and Dorahy, 2009 p.15). Fairbairn found that the psychoanalytic theory did not entirely fit and that psychoanalytic technique did not efficiently help his patients and describes his intent to 'bring basic psychoanalytic concepts….into more conformity with observed clinical data' (Fairbairn, 1951 p.162). It seems no coincidence this 'clinical data' was observations of children who had been sexually assaulted or who had 'unsatisfactory homes' (ibid. p.165) and also psychoanalytic work with soldiers who suffered what were then termed the 'war neuroses' (Fairbairn, 1943b). Like many of Ferenczi's patients, all would have been exposed to the severe and/or frequent trauma, which Fairbairn came to understand as central in precipitating psychopathology of all kinds including 'cases of multiple personality.…(that) are only exaggerated examples of the dissociation phenomena characteristic of hysteria' (Fairbairn, 1949 p.159).

In fact Fairbairn does not use the term 'dissociation' more than a handful of times, but instead reframes Freud's id-ego-superego to a triad of subsidiary parts of a split ego, all of which he views as inherently dynamic structures in relationship with each other (ibid. pp.158-160) yet several aspects of his reformulation prefigure our modern understanding. The language of attachment was of course yet to be created, but Fairbairn identified that negotiating infantile dependence is fundamental to later psychological health (Fairbairn, 1943b p.259) and that it is developmental failure of this task which diminishes an individual's 'capacity to endure danger' as an adult (ibid. p.267). His conceptualising of the libido as 'object-seeking' (Fairbairn, 1949 p.155) seems to foreshadow attachment motivational systems primed to ensure proximity to care-givers:

> The child not only internalizes his bad objects because they force themselves upon him and he seeks to control them, but also, and above all, because he *needs* them. If a child's parents are bad objects, he cannot reject them, even if they do not force themselves upon him; for he cannot do without them. Even if they neglect him, he cannot reject them; for if they neglect him his need for them is increased.
>
> Fairbairn, 1943a p.67 (italics author's own)

- and his poetic description of the internal state of 'J.T.' perfectly illustrates the approach-avoidance conflict of an attachment dilemma:

> He was thus reduced, at the deeper mental level, to the position of a child tossed to and fro between two mother figures, neither of whom he could trust, and neither of whom he could do without.
>
> Fairbairn, 1943b p.275

Fairbairn included an infant's separation from his or her mother as a necessarily traumatic event (Fairbairn, 1951 p.172) and described the infant's depressive and schizoid responses to what we would now assess as ill-attuned caregivers (ibid. p.163), introducing the notion of an infantile state of 'futility' which, to my reading, parallels the collapse of babies in still-face experiments (Tronick, 2004). Most pertinent to an investigation of dissociative children and the puzzle of how hostile and perverse internal voices or alters are created, Fairbairn theorized the internalisation of bad objects and subsequent identification with these as a way of preserving the sense of good objects and a good world. Fairbairn extends psychoanalytic understanding beyond Anna Freud's view of identification with the aggressor as a normal stage of superego development (A. Freud, 1936) to conceptualise the young child's need for and use of a 'moral defence' (Fairbairn, 1943a p.65) in which conceiving of himself as conditionally bad is preferable to understanding himself to be in an unconditionally bad world – 'better to be a sinner in a world ruled by God than to live in a world ruled by the Devil.' (ibid. p.67). Such a defence is especially necessary for children whose real-world parents are neglectful or abusive, preserving some hope of security and redemption but at the cost of guilt, impoverished self esteem and relentless internal persecutions. From here it is easy to see how an abusive internal voice or personified state would become the segregated expression of the internalised abuser in children who have already had recourse to dissociative manoeuvres.

Fairbairn also recognised the essential task of the infant in regulating him or herself (albeit in relation to internal objects rather than actual over-exciting or over-frustrating carers) and considered the infant's particular regulatory techniques as determinant of later health or psychpathology. (Fairbairn, 1951 p.163).

2.3.4 The Imaginary Twin - Bion

In his paper 'The Imaginary Twin' (Bion, 1967a, first read to the British Psycho-analytic Society 1950) Bion gives an intriguing account of his treatment and understanding of several patients who bring material in which twin versions of themselves are in evidence. Bion describes a dramatic change in patient A's physical demeanour when, after some two years of work together, and following the patient's admission that much of what he has brought as factual has been imagined, he interprets that the patient has cast himself (Bion) as his twin. Bion ascribes his patient's altered demeanour to the unavoidable re-introjection of the personified split-off parts of the personality that his interpretation forces. It becomes clear that up until this point patient A has been presenting a twin 'locum' version of himself for analysis in order (we presume unconsciously) to avoid the attention Bion's treatment would necessarily draw to his intra-psychic processes and so 'leave him and his objects more or less in peace' (ibid. p13). Following this 'eureka' moment, the course of the analysis improves in both engagement and momentum[4], and Bion understands the work going forward as that of helping his patient to 'develop by reuniting the various splits in his personality – 'particularly in allowing hatred to return as a part of himself in his relationship with me.' (ibid. p.11).

Reading between the lines there is the impression that Bion is rather struck by the experience of being in receipt of Patient A's 'externalised' presentations of himself, comparing it to 'play therapy' since he 'personified his splits with such success' (ibid. p.16) and his acceptance of the need for an accepting observing stance seems to be intuitively in line with the attitude to dissociative states advised by many practitioners

[4] Rather sadly there is a note at the beginning of the account that the analysis ended when Bion advised a leucotomy, suggesting that improvement in the patient's condition was either not sufficient or not sustained, and that a last resort of invasive surgical splitting was the eventual remedy proposed for his debilitating mental splitting.

today (see sections 7.1 and 7.2 for further discussions of this aspect of technique). Bion's willingness to accept the meaningfulness of imagined material and to analyse this as real information about the internal world of his patient is indeed impressive. However it is not clear that Bion is thinking in terms of dissociation as a dynamic internal defence mechanism issuing in organised altered states of consciousness. He uses the term only once: *'in the dream the patient uses me as a personification of the' bad part of himself from which he wishes to be dissociated'* (ibid. p.9). In this context 'dissociated' seems to mean deliberately 'dis-avowed' or 'denied' as in 'dis-associated' and is purposive and specific in the mode of repression. Patient A's twin part of himself, the complaining aspect and the 'locum' aspect are precisely as described in Bion's title – *'imaginary'*, and are expressed symbolically via dreams and imaginings or 'play'. These aspects have 'real' meaning and important defensive roles and it is the business of the analysis to uncover and resolve these, but the personification appears to be symbolic rather than actualised and so not easily recognisable from the narrative as truly dissociative.

2.3.5

The Pathological Organisation - Rosenfeld

Rosenfeld's concept of pathological organisation has stood the test of time within the psychoanalytic community and draws on the theorising of Freud, Klein and Reich (Reich, 1933) concerning the defusion of the life and death instincts produced by a splitting of the ego (Rosenfeld, 1971). Rosenfeld delineates two kinds of narcissistic idealisation, one of omnipotent independence in which the ego seems to be asserting 'all the good I have is derived in or from myself' and the other an idealisation of the destructive parts of the self. Rosenfeld contends that it is this second idealisation, often more hidden, which can be highly organised and keeps the more positive sane self from engaging with analysis. His description of the struggle one encounters in the psychoanalysis of patients with this kind of internal landscape might indeed be familiar

to therapists trying to help those with dissociative disorders, especially where there are dissociative states identified with abusers:

> The destructive narcissism of these patients appears often highly organized, as if one were dealing with a powerful gang dominated by a leader, who controls all the members of the gang to see that they support one another in making the criminal destructive work more effective and powerful.
>
> Rosenfeld, 1971

He identifies that this internal pathological organization is dedicated to 'self-sufficiency' and is extremely resistant to both object-relatedness and recovery, including threatening the self with death 'if you dare to tell', all of which could be recognised very regularly from our treatment journeys with dissociative patients.

However in the material Rosenfeld offers for illustration, this powerful internal gang is not expressed in personified identities with a felt sense of autonomy (dissociative states) but in acting out behaviours (routinely showing up late for or missing a Monday session), dreams (of murderous rage and intent) and in somatic reactions (shaking violent hands that are impelled to destroy). As we might expect for a prominent psychoanalyst of this era, Rosenfeld looks entirely to the patient's internal world for an understanding of the aetiological dynamics of how such a pathological organization might be generated and sustained. Rosenfeld proposes that the patient undergoes a narcissistic withdrawal under the influence of the death instinct motivated at source by an envy for the good object's capacity and a denial of necessary dependence. There is no room in this schema for how the infant's attempt to negotiate a neglectful, unpredictable, capricious or cruel object may have influenced his or her psychological development, and certainly no sense that this could be an *adaptive* sane response to life in an 'insane' maternal landscape rather than purely a pathological defensive response out of which the sane part of the self must be retrieved.

2.3.6

The Internal Cohabitee - Michael Sinason

The concept of the internal cohabitee is explored in Michael Sinason's paper *'Who is the mad voice inside?'* (M. Sinason, 1993) and bears inclusion as it presents another moment when a committed psychoanalytic therapist grapples with issues of how to approach work with patients who have coherently organised but separated internal

systems of behaviours and responses. Sinason draws on his clinical work with psychotic patients and on the theoretical backdrop of Freud, Rosenfeld, Bion and Sohn (Sohn, 1985), to delineate a split between a diminished non-psychotic ego orientated towards the demands of reality and a psychotic part that acts to get rid not only of unwanted perceptions but also of the part of the mind that registers them – the 'internal cohabitee'. Following Rosenfeld, Sinason understands this pathological part to be both organised and sentient so that the patient's situation becomes one of there being a *'cohabitation of two minds in one body'* (ibid.). The treatment he advocates and illustrates is directed towards getting the patient to recognise, accept and become compassionate towards the cohabitee, rather than to condemn and expunge it. Whilst Sinason takes care to reiterate the 'business as usual' psychoanalytic approach, there is a strain of tenderness, interest and respect for the clearly damaged cohabitee self here that has much in common with the modern treatment models of Marks (2014), Silberg (2013) and Struik (2014) with dissociative children. These clinicians begin with the premise that the 'cohabitee' dissociative states would all, at their inception, have an adaptive purpose and would agree wholeheartedly with Sinason's perspective that *'destructive consequences do not always come from destructive aims'* (M. Sinason, 1993). However the paper is essentially about technique with a psychotic patient population and does not, of itself, advance a psychoanalytic understanding of dissociation or its genesis.

2.3.7 Relational Psychoanalysis

At about the same time as Fairbairn was writing, but on the other side of the Atlantic, Harry Stack Sullivan, a talented psychiatrist working largely with hospitalised schizophrenic clients, put dissociation firmly back on the map within the non-medical section of the American psychoanalytic community. Sullivan not only abjured Freudian drive-theory to develop new relational model of the self, but placed dissociation at the centre of this as the primary response to trauma (Sullivan, 1953). Sullivan hypothesised that elements in relational experience which cause extreme anxiety are subjected to an active process of 'selective inattention' which causes multiple dissociative gaps and that

these are maintained in order to avoid the felt danger. However this is to the detriment of the self which becomes highly attenuated and distorted. Sullivan pioneered a very successful therapeutic approach in which the therapist endeavoured to remain completely out of the field of transference-countertransference enactment in order to regulate the patient's felt sense of safety and focused on making a very detailed enquiry into the patient's interpersonal story (Sullivan, 1954). His approach has a great deal in common with the modern mentalization based approach pioneered at the Anna Freud centre under Peter Fonagy and used effectively with traumatised young people (Fonagy, 2006).

Recognising the clinical accuracies of Sullivan's dissociative model of the mind Philip Bromberg and Donnel Stern have been a major modern influences in the field, responding to the challenge, in Bromberg's words of 'how to make use of this recognition in a way that would enrich what (he) was doing as an analyst rather than replace it' (Chefetz and Bromberg, 2012, p.156). In a ground-breaking collection of papers 'Standing in the Spaces' combining admirable personal honesty with finely incisive formulation, Bromberg argues that the primacy of repression in psychoanalysis 'at best underestimates and at worst ignores the dissociative structure of the human mind' (Bromberg, 1998 p.8). Bromberg conceptualises dissociation thus:

> Interestingly, dissociation, in human beings, is fundamentally not a defense but a normal hypnoid capacity of the mind that works in the service of creative adaptation. It is a normal process that can become a mental structure. As a process, it can become enlisted as a defense against trauma by disconnecting the mind from its capacity to perceive what is too much for selfhood and sometimes sanity to bear. It reduces what is in front of someone's eyes to a narrow band of perceptual reality ("whatever is going on is not happening to me")….Its key quality is its ability to retain the adaptational protection afforded by the hypnoid separateness of incompatible self-states, so that each can continue to play its own role, unimpeded by awareness of the others.
>
> Bromberg, 2003 p. 560

He then arrives at a psychoanalytic approach that re-integrates the use of transference and counter-transference and champions the sub-symbolic enactments of dissociative patients in psychotherapy as a vital source of learning and recovery. Bromberg views the process elements of the psychoanalytic encounter as the active ingredient: 'it's not the linguistic content but the emotional content that teaches (the patient) she is understood' (Chefetz and Bromberg, 2012 p.181). He describes the condition of DID patients as 'isolated subjectivity personified' (ibid. p. 173) and sees the task of the

psychoanalysis as providing a sufficiently safe interpersonal context to begin conversations with and between dissociated parts of the self in order to allow unsymbolised traumatic material to emerge: 'In this light, a core dimension of the therapeutic processes to increase competency in regulating affective states without triggering the dread of retraumatisation' (Bromberg, 2003 p.559).

Unformulated experience

Stern too takes Sullivan's repositioning of dissociation as his 'keystone' in pursuit of a model of the mind that is 'clinically useful, hermeneutically grounded and phenomenologically recognizable' (Stern, 2009 p.653). Stern's contribution is a fundamental reversal of the psychoanalytic understanding that consciousness is the result of compromise made between drives and defences, with the corollary that what is unconscious has been purposively repressed. Stern draws on research psychology to assert that perception, knowing and understanding are all constructed from what he describes as 'unformulated experience', so that 'consciousness is an active creation - an accomplishment - not a leftover' (ibid. p.657). Clearly so far there are distinct parallels here with Bion's conceptual scheme in which 'alpha-function' corresponds to 'formulating' as the means by which the 'beta-elements' of unformulated experience are transformed into 'thinkable' alpha elements: *'alpha-function makes the sense impressions of the emotional experience available for conscious and dream-thought'* (Bion, 1962 p.7). So from Stern's perspective, defence becomes not the pushing away of unwanted content into the unconscious, a mechanism of repression, but the prevention of formulating unformulated experience, a mechanism of dissociation. '…we define dissociation as the inability or unconscious unwillingness to formulate experience in symbolic form' (ibid. p.658)

Kluft

A brief history of the field would not be complete without mention of Richard Kluft, a psychiatrist and psychoanalyst who has been practising and publishing in the field of therapeutic work with dissociative adults for over thirty years, a founding member and past president of what is now ISSTD (International Society for the Study of Trauma and Dissociation). Kluft's thinking and experience are directly relevant to the investigative endeavour of this study in terms of what adaptations to psychoanalytic technique may be necessitated by the highly traumatic backgrounds

and defensive presentation of dissociative patients: '…DID often requires the imbrication of a number of interventions that are derived from diverse models and armamentaria within the overall texture of a single psychotherapeutic process…' (Kluft, 2000 p.261) In his honest and lively account of the psychotherapy of a dissociative young woman a clear psychoanalytic orientation comes through alongside a deliberate and active building of a positive therapeutic alliance, psychoeducation about dissociation, the teaching of autohypnotic techniques for self-calming, persuasion and the use of reconfiguring hypnosis to contact parts of the self otherwise refusing to become available (Kluft, 2009 p.602). Perhaps his most helpful theoretical concept is that DID is better described as a 'multiple reality disorder' within which the defensive function of the alters is to 'express the wish, the fantasy, of supplanting an intolerable reality with a more tolerable one.' (Kluft, 2000, p.262). Within the consulting room the interactions with and between alters are understood in the same way as play or dream material might be as acting to 'express and/or enact crucial dynamics and subjectively experienced historical material' (Kluft, 2009 p.609) all of which Kluft takes as useful grist to the psychoanalytic mill. This has much on common with a child psychotherapy approach and we shall return to Kluft's work in the discussions of Chapter 7.

2.4 Summary

However most of the theoretical and clinical development in the field of dissociation is occurring at some distance from the European psychoanalytic community both geographically and culturally. Within the UK it is undoubtedly Valerie Sinason, both a child psychotherapist and an adult psychoanalyst, with her characteristically keen apperception of marginalised and societally 'invisible' populations that has championed the reality of dissociative conditions and the veracity of the severe relational and sexual trauma that produce such a drastic pathological response. Sinason founded the Centre for Dissociative Studies in London in 1998, which remains the only provision nationally specifically commissioned for treating adults with dissociative disorders[5] and has edited

[5]To date there is no UK body known to the author specifically dedicated to researching and treating dissociative conditions suffered by children and young people.

key publications which bring together celebrated theorists and clinicians including Bentovim, Fonagy, Nijenuis, Mollon, and Bromberg (Sinason, 2002, 2012).

So where does all this leave child psychotherapists in the UK? The importance of the integrative tasks of the first year of life is clearly present in Klein's thinking on the movement from paranoid-schizoid (polarised, discrete, extreme) to depressive (integrated) states of mind in the early months, (Klein, 1946), and paralles can also be drawn between dissociative processes and the schizoid mechanism she delineates in which a part of the personality is effectively 'killed off' (ibid. p.19-20). The central role of the caregiving other is visible in both Bion's algebraics of parents/analyst converting their infant's/patient's fragmented beta-elements into thinkable alpha-elements (Bion 1962) and Winnicott's advocacy of the vital function of every ordinary mother in offering ego-support to her infant who would otherwise be overcome by unruly 'id forces' (Winnicott 1960a, 1964). This much modern British psychoanalysis can share with the state-change, attachment and neuroscience models. However, with the possible exceptions of Winnicott and Bion, even those such as the independent 'middle' school who may have less resistance to utilising what we can learn from Ferenczi and Fairbairn, are drawing on concepts within an essentially one-person *internal world* model whereas the findings of both the attachment and neuroscience research set dissociative aetiology firmly within a relational intersubjective context. It is perhaps no surprise that theory which focuses on the infantile *internal* dynamics in an assumed context of adequate parenting produces an analysis of a patient's present troubles that emphasises envy of a good *internal* object and the twists and turns, including sentient pathological organisation, that the mind may make to avoid the pains and losses of mutual interdependence.

Consistent with this starting perspective on a relational crucible for dissociative aetiology, is the centrality of trauma within all of the non-psychoanalytic models. The timing and recurrence of the generating trauma may vary between models - persistent and infantile (attachment / neuroscience theory) or later in life and discrete (allowed for in the secondary dissociation of structural dissociation theory), and the nature of the trauma may also vary - relational trauma in neglect, bodily trauma in physical abuse, additional emotional trauma in sexual abuse, betrayal by a carer (Freyd, 2005),'moral injury' in combat situations (Shay 1994). However these theories do all share a fundamental commitment to the centrality of traumatic experience in the aetiology of

the dissociative disorders. Despite a clinical landscape in which child psychotherapists are increasingly called upon to work with chronically traumatised individuals, we demur from a direct reprising of Freud's retreat from the significance of trauma as a primary aetiological determinant of ensuing psychopathology. Kluft may have his tongue firmly in his cheek but there is some tart truth in his summing up:

> Dissociative multiplicity is a persona non grata in the psychoanalytic mainstream…there have been more attempts to explain it away than attempts it come to terms with it…My explanation for this is that proximity to the IPA is inversely proportional to the ability to think about or recognize, hypnoid defenses and dissociation.
>
> Kluft, 2009 p.301-2

This study hopes to stimulate further attention to the subject from psychoanalytic child psychotherapists by offering a close perspective on the presentation and treatment of dissociative children. It is to the histories of the participants, especially as these relate to attachment and trauma experiences we next turn.

Chapter 3: CASE HISTORIES - HOW 'I' BECAME 'US'

The narratives which unfold below are necessarily heavily disguised and attenuated versions of the children's lives. Kayleigh's story is told first as it offers a relatively straightforward account for readers unfamiliar with the genesis of dissociative conditions, followed by Frank's painful journey illuminating circumstances in which dissociation may have become the only adaptive response. There was little history available for Robbie, so that his story appears briefly at the end of the chapter and is offered for information rather than illustration.

3.1 Kayleigh's Story

3.1.1 A Compromised Parental Landscape

Kayleigh's mother Jessica was just sixteen when she became pregnant with her during her very first sexual relationship. Over her own teenage years, in a flurry of uncontained retaliatory remarks between her parents for whom she was the only conduit, Kayleigh learned from her mother that her father, Ian, had persistently wanted her aborted and from her father that he had only 'got with' her mother 'because she was an easy lay'. During 'laddish' drinking sessions with a 13/14 year old Kayleigh, her father further coloured her understanding of her conception with graphic descriptions of his and the teenage Jessica's perverse sexual activities, communicating powerfully to Kayleigh that although her mother might seem appropriately 'up tight' and strict in limiting Kayleigh's sexuality nowadays, underneath she was really 'just a dirty bitch'. Kayleigh was hence powerfully given to believe that the relational crucible for her creation was a union based on compulsive sexual excitement, of which she was an unplanned and largely unwanted by-product. Romance, affection, caring or thoughtfulness are absent from her understanding of how and why she was made.

Although not explicitly implicated in the sexual abuse she suffered, Kayleigh's irregular encounters with him confirm that her father consistently intruded on her with his own sexual preoccupations and undermined her mother's attempts to instill appropriate sexual boundaries for their daughter. Kayleigh describes Ian as 'like three different fathers'; in addition to his approach to her as 'one of the boys' which includes talking about women as sexual objects and offering cannabis or alcohol, he could be flirtatious just up to but not beyond the point of playfully smacking her bottom, and on occasion be more appropriately protective of her as a young girl in his care. Given his own alcohol and mental health problems, and reported sexual abuse, it is likely that Ian is unpredictable and quite possibly dissociative himself, hence Kayleigh's experience of distinct shifting parenting styles.

In her infancy there is no sense that the little family had much time to enjoy each other and create the 'ordinary devoted parenting' required for making a good beginning (Winnicott, 1949, 1964 p.17) before Kayleigh's father had left. Certainly Kayleigh can remember very little from her time as a toddler, and has none of the reassuring nostalgia for a favourite toy, pet or game which convey that a child has had sufficient enjoyed experience to form a benign focal memory. The net result is that Kayleigh cannot refer even symbolically to an idealised time when she felt safe and happy as the centre of her

mother's world or the apple of her father's eye. Kayleigh's mother had a swift series of partners, and a second daughter, Natalie, was born when Kayleigh was three and a half by a father that Natalie has never met.

3.1.2 Surviving in Shifting Sands and High Seas

The little Kayleigh's shifting family landscape in which men came, were adored, misbehaved, abused and then left, was mirrored and further destabilised by a repeatedly shifting geographical landscape. Fleeing from one particularly violent man, just as Kayleigh had started in school, her mother briefly settled hundreds of miles north in Liverpool, where the other children's accents in the playground sounded like a different language to a five year old Kayleigh. However Jessica was at once homesick, longed for her sisters' company, and spent the next eight years in sequential council house-swaps to 'get back home'. Kayleigh remembers getting on well at school and being quick to make friends but her mother's determined pilgrimage back to the capital meant that she was constantly uprooted and starting afresh. Kayleigh did not bemoan the many moves, other than the last at age 12 which had taken her from a group of slightly older boys (13/14) to whom she felt special. Instead she wore it as badge, declaring: 'Ten schools in eight years!' rather in the boastful vein of an elderly person celebrating their survival 'Yes, 95 and still got all my own teeth!' Perhaps no wonder that Kayleigh would later express such an affinity with the traveller community.

Kayleigh has it from her mother that she found her no trouble at all throughout her young childhood (age 3 – 10), although Kayleigh does recall that when mum's partners 'got leery' or threatened to assault mum, she would become a little fireball of aggression, trying to get in the way and protect her mother so that she became known in the extended family, with some misplaced affection, as 'Mummy's Little Rottweiler'. For an otherwise quiet compliant little girl I do wonder about this reactive fluorescence of protective fury, and whether fluid switching between states honed dissociative skills that brought her closer to the creation of a personified dissociative state in *Priti,* who at age 8 was still just a helpful imaginary friend that kept her company when lonely or bored. Kayleigh had to adapt to an attachment environment in which she was faced with a contradiction of needing quick access to sufficient passivity to be uncomplaining about yet another move, sufficient energy and creativity to make friends in yet another new peer group and simultaneous quick access to sufficient aggression to defend her

only permanent carer. In conclusion whilst Kayleigh's early life circumstances conspired to significantly compromise her opportunity to internalise reliably attuned and caring parental figures from which secure base she could meet and negotiate what was to come, she did not show obvious signs of DA, and her mind had evidently developed in a sufficiently organised fashion to more than adequately attend to learning at school,

3.1.3 Precipitating Trauma – a first incidence of sexual abuse, (imaginary friend) *Priti* becomes more than 'just pretend'

When she was just six years old, Kayleigh's mother fell into another new relationship which there seemed good reason to hope would be different. Anthony came with no baggage in terms of previous children or difficult ex-wives, and was a hard worker, lifting the family clear of precarious finances. Kayleigh remembers she and Natalie had their own rooms for the first time, there were new clothes and a telly each. After several months Jessica agreed to marry him, and Anthony set about formally adopting Natalie. Kayleigh describes feeling that they had become 'normal'. In reality this new normal still included regular loud arguments between the adults that threatened to become physical and a certain amount of rough handling and forceful chastisement of the children, but for Kayleigh none of this was out of the ordinary, it was pretty much all she and Natalie had ever known and anyway *Mum was happier than she had been in a long time.*

However, whether planned or spontaneous, Anthony sexually abused Kayleigh at a family party when she was aged just 8, and Kayleigh told her mother who, to her credit, immediately phoned the police. Anthony was arrested, her clothes were taken away and examined, as was she, and he was charged. This event led to a huge change in family fortunes. To the trauma of the abuse, which Kayleigh remembers as mentally confusing rather than painful or repulsing, were added the strangeness and seriousness of police interviewing, the paradox of being the chief witness in the judging and punishing of a previously loved family member, the immediate breakdown of the relationship in which her mother had finally been happy, her sister's loss of a newly adoptive father, a house move, a school move, and an inevitable slide back into poverty. Kayleigh recalls that having had the courage to speak up, she felt exhausted, overwhelmed by guilt and that she retreated to quiet compliance; yet we can imagine there was still so much she

needed strength and sociability for. Kayleigh is clear that it was around this time that *Priti*, having previously been just an important imaginary friend, became a person in her own right, arriving to help Kayleigh who often no longer felt strong or confident or capable. She would *come out* (or at this early stage perhaps she *was allowed to take over* is a better description) with cleverness and attitude when Kayleigh felt inadequate and small[6]. In due course Anthony was convicted and Kayleigh's mother told her that he had gone to prison.

3.1.4 A compounding trauma – perceived discovery of maternal betrayal, *Priti* is invited to take over

During the subsequent years, Kayleigh remembers little of note and imagines things rumbled on much the same as before, although Jessica met Harry during this period, a hard-working unassuming man who remains the somewhat 'silent partner' in their family to this day. However around her 11th birthday, having had a visit from her Dad, his sister let slip that Anthony had not gone to prison, and Kayleigh aggressively confronted her mother to be told that this was true. Her mother had lied because she thought this best for Kayleigh, felt that justice ought to have been seen to be done in her little girl's world. For Kayleigh it was as though a time-bomb had gone off, shattering their relationship for ever, all her rage about her mother's mistakes and inadequacies flew down the lightening rod of this well-meaning deceit and appeared to her as entirely unforgivable; in her view her mother had betrayed her far worse than Anthony had ever done.

Kayleigh was on the cusp of puberty and the revelation that Anthony was not in fact punished seemed to trigger a determination to actively involve herself in any sexual liaison on offer. As with so many girls and young women who have been abusively introduced to unsolicited sexual activity, Kayleigh increasingly felt compelled to engage with men in a bold flirtatious way, often consciously sending *Priti* into the fray when as Kayleigh she felt too shy or lacking in allure. To start with Kayleigh kept what she knew of *Priti's* activity to herself, rightly deducing that her family would not understand or approve, and evidently, at this stage, having sufficient control or

[6] See Silberg, 1998 p.66, for a similar description of development of DID by her 12 year old patient Lizzie.

cooperation between the two to execute such a self-state management strategy successfully. If Kayleigh had not suffered the second trauma we might have predicted that a working co-consciousness would have remained and that no amnesia between the two would have developed. We could therefore reasonably have hoped that ordinary developmental processes, including the readjustments to identity that every adolescent must negotiate and resolve, would have helped Kayleigh grow up into a less divided self.

3.1.5 A second precipitating trauma – violent sexual assault at age 14,

Unsurprisingly Kayleigh and *Priti's* pursuit of sexual encounters drew her into the local gang in which the largely dominant young men had very little respect for the largely objectified young women. At 14 Kayleigh was so pleased to be selected as a *bona fide* girlfriend for one of the key players that any intelligent appraisal of who 17 year old David might actually be was entirely overrun by delight that she could now finally *belong* to a man and so belong to a group.

A tragic series of events unfolded between them. Drugs and alcohol were involved when David raped Kayleigh for the first time. She remembers protesting but very little detail since she was so very 'out of it', something she ascribes to the cannabis and might well have included her already developed dissociative capabilities. Kayleigh went home but told no-one since she knew her mother and grandmother would be appalled and would be likely to prohibit her movements. She tried to avoid David over the next few days, but he professed contrition, holding the substances rather than himself responsible and Kayleigh, a great champion of second chances (as the hopeful daughters of feckless fathers may have to be), agreed to see him again. We can imagine that she was also psychologically at sea, having exiled her actual mother for lying to her, and having no reliable internal mother or father figure to advise or protect her. However just two months later, once more both under the influence, David again pressed her for intercourse, she resisted and he became violent, holding her up against a tree by her throat and raping her both vaginally and anally.

It is perhaps telling of the fundamental lack of trust she felt in relation to her mother that she kept her distress to herself and only some days later, when still bleeding from the attack, she turned to her father, who she judged would be more accepting, telling him

what had happened and asking if the bleeding was only to be expected. This enquiry sounds immensely naïve, but is congruent with Kayleigh's fragile sense of self: she had insufficient anchoring self-worth or orientating relational common sense to appreciate that she was the injured party in every sense of those words. It seems that in her mind the event itself, despite being a terrifying ordeal, had not registered as an act for which David was culpable rather than herself, let alone as a crime of which she was the victim for which society might rightly pursue prosecution. She felt herself to blame not only because she had returned to a relationship which she should have walked away from, but also because internally she was forced back around the circuit of her former experience of sexual abuse from her stepfather at age eight for which she had also felt responsible. The response she received is further testament to the confused sexual mores of Ian and those in his orbit; whilst interested and believing, he put his partner Cheryl on the phone who in the spirit of 'all us girls together' sought to reassure Kayleigh by telling her that she (Cheryl) had 'a lot of tricks up her sleeve' which she could pass on so that next time this sort of thing happened Kayleigh could make sure it was less painful.

So Kayleigh did not, as a first response on disclosing violent rape, receive comfort, righteous outrage or important medical attention, including the sensitive gathering of forensic evidence. Instead she had her suspicion that this was a fairly normal sexual event confirmed and was given the idea that growing up was going to be about learning to manage sexual trauma with less fuss. Ian told Jessica, who was appalled by his response, frustrated with Kayleigh, and immediately referred the matter to the police. However given the delay in reporting, the misuse of alcohol and drugs, and the circumstantial reality that Kayleigh had initially gone willingly with David, it was never going to be an easy case to prosecute and Kayleigh's perception that she was treated like a time-waster feels sadly credible. In her psychotherapy Kayleigh repeatedly recalled the moment when a police woman shouted in her face because she could not remember important details about the evening in question; this event stood out for her as significantly shocking, confirming yet again that she could not have confidence in her felt experience, that she was inadequate, wrong, bad. Kayleigh remained consistently frightened of police women, the police uniform and police in general, and her poor experience of being contained by a good authority figure was compounded. As with her enduring fury at her mother's 'betrayal' in lying about Anthony's sentence,

the most coherent memory, in which strong emotion and narrative are comprehensively matched is that of being maltreated by a female 'who should have known better' (the policewoman).

3.1.6 Dissociative Escalation – *Priti* takes over uninvited

Possibly if Kayleigh had been offered an opportunity to talk and think about what had happened *at that time*, and if she could have allowed herself to engage with such an offer, then she could have begun to process both sets of abuse and to heal. But Kayleigh was already adept at dissociating in order to manage situations she felt overwhelmed by; if defensive strategies are etched into our neurology by the well-travelled physical pathways between neurones, then a dissociative neural highway was already well under construction within her. From Kayleigh's perspective it was at this juncture that *Priti* got cross with her for being 'so weak' and took matters into her own hands, no longer coming on board to take over at Kayleigh's request when she (Kayleigh) felt faced with scary social situations, but instead taking over uninvited and actively creating an alternative romantic life, first via social media and then in real time and space. In addition Kayleigh now experienced confusing amnesia for much of what *Priti* got up to, would find several hours of the day unaccounted for, or would 'come to' with people she did not know, dressed in unfamiliar clothes, and have to make a sharp exit covering her confusion. All of this she kept to herself for fear of being seen as mad.

Matters came to head when *Priti's* determination to spend time with her boyfriend Josh, 15, broke through to interrupt Kayleigh's hitherto protected life at school. The liaison with Josh, a studious young man on the other side of London, was one of which Kayleigh had no conscious direct knowledge, only a dim awareness that *Priti* was 'trying to sort out a boyfriend for us'. Prior to this Kayleigh was recognised by staff and peers alike as an earnest, creative, diligent young woman, both sensitive and likeable, transparent in declaring her anxieties and in appealing for extra help both academically and socially. Later her teachers would concur that true, there was always something puzzling about how such an able girl could be simultaneously so naïve, and would agree that it was surprising that she remained a bit of a loner at large when in class, anyway, she always had such a good rapport, but they had always previously put

this down to her late arrival into year 10 following her unplanned move, rather than more serious emotional difficulties.

Priti managed to secure several permissions to go to 'appointments' and finally a whole morning off school for a fictitious medical investigation. In terms of how different *Priti* and Kayleigh were, it is worth noting that the contained presence of mind needed to fabricate and sustain this sort of deceit is quite beyond Kayleigh, who wears her heart on her sleeve and is liable to say rather too much truth, all in a rush, rather than to lie. *Priti* could contain her emotions, was bold in manipulating others, could tolerate not being liked or trusted by people in authority, indeed Kayleigh rather envied her easy liberty of 'not caring'. It was during this longer outing, meeting up once more with Josh at a park café some 30 miles from home, that Kayleigh/*Priti's* double life got dramatically found out. Jessica could not reach Kayleigh by text and so called the school in a state of some anxiety, who broke confidentiality to let her know about the 'medical' appointments. A phone call to their GP, and a scan of the most recent facebook contacts on Kayleigh's laptop revealed where she was actually intending to be, but could not confirm the identity of the young man she was meeting. No-one could determine whether 'Josh' was actually 15 or a dangerous predatory adult. An emergency police hunt ensued culminating in the couple being confronted in the middle of their date. Understandably Josh was utterly shocked to find himself not only in such serious trouble but also to have been lied to so thoroughly by the young woman he thought was his girlfriend, and immediately declared he wanted nothing more to do with her. *Priti's* exposure and humiliation was compounded by huge distress at the loss of the precious relationship to which all the effort had been directed and she became physically distraught. Attempts to abscond led to her being forcibly restrained and returned home.

Her mother and stepfather were at once furious with and fearful for her, caught between their frustration that she had determinedly caused so much dramatic upset, and fearful that she was seriously mentally ill. Her mother, in particular, was deeply affected by witnessing the state she was in when brought home by the police that day: *It wasn't her, it wasn't Kayleigh, she was completely someone else. I can't say whether it was Priti or not, I'm not sure what I think about all that, but it definitely wasn't my daughter, I could hardly recognise her!'* On 'coming to' later that evening, Kayleigh herself was

mortified and became somewhat frightened of *Priti* who had previously always been much more of a help than a hindrance. Over the next few days she was continually tearful, remorseful and despairing, begging to be allowed to apologise to Josh face to face, '*to try to explain',* and feeling that she would be better off dead.

Within a week Kayleigh was urgently seen for psychiatric assessment and then referred to myself so that we could make a decision together on whether psychotherapy seemed likely to be of some help.

3.2 Frank's Story

In contrast to the clarity with which Kayleigh was both willing and able to access a reasonably rounded version of her life story, Frank's states of mind rendered this impossible. He did not suffer wholesale amnesia, but rather constellated a narrative around fixed islands of remembered significance and used these to elaborate a subjectively meaningful but objectively inaccurate life history. Re-reading the extensive record it became apparent that some of these 'hidden islands of segregated affect and experience' (Silberg, 2013 p.21) were not relatively recent events, as he remembered them, but had occurred over half his lifetime ago.

3.2.1 Compromised from before the beginning?

Frank's Mother Sally had her own troubled history. She struggled with learning difficulties and had been erratically educated in a special school, revealing that she too was a victim of familial sexual abuse during Frank's first in-patient assessment (Frank aged 6.5). Official records confirm that Frank's biological father was a solvent abuser and alcoholic with a reputation for sadistic domestic violence, and although Sally was only with him for seven months, her description of him as 'a very bad man' leaves the chilling probability that he was violent to her whilst pregnant with Frank. Frank was born a healthy weight at term but spent 10 days on the SCBU for breathing and feeding difficulties; Sally remembers him sleeping really well but 'not taking the bottle', a baby who only slowly grew as he should. Is it possible that a dispositional tendency to dissociation was potential in Frank from the start? Did an infant Frank, assailed in the womb by his father's aggression and his mother's adrenalin responses, and at birth then impinged on by the necessary interferences of medical interventions, turn away from engagement in the here and now, including that with the bottle, to find solace in sleep?

What we do know is that by just one month of age Frank was placed on the CPR, category 'neglect'.

3.2.2 Primary Neglect

In contrast to primary maternal preoccupation (Winnicott, 1956), Frank's maternal environment during his early years can be pieced together as, at best, sporadically affectionate. When Sally did attend health appointments she showed herself able to notice what was unusual about her younger son, for example, that aged 3.7 he showed little response to pain and never appealed to her for help when he fell over etc., but she had no understanding of how this might be connected with their relationship. She complained that he exhausted her with his demands, always hungry and getting her up at dawn with his hyperactivity, whilst Health Visitors and Family Aides sent in to advise and supplement her parenting reported very little spontaneous interaction between them. One memorable report from a local child psychiatrist describes how when Frank showed interest in her stethoscope she let him try it on. Frank then turned in excitement to show his mother, but Sally, rather than playing with him, took it away to explore it by herself! Given her lack of physical care and her regular physical absence from the family home, we may infer that Sally was very poor at the *contingent responsiveness* babies need to develop secure attachment and a well functioning mind (Murray & Trevarthen 1985 referenced by Moore 2012, Tronick, 2004). At home then it seems likely that Frank had neither an attentive nor an attuned parent so that his infant potential to learn how to organise his thoughts and regulate his emotions was profoundly compromised from the start.

Unsurprisingly perhaps Social Services' records of Frank's pre-school years are replete with the evidence of poor physical care – repeated visits by official agencies discover Frank and his older brother Gerry boys barefoot, dirty and hungry, with absent or damp and mouldy bedding, the bathroom walls smeared with faeces, decaying rubbish in open bags surrounded by flies, little edible food in the house. In the several thick files, official reports are interspersed with anonymous referrals from neighbours who report Frank hanging out of an upstairs window aged 3.7 years, asserting also that the boys are habitually left alone in the house whilst their mother goes to work or to bingo, and that they are both continually trying to beg food by knocking on doors every early evening. At age both 4.3 and 4.5 emergency services are called when Gerry (aged nearly 7) sets

fires to try to keep them warm, and at 4.7 Frank is taken to hospital and treated for an 'alcohol overdose' having scavenged half a bottle of cider from the fridge. So far so much unequivocal neglect under the care of a mother whose own interests and needs dominate her decision-making.

However a dual picture emerges. Alongside the neglectful home environment, from just two and a half, Frank was picked up daily for playschool, and this was supplemented with additional full day nursery school from age 3.1. In view of how Frank's mind developed parallel streams of consciousness, we may hypothesise about the organising and dis-organising impact of two such different 'maternal' environments. At home safety and survival sometimes required an avoidant and hypo-aroused approach, privileging independence and compliance as the neighbours reported, and at other times an ambivalent and hyper-aroused approach, featuring the noisy insistent demands his mother complained of. At any good playschool or nursery, thoughtful and caring staff would have engendered quite a different attachment style: Frank would have been attended to physically and experienced a shared interest in the world around him, he would have had repeated opportunity to feel valued and to begin to connect feelings, thoughts and actions. Indeed I do wonder if his enduring love of singing and karaoke had its roots in the traditional shared songs of the nursery, offering the joy and relief of rhythmical communication and predictable cycles of arousal and calming. This remained one of Frank's only truly 'innocent' pleasures.

Reports of Frank's capabilities in the two environments reflect this. On a visit to CAMHS when Frank is aged 4.6, Sally describes him as easily bored, highly distractible, showing little response to pain, whilst an Educational Psychologist assessing him at the nursery describes him as 'active, cheerful, containable'. A comprehensive psychiatric and cognitive profile at this time concludes a mixed picture, of mild delay in some areas but in advance of his age along many axes, summing up 'a beleaguered but bright little fellow'. A further Educational Psychology report some 4 months later concurs that Frank has 'good learning potential' and will *not* need a special school. Given what follows it seems likely that Frank may have already been becoming good at adapting to his caring environment in radical ways included cutting off or attenuating certain capabilities whilst embracing and enhancing others. Dissociation into separate identities may not be such a great leap from here.

3.2.3 Physical and Sexual Abuse

A hammer blow arrived just as Frank turned five, in the form of older half-brother Andrew, aged 17, who came to live with their mother after allegations of abuse in the home of his (Andrew's) father. It seems significant that the record leaves it unclear whether Andrew was the victim or perpetrator of the sexual abuse and whether the move was to remove *him* to a place of safety or to protect others *from him*. This young man shared a bedroom with Frank and brother Gerry (now aged 7.5) and on very first appearances was a hopeful addition to the family. Visiting social workers observed Andrew responding appropriately to the boys' requests for affection, with playfulness and tenderness, and record him challenging Sally's assurances that she was spending quality time with his brothers with the assertion that she was always out working or with her mates at the pub. Where Sally was self-preoccupied and unempathic, it seemed that Andrew was both willing and able to notice their needs and respond sensitively. We can imagine that Frank would have been able to recognise and respond to his brother's overtures because of his positive experiences at nursery and school, and maybe that his arrival heralded some temporary relief from the physical deprivations of neglect.

However only two months later, with Frank aged just 5.3 years, neighbours wrote to social services after Frank engaged a local three year old in sexual play suggesting a 'suck the willy' game. His sexual preoccupations and distress quickly invaded his erstwhile equilibrium at primary school where he urinated in the playground, compulsively undressed, repeatedly asked staff if they want to see his penis, made grinding and rubbing movements, shouted sexual insults across the classroom. Brother Gerry also showed sexualised behaviours for the first time. In addition Frank also became physically oppositional and aggressive, he kicked, bit and punched staff who denied him anything and continually absconded if he did not get his way. Only a year after the Ed Psych report concluding that Frank was no cause for concern academically, a re-assessment for a Statement of Educational Special Needs declared him to have a general developmental delay, a severe delay in attention and listening skills, 'unrestrained behaviour' and inadequate social awareness.

The full reality of what occurred between the adults and children sexually in his home remains somewhere locked inside Frank and his fragmented alters. Although Andrew was eventually subject to an exclusion order following discovery of a non-accidental cigarette burn he had administered to Frank aged 6.4 to 'teach him a lesson', and was subsequently convicted of sexual assaults on two young girls (aged 6 and 8), he did not feature strongly in Frank's preoccupations when I worked with him and Frank only showed a passing interest in *what actually happened* between them. At the time (6.5) Frank disclosed clearly that Andrew had 'drunk his wee' but later (7.1) it emerged that his mother's part was at least as damaging: to his dismayed foster carers Frank simulated oral sex and asserted that he had done this to his mother; the boys also said they had watched sexual videos, that Andrew and Sally slept together, and Frank added that he had seen two women having oral sex with Sally. Frank also reported having had anal sex with Gerry, but Gerry gave no corroboration to this. It is impossible to determine whether the disturbed 16 year old Andrew consciously set out to gain the boys' dependent affection in order to abuse them or whether in his altered world sexual gratifications were the 'natural' expression of intimate parent-child relationships. It is also impossible to deduce whether Sally's sexual boundaries both for her own relationships and for those with her children had always been so lacking/distorted or whether something from her own past was triggered by Andrew's return.

What could be unequivocally observed was that Frank became hugely sexualised, aggressive and distressed. For at least a year (5.3-6.3) Frank was at the mercy of carers who could be variously affectionate, confusingly sexual and sadistically cruel and his fragile strands of secure relating broke down. There is a terribly painful verbatim record of Frank during this time asking a Family Aide about her relationship with her own children 'You wouldn't do anything dirty to them would you? Like touch their willies or fannies?' as if he is trying to still organise a world in his mind in which *some* sane adults treat children properly. Very sadly, as I got to know him, aged 11.9 it was clear that Frank has become convinced that all adults are entirely preoccupied with sexual matters all the time, not only family members but also all teachers, doctors, carers, policemen, his therapist and even, on a bad day, his adored pop stars. From this point on, the boy who can be glimpsed through the record is fragmented, institutionalised, bizarre and unpredictable.

3.2.4 Institutionalisation

Following the discovery of physical abuse and permanent exclusion from school, Frank had an in-patient stay where a thorough multi-disciplinary assessment concluded that Frank had a *functional* learning disability but cautioned that this conclusion was at odds with his observed problem-solving and rich vocabulary. In something of a disclaimer the team highlighted a caveat that as his distractibility was so extreme Frank might well be much more capable than the tests suggested and that in addition his environment was the likely cause of his difficulties. Under their close observation Frank is described as having *moment by moment mood swings* flipping from sitting calmly and quietly on a carer's lap to excitedly climbing all over the kitchen work surfaces shouting pop songs to sneaking off to urinate on another child's mattress. A retrospective reading might identify signs of emerging dissociative defences – the rapid switching in which previous experience/mood seems to have no sway, and an inconsistent cognitive capacity that defies clear assessment.

Tragically despite then being taken into foster care (6.10) and the fuller disclosures he and Gerry voiced in this safer environment (7.1), Frank could not recover quickly enough to limit his compulsive re-enactments. In an enlightened care system, this surely would have been the time to begin therapeutic work. Unfortunately, following open sexualised interest in the two year old daughter of a family friend (7.3), the foster parents refuse to keep Frank and so, already on his sixth social worker, he was moved to the first of four children's homes, leaving Gerry behind with them aged just 7.7 years.

The detailed narrative record becomes much thinner across this period, perhaps illustrating the shameful possibility that close observation and attentive assessment were applied not so much in order to help Frank recover, but as imperatives of the child protection process. Once the apparent risk to Frank from being in his mother's care had been determined and the 'remedy' of his being placed in the care of the local authority had been executed, it seems his wellbeing was no longer a matter of priority. What is clear are the stark facts of further moves, a lack of meaningful education and fragments from professionals describing an increasingly disturbed and debilitated young man. Two care plan reviews in his first year in residential care judged Frank's increasing bouts of infantile and disabled behaviour and frequent periods of several hours spent in apparent cross-gendered parody - dramatisations of which he later seemed to know

nothing - to be products of ‘institutionalisation’ and concluded in writing that he needed to move on as matter of some urgency. In view of the dissociative perosnalities that I met later, it seems likely that his infantilised behaviour pre-figured *Little Frankie* and his disabled behaviour *Vanessa*. Despite the explicit conclusion that it was the wrong place for him, Frank spent over three years at that first children’s’ home, whilst repeated unsuccessful attempts were made to find long term foster carers, all the while being driven two hours each way to a special school for children with severe learning difficulties, the only facility that would agree to ‘house’ him for the school day.

During this extended period Frank received no formal mental health input, and there seems to have been no consideration that his confused troublesome presentation might be consequent on the abuse he had suffered and that he might benefit from some therapeutic work to help him process and recover from it. Rather to the contrary, there is speculation recorded about whether Frank might actually have ‘a genetic abnormality’ (9.1) and assessment by an educational psychologist that ascribes Frank the IQ of a four and a half year old (9.3). Frank is here judged not as the victim of appalling crimes that necessitated creative but confusing mental strategies, but as someone *damaged from before the start* for whom recovery should not be expected and for whom the duty of care will be safe management rather than therapy.

After three years (10.8) Frank’s behaviour and bizarre presentation had deteriorated sufficiently for those in loco parentis to decide that foster care would no longer be a viable option and he was finally moved to a much feted residential Steiner School. Here staff managed for just one month before excluding Frank permanently and delivering him overnight to an emergency children's home (10.9). Frank must have now found himself confronting the almost immediate failure of the long awaited move, and the stress of having to survive in another new place, with new carers, new and much younger peers, new ways of doing things, as well as the deprivation of being out of education and out of the potentially normative influence of socialising with children his own age.

It emerges that at this point Frank appears to have stopped trying to fit in and became almost professionally ‘difficult’. Perhaps he just stopped trying *not* to be dissociative. His keyworker wrote: ‘Frank provokes situations with both staff and the other children

that result in us having to restrain him almost daily – sometimes for as much as three hours at a time. Some of Frank's behaviour appears to be the stubborn behaviour of a child that is not getting his own way, other times his negative behaviour does not appear to have any reason to it and he will suddenly 'snap out of it' and return to his affectionate babyish self or try to engage me in chatting about Kylie or Beyoncé. Often he will claim it is not him but one of the other children who has damaged things and he seems not to understand the principles of cause and effect (11.0)' Within this small description we have suggestions of switching, confusion, amnesia, and oppositional behaviour without discernible cause, all commensurate with an established dissociative condition. It is also recorded that Frank was considered physically inappropriate (though not observably sexual) with the younger children, so that he could not be left unsupervised because of his attempts to engage them in bizarre or rough 'play'. Is it possible that the fury, anxiety and disappointment of yet another move, without the means to communicate about it or any stable figure to communicate to, triggered further dissociative creations in Frank? If the infantilised/learning disabled Frank was a strategy for keeping potentially neglectful or self-obsessed carers' close and attentive, then was a bizarre/perverse Frank a parallel strategy for keeping potentially abusive or sexually predatory carers at bay?

Dissociation is explicitly mentioned for the first time by Frank's sixth Social Worker whose view is recorded in a contribution to a psychological assessment shortly after he had moved to the residential school, his fourth institution, where I was about to start working with him (11.6): 'Frank uses dissociation as a way of coping, i.e. he separates his feelings from his behaviour, and fantasises about his past and close relationships he had with family members, which in fact he never had.' This rather old fashioned childrens home was the remnant of a much larger philanthropic endeavour from the Victorian era; it benefitted from a strong ethos and a stable staff team, and included a small on-site school with specific expertise in helping children with learning difficulties. In line with such origins the dominant approach was no-nonsense behavioural, with only a nod to a psychodynamic approach in the person of myself, a psychoanalytic child psychotherapist. I came to learn that part of my function was to be a repository for all the disturbing thoughts and feelings that the staff felt unable to engage with, and so tacitly agreed to dissociate into the therapy space with myself as an

institutional ‘toilet therapist’ expected to receive all the toxic excreta and flush them away.

3.3 Robbie's Story

I worked with Robbie for just 18 months at a primary pupil referral unit that held children who were unable to manage at a mainstream school, beginning when he was 9 years and 8 months old. There were no social services or health records available so that my knowledge of his early history is necessarily brief. Robbie lived with his mother and his stepfather and two younger sisters – the biological children of these two. A fourth baby was due just as I began working with him. The only back story available to the staff was that Robbie’s mother had been outraged at a CAMHS’s diagnosis of a severe attachment disorder for her son and so, despite her own a lack of education and rather humble social circumstances, had successfully lobbied for a second and then a third opinion and had finally secured for him a diagnosis of both ADHD and ASC from a private consultant in a neighbouring county. Symptoms of either condition were not discernible by the clinicians and teachers left to work with Robbie, who found him irritating and unfathomable rather than distracted or antisocial, but his mother’s view of herself as a beleaguered parent caring for a ‘very special little boy’ in straightened circumstances was confirmed. All three children were considered ‘in need’ but not ‘at risk’ and the family were regularly in receipt of additional support from social services to improve their parenting and make good the physical home environment. The level of input was increased still further when Robbie’s younger sister was assessed as having a global developmental delay. Robbie was put forward for psychotherapy at school because of the obvious disturbance in his relationships with peers, and an apparent disconnect between rapidly shifting ways of being from a blithe little cherub to an infuriated bully to a whining victim which dumbfounded his teachers.

3.4 The Participants and Diagnosis

The first criterion for the diagnosis of DID, taken from the fifth edition of the DSM, describes:

> The disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption of marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.

Kayleigh's presentation clearly met this criterion as did Frank's. Whilst Kayleigh (aged 15) could talk coherently about the differences between herself and *Priti*, articulating a meta-perspective on her selves – *'She's real but she doesn't have her own body'*, she came always as Kayleigh to her sessions. Nevertheless I got to know *Priti* well as a clearly 'distinct personality state': *Priti* was older than Kayleigh and spoke with an American accent, she was consistently feisty and courageous, reliably able to argue, lie or fight when they (Kayleigh and *Priti*) were threatened, pretty (as her name phonetically suggests) and, importantly, 'confident with boys'. In addition the second criterion, of amnesia between states described as: 'recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting' (ibid.) was also part of Kayleigh's experience and something which troubled her greatly.

Frank's presentation (aged 11.9 at the start of treatment), indeed his whole experienced life, was much more chopped up, an apparently chaotic stream of jumbled nonsense until one had the opportunity over time to tune in and identify the various personalities in evidence. Mostly his carers and teachers just found Frank irritating and, assuming his switching to be under conscious control, judged his behaviour to be deliberate malingering or attention-seeking. However in Frank's presentation there were too a distinct and reliable set of personified dissociative states, perceivably consistent in their characteristics and their inter-relationships, with preoccupations and attitudes which could be comprehensively observed and described.

Frank's 'given-name' identity or ANP (Nijenhuis and Van der Hart, 2011 after Myers, 1940 see section 2.1 above), was a camp young man, an avid follower of television soap operas, and a lover of karaoke, who could often be heard singing tuneless but hearty renditions of love ballads as he made his way around the school. This was also his most cognitively able and straightforward state, and the one which all those around would have liked to gather him into permanently. This 'Frank' would break off from inarticulate rambling as the mentally and physically disabled *Vanessa* to ask me directly what 'dramatic' really meant or to tell me quite convincingly why a certain person should win 'X Factor'. Just a moment after my reply, though, particularly if I tried to make any sort of meaningful connection rather than simply dispensing information,

Vanessa could be back with her distorted speech and uncontrolled spastic limbs, or the *Mean Old Granny* alter could offer me a poisonous 'cup of tea' in her sickly sweet voice, turning away to mutter a barely audible tourettes-like insult. In an instant the years could dissolve and I would be uncomfortably in the presence of a *Little Frankie* whose only real drive was to suck and chomp, activities infused with a perverse sexuality, then to be relieved when *Little Frankie* gave way to *Ben+Ben*, a more hopeful identity of an eight year old called 'Ben' with ordinary needs and a loving relationship with his pet dog who always accompanied him, also called 'Ben'.

These five – Frank, *Vanessa*, *Mean Old Granny*, *Ben+Ben* and *Little Frankie*, were the mainstays and whilst there were fluctuations in their ascendancy and some less visible 'others' fluttered about, they certainly meet the criterion of 'distinct identities'. Frank himself was only mildly interested in my interest in the various characteristics of these five, cooperating with just a modicum of energy when I tried to gather the 'vital statistics' of each, but he did, at least as Frank, recognise their independent existences and particularities. The rapid mixture of deliberate evasion, traumatic dissociation and secondary handicap (Sinason, 2010) made it impossible to determine precisely when and how amnesia may have been at play, but he too certainly demonstrated 'recurrent gaps' which impaired his learning and relating.

So then, whilst Kayleigh and Frank's presentations observably met both the first and second criterion, Robbie's was less clear. Robbie did not have fully personified dissociative states, did not speak of himself as if someone else or in the third person and did not report imaginary friends or internal voices, so in what sense could he be judged to be dissociative? In addition he reported no confusion or sense of having 'lost time', although all those in his orbit experienced this at one remove. Robbie's case is perhaps closer to one of the example presentations of ODSS which describes:

> Chronic and recurrent syndromes of mixed dissociative symptoms. This category includes identity disturbance association with less than marked discontinuities in sense of self and agency, or alterations of identity or episodes of possession in an individual who reports no dissociative amnesia.
>
> APA, 2013

Robbie observably had more than one *modus operandi* or way of being, which I and his teachers could reliably and consistently identify and which had 'enduring patterns of perceiving, relating to and thinking about the environment and self' (APA, 2000). Robbie habitually approached his psychotherapy in '*Mr. Angry of Tunbridge Wells'*

mode, like an incensed middle-aged Daily Mail reader, firing off a volley of self-righteous invective at my obvious inadequacies and subsequently conjuring up various 'wrongs' for which he could continue to contemptuously lambast me once we entered the therapy room together. By contrast *Mr. Angry's* equally disgruntled but less overtly irate counterpart was a floppy, moaning Robbie, who could whine for England, and felt himself to be the victim of a deliberate depriving world, condemned to be miserable and left out forever, an evasive helpless and hopeless creature that his teachers found profoundly irritating. In addition Robbie spent at least as much time in *'fay fairy'* mode, tripping about the place in a committed parody of an angelic little boy full of faux innocence; somewhat confusingly given his other modes, he absolutely looked this part - piercing blue eyes, tumbling blond curls, pretty features. This last was also his most intelligent incarnation, the mode in which all his academic learning got done and also the one which most infuriated his peers. However although none of these modes of being were Robbie by themselves, and no one was dispensable, they were not quite the 'distinct identities' of the criterion. Robbie had little time or patience to reflect on himself or to consider how connected or disconnected these modes might be, but they would be more accurately described as 'distinct mood states' than 'distinct identities' and could be referred to as '*angry Robbie' 'moany Robbie'* and *'angel Robbie'* rather than by separate names.

3. 5 Summary - Dissociation three ways

.Kayleigh, Frank and Robbie show something of the breadth of the expression of dissociative features in children and young people, prompted by the different life circumstances that had shaped their neurology, personality and behaviour. Kayleigh's journey towards pathological dissociation resulted from particular traumatic events at the hands of those she trusted, against a backdrop of attachment insecurities, and issued in the creation of a distinct dissociative personality, with relatively clear lines of dissociation and amnestic experience. With Kayleigh, compromised attachment *plus* trauma equal a dissociative disorder. However, whilst Kayleigh would be accurately described as 'a young woman who dissociates', Frank might be truly described as 'a dissociative child' on account of the persistent, pervasive and impairing dominance of rapid continual switching between different states which appeared to have become his general way of being. His early life, so sadly lacking in attuned love and thoughtfulness, and overlaid with neglect and abuse, is consistent with the development of a mind that

struggles to integrate incompatible relational experiences and within which dissociation is the primary default strategy. For Frank, chronic relational trauma appears to have produced a thoroughly dissociative internal landscape. Robbie shows something different again, shifting states which are identifiable and impairing but somewhat less sharply delineated. Could this be a window on a more serious dissociative disorder 'under construction', with the possibility that improved care and effective therapy could help him towards a more integrated self?

In the next chapter I describe the approach taken to the gathering and analysing of how these dissociative features presented and played out in each child's psychotherapy with me.

Chapter 4: METHODOLOGY

In designing and executing a research investigation there are a series of decisions that must be made regarding what data to attempt to collect and how to analyse this in the most revealing way. In this chapter each of these necessary research choices is presented in chronological order, along with an evaluative discussion regarding the 'best-fit' approach to each finally decided upon.

4.1 Selecting the Participants

Traditional psychoanalytic research is directed in large part by those who present for treatment and the challenges they pose their therapists trying to help them. A developing interest and/or expertise on the part of the researching clinician might be taken as reason to refer or to accept for treatment more cases of a similar type or challenge, but by and large the participants are not actively recruited. I initially proposed exploring how Frank and Robbie presented because of the striking similarity of the effect their infantile states of being had on those trying to care for, teach or treat them, including myself in this group. When I got deeper into the work with Frank and began to comprehend the history and stability of his dissociative identities, my interest broadened in wanting to investigate such a debilitating response to severe early trauma. So when Kayleigh was referred by the psychiatrist who had diagnosed her and knew of my interest, she made a natural addition to the project. However whilst Kayleigh was aware of suffering emotional difficulties and had come for help to a service dedicated to children's mental health, both Robbie and Frank had sessions as part of their school programme along with approximately 50% of their class mates in small special school settings where I was the only therapist. In these terms the participants were 'selected' primarily on the basis of their pathology and my interest, with a nod to the circumstances that caused our paths to cross. A research project where the participants are connected to the researching clinician primarily because of their need for treatment and only secondarily, sometimes even only as a result of what transpires in the consulting room, considered for research, may pose particular ethical issues in terms of seeking truly voluntary informed consent and it is to this we turn next.

4.2 Ethics and Informed Consent

Central to this project was the proposal that detailed material from participants' individual psychotherapy would be systematically analysed; this reality posed particular challenges when considering how best to seek informed consent. Some of these challenges were those common to all studies whose participants are in a psychotherapeutic relationship with the investigator, and where process recordings of sensitive intimate material from individual psychotherapy sessions may be easily identifiable by the client even if entirely disguised from the possibility of public identification. The potential in this electronic age for ex-patients to google their former therapist's name and discover what she or he may have concluded about or learned from their work together adds a further complication, though possibly one that may galvanise us towards an improved ethical approach necessitating greater caution in what details

we share and in how freely we speculate. However, in addition there are also some further challenges particular to work with child dissociative patients. For consent to be valid in the terms of the General Medical Council, it must be truly voluntary, fully informed and the participant must have the capacity to understand both the nature of the research and what is being asked of them (General Medical Council, 2010), and this must be our starting point.

4.2.1 Seeking consents from children in psychotherapy: how do we find a route that is both ethical and therapeutic?

It is lamentably the case that whilst the standards set in relation to acceptable consent to participate in research are drawn from principles enshrined over half a century ago in the Nuremberg Code (Nuremberg Code, 1949) and the Helsinki Declaration (World Medical Association, 1964), the out-working of these in the field of psychoanalytic research has been somewhat tardy. Indeed it is somewhat counter-intuitive that the psychoanalytic community, championing as it does the view that very little can be truly hidden, and that unconscious interests communicate themselves most powerfully even when unexpressed verbally, for so long approached writing up cases for research and publication as though 'what they don't know won't hurt them' and assuming that anonymising material was sufficient execution of a patient's rights over the use made of any learning derived from their personal treatment. Whilst the early psychoanalysts, including those practising with children, understood well that the treatment space offered in therapeutic sessions 'brooks no listener' (Freud, 1916 p.17) and that any audience would be 'absolutely against the fundamental principles on which psycho-analysis rests' (Klein, 1961 p.11), what happened to accounts of this intimate tender work *after* the treatment has not necessarily been subject to the same respect or ethical rigour.

It is comparatively easy to provide full and frank information in a form and manner appropriate to each participant's maturity and cognitive abilities (see the Participant Information Sheets Appendix 4.2a and 4.2b). However it is much more difficult to marry this with simultaneously maintaining an unaltered treatment situation for the participants and the research 'laboratory' of the consulting room as an uncontaminated field of operation, where the raw data of session material can still be generated for treatment and collected for research free of any distorting influence.

One of the cornerstones of the psychoanalytic technique is that the patient attends sessions in as reliable and unfettered a setting as possible. Traditionally a psychoanalytic psychotherapist takes care to construct a setting in which he or she provides very few identifying factors about themselves which might limit the patient's liberty to truly 'free associate' (Freud, 1913 p.135), that is to bring their own fears and phantasies to the session from within as these arise, rather than in response to 'sign posts' from without. The approach is accurately described as unstructured in that the psychotherapist will endeavour to arrive at the session with no agenda other than to receive, digest and ultimately find words for the patient's present preoccupations in the service of an overall journey of exploration into the landscape of the hitherto unconscious. For my own part aspiring to Keats' 'negative capability' (Keats, 1817 p.277) and in mindful approximation to Bion's injunction of 'eschewing memory and desire' (Bion, 1967 p.272), I would endeavour to approach each session as a human 'satellite dish', focused on open minded and open hearted receiving, containing and, with a fair wind, some helpful observation, commentary or interpretation.

However there is an unavoidable conflict here with the necessary imperative that a participant in research be given some accurate information about the nature of the research to which their consent or assent is being sought. Whilst the direction of therapeutic travel for the patient needs to be untrammelled, allowed to emerge from the unconscious, changing within and between sessions, the direction of travel of the research interest is definitive and declared. In this particular project, where the psychotherapist and the researching investigator are one and the same person, there cannot fail to be an extra and significant piece of 'fettering' information given to the patient by the seeking of informed consent, namely that 'my psychotherapist is especially interested in my dissociative features / identities'.

In my own view, despite our best intentions, we psychotherapists can only ever approximate to the level playing field of a psychoanalytic setting in which *only* the patient's material enters the fray. In reality we are managing interruptions or intrusions all the time which 'queer the pitch' whether this be our patient arriving early at the clinic to see us returning from lunch with a colleague, or the discovery of another patient's ball left under a chair, or some other unanticipated event. In general we

approach these distortions to our therapeutic work together as all 'grist to the mill' incorporating them into the ongoing dialogue between us rather than trying to ignore, deny or expunge them[7].

In this project the decision was made to take the same approach with the necessary 'external fact' of the nature of the research for which the participants' consent was to be sought, betraying as it might do their therapist's particular interest in dissociative phenomena. Here the interruption was acknowledged as 'unideal' but thoughtfully planned for rather than unexpected, and I steeled myself to endeavour to remain open to whatever the news brought up for my young patients. This would mean keeping a 'weather eye' throughout their treatment on signs that they were responding to their perceptions of my interest rather than to their own pre-occupying agenda, and being careful to connect this not just to their own fears and phantasies but also to the reality of the fact of the research. This felt especially important since the participants of this study were selected because they had dissociative features / identities and the histories of such patients so often include *real* abusive and controlling parental figures to whose *real* egocentric and sadistic agendas their children had to continually capitulate and submit. I knew I would have to remain alert to the possibility that once the news was out that I was especially interested in dissociative phenomena, my patients might experience impulses to give me more of what they thought I wanted in order to keep me sweet, or maybe do the opposite of rebelling and keeping parts of themselves more hidden from view in order to protect themselves from my partisan interest, or to get their own back on me as a self-interested scientist posing as a caring therapist, or some other unforeseen response.

4.2.2 Seeking consent from participants with dissociative conditions: approaching a disparate group

[7] For example, for the child that discovers another child's ball in the room, it is no longer a matter of phantasy that someone else has been in the room with a toy which is not theirs. It is no good pretending that this is not the case, glossing over it or wholesale refusing to talk about it, including being open to a rightful accusation that we have not taken sufficient care to stick to our own rules about the best conditions for the psychotherapy we are offering. Instead we acknowledge that something unexpected and unplanned for has happened - *you've found something that really shouldn't be here in your session*, we take responsibility where we need to – *I haven't done my job properly in getting the room ready for you today*, and we remain curious about what thoughts and feelings our young patients may have about the event, balancing what has occurred in the external 'real' world between us with what may be occurring in their internal world.

In addition the notion of capacity is further vexed when, by definition, the participant population for the study is one whose mental health is profoundly compromised by discontinuities in the sense of self and consequent confusions and amnesias. A strict application of the notion that anyone participating in research must be 'of sound mind' might lead to discrimination of a different kind and a patently absurd situation in which no research could ever be done that directly involved this needy group, or could only involve participants of such compromised capacity that consent must always be sought from responsible others instead. By virtue of the severe mental health problem under investigation, potential participants are likely to have compromised capacity so the Helsinki Declaration direction that if possible 'the research (should) instead be performed with persons capable of providing informed consent' (WMA, 1964) may well not be achievable.

The situation of a participant with DID or OSDD is particular in this regard and poses a conundrum for both the potential participant and the researching therapist. A young person with several dissociative identities may be variously able, unable and disinterested in giving consent. A central organising personality may be able to see the benefit of research to help other children and clearly assent to their sessions being recorded or analysed, whilst a frightened child state may feel confused and deeply paranoid about the idea and so refuse - whose word should the researching therapist choose to listen to?

Frank's dissociative presentation was especially problematic; how to establish a truly valid consent from a young person living in so many parts would indeed be challenging. At the time of the treatment sessions to be used in the research, Frank was nearly 12 years old, a young man whose dissociative identities emerged and shifted in rapid succession and for whom the therapy sessions gave relief and 'licence' for each to show themselves. Frank's residential school were floored by his confusing presentation; his glaring difference from all the other boys in their care, and the irritation they felt at a demanding lisping infantile personality he readily inhabited despite their best behavioural attempts to insist that he 'act his age' and to reinforce this with a robust system of rewards and sanctions for age appropriate behaviour. In this residential environment and against a back drop of years of sexual and emotional compliance with a personality disordered mother, most of his dissociative parts might well have agreed

to anything. I could have predicted that Frank as his age congruent self might take the participant information and request for consent as something of compliment, becoming self-importantly flamboyant or grandiose, whilst *Ben+Ben* would consent as a compliant 'pet', *Vanessa* as a 'good girl' hiding behind a disabled mind, and *Little Frankie* might nod assent as he continued to suck salaciously from whatever nipple/penis substitute he could find. All these responses could reasonably be described as consenting. However I could not have relied on *The Mean Old Granny* to concur; she was perversely intent on disrupting every positive endeavour and there are many forms her response might have taken. She might refuse wholesale whilst sweetly patronising me 'No thanks, dearie, not today!' or apparently go along with the idea only to pull the rug and retract her consent *after* the research sessions had occurred; the only certainty I feel sure of is that she would not have been straightforward. I would have been left with a dilemma, whether to go with Frank's 'host' or ANP incarnation, or whether to be democratic and 'add up the votes' from all the personalities thereby probably overruling the *Mean Old Granny*. Neither feels satisfactory, not least because the dissociative identities are not all 'equal players' in the group drama, and may wax and wane in influence across a treatment period.

What does seem clear is that practitioners working with dissociative clients and those conducting research in this area will surely have to continue to try and manage these very particular quandaries going forward. My own suggestion would be a 'belt and braces' approach: that consent at the start and close of the research period is sought from as many identities as will engage and where possible after some age-appropriate psychoeducation about the nature of dissociative conditions, that particular attention is paid at both points in time to the responses of the ANP or host personality where this is in evidence, and that in addition, carers, next of kin and involved professionals are consulted as to their assessment of whether *on balance* the consent can be judged as sufficient.

4.2.3 Seeking consent from Kayleigh, Frank and Robbie

Kayleigh

Kayleigh was aged fifteen when we started work together, so she was technically a child below the age of 16 at which it is automatically legal for a young person to make medical decisions independent of a parent. Yet she more than demonstrated the

capacity to comprehend the nature of research and what implications this might have for her, and, in consultation with colleagues, we judged her 'Gillick competent' (Gillick v. West Norfolk 1985). I had some initial disquiet about whether her delight in my consistent therapeutic attention might render Kayleigh unduly compliant, willing to consent just to keep me sweet, intuitively mindful that 'When seeking informed consent for participation in a research study the physician must be particularly cautious if the potential subject is in a dependent relationship with the physician or may consent under duress' (WMA 1964)

However in the event Kayleigh's serious and careful questions of me during the session in which we read through the information sheet together reassured me: Kayleigh took time to satisfy herself that she knew what the deal was with how her anonymity would be guaranteed, what might be published, how her care would go forward at CAMHS, and so on, and signed her consent with a working knowledge of what all this meant for her, readily investing in being part of something that might help therapists learn more about DID. *Priti* was also an intelligent and capable young woman, so gaining this additional assent was certainly more straightforward than it might have been with Frank. Kayleigh let me know at once that the sharper, less compliant, *Priti* had immediately piped up rather fiercely wanting me to understand the importance of anonymity: 'I'll only agree as long as no one knows our real names, I'm not having her (Kayleigh) bullied again!' (Kayleigh, Session 15). Importantly, Kayleigh's mother also gave her signed consent. My distinct impression was that the process had a positive effect on Kayleigh's commitment to the therapy and to her sense of self-esteem as being able to contribute to helping others in difficult circumstances.

Frank

As I began to get to know Frank well, and considered the likely effects of my seeking his informed consent, I began to feel very reticent about bringing the additional confusion of a research agenda into his unfathomably chaotic sessions and was able, with the help of an incisive supervisor, to understand that my misgiving rested primarily on not wishing to inflame his sense that all adults had (perverse) ulterior motives for their interest in him. One of Frank's underlying assumptions about me was that I saw him in psychotherapy for my own excitement and satisfaction, and that any suggestion I might be interested in helping him was just a poor pretence. It was hard enough to

swim against the tide of this internal assumption of his and to make room for some alternative, for instance that there might be some benign unselfish care and attention available to him, without inadvertently adding fuel to the fire. We agreed with his social worker that it was, on balance, in Frank's best interests *not* to inform him or seek his assent since this would be more helpful clinically and given that his sessions would in any case be unaffected by the research.[8] This would have been much harder to justify had Frank been of age or judged to have capacity, since I could not have simply deferred to a legal guardian to make the decision, but would have had to consult with psychiatric colleagues or take the risk of compromising the therapy. If he were an adult with capacity the ethical decision might well have been not to include him in the research and to privilege his psychotherapy.

Robbie

Even though, because of his age, I would necessarily seek parental consent, I composed the information sheet for children (Appendix 4.2a) very much with Robbie in mind and attempted on two occasions to let him know I hoped to use our work to learn something and to engage him in thinking about what that could mean. This information for children does not refer to a specific interest in dissociation, and generalises from his therapist's focus to a more general plural pronoun: it states simply that 'we' are wanting permission to learn from our work with him in order to help other children. Both Robbie's response and his assent were unsophisticated and characteristically self-centred, pausing a stumbling onslaught to merely glance at the information sheet and then enquire gleefully as to whether this meant that I would still 'Come and be his target?' and on a later attempt dismissing my re-introduction of the subject with 'That's adult business, fine do it - can I take the spiderman home now?' (a request which he knew by then I routinely denied). In truth Robbie could not have been said to be 'well-informed' about the research project and his participation in it, not even in 9-year-old terms, because, at least in our sessions, he could rarely be interested in anything outside of his own immediate orbit. Had he been older, his robust indifference might have been more of an obstacle. However because of his age, the ethical onus still rested with his

[8] There was of course the possibility that if Frank did become a participant I might pay closer scrutiny to our work, might write more detailed clinical notes about it and would receive additional clinical supervision, but it was assumed that these effects would be likely to be positive rather than detrimental to his progress overall. There is of course also the possibility that 'the unconscious is very perspicacious' (Klein 1961 p.17) and somewhere inside Frank and his alters picked up on my especial interest notwithstanding our decision to keep his psychotherapy consciously free of it.

parents, who took the request in their stride as the carers for a son with 'extreme special needs' as they saw it, and following consultation with me gave their consent without demur, asserting that Robbie's involvement would be just as unlikely to affect him either way as they assumed my treatment would.

The information sheets can be found in Appendices 4.2a (Children) and 4.2b (Teenagers) together with 4.2c, the Consent Forms for participants and 4.2d, the Consent Form for those with parental responsibility for participants. Appendix 4.2e is a copy of the ethical clearance letter.

4.3 The Single Case Study Methodology

There is a rich tradition within psychoanalysis of presenting detailed histories and material from the therapy of children to derive and illustrate evolving theory. Single case studies are the volumes which fill the shelves of the library of experience that informs and references our understanding of how to treat disturbed young minds. Freud uses the treatment of 'Little Hans' by his father to evidence his discovery of the existence of infantile sexuality (Freud, 1909a), and Klein offers her 'Narrative of a Child Analysis' not only to illuminate her conceptualisation of object relations but also to illustrate the 'conduct of the psychoanalysis of children' (Klein, 1961). From Winnicott's 'The Piggle' we learn that psychoanalysis can be effective 'on demand' and about the power of examined play (Winnicott, 1971) and from McDougall's 'Dialogue with Sammy' we witness the potential of child analysis to ameliorate psychosis (McDougall, 1969). The subsequent historical archive of narrative single case studies is undeniably valuable in generating psychoanalytic theory (Rustin, 2007, 2009).

Yet in an era where the Randomised Controlled Trial (RCT) is the aspired standard, what Midgely aptly terms a research 'context of justification' (Midgley, 2006 p.133), this kind of learning may be dismissed because the methodology is judged to be both weak (lacking in rigour) and irrelevant (lacking in generalizability). The criticism of inadequate rigour is largely one of the subjective selective gathering of data via the therapist's note-taking and subsequent unsystematised analysis which is debated in the discussions below on process-recording as a method of data collection (4.4) and on the use of thematic analysis as the methodology (4.6). The key remaining argument against the use of single case studies is that the results have limited generalizability; findings

are unlikely to have statistical inference that can be applied across the board. This perspective has it that 'discovering' a phenomenon or a correlation between variables within one child's treatment tells us nothing about whether the same feature or link will be found in the psychotherapy of other young people, and that this considerably diminishes the value of the research. Of course it is possible to make the argument in exactly the reverse direction: even an RCT 'gold standard' finding will not tell us whether treatment will help the particular complex human beings we meet in our consulting rooms. Just because, say, a putative RCT evidences that 67% of young people report improved peer relationships and self -esteem after ten sessions of child psychotherapy, does not tell me whether this will be effective or sufficient treatment to offer the isolated unhappy 17 year old young woman I may be meeting for assessment later this morning. In the consulting room even the most robust finding is at best a pointer.

In assessing whether the findings of a particular investigation have generalizability the significant factor must surely be what is the question being asked of them? The endeavour of this study, one of the first in the field of child psychotherapy for dissociative children, is to answer twin questions of 'what might be out there' and 'how we might need to respond'. Suppose, for a moment, that instead of psychoanalytic work with dissociative children, the study involved an 'advance party' visit to an unexplored planet but with the same twin questions 'what might be out there' and 'how we might need to respond'. The visit only involves one small patch of territory and one small party of explorers across a limited time window. During the visit the group come across several mountains which have patches of sheet ice and have to adapt their walking boots with the addition of crampon spikes to make progress. When they return do they have any useful information to offer from their investigation to those coming after? The answer of course is a resounding 'Yes!', they have made two potentially life-saving findings: firstly that 'there are some mountains out there' and secondly that 'crampons were helpful'. This is valuable, relevant advice, generalizable in its 'context of discovery' (ibid. p.133), *all* pioneers would be wise to take note. If we extend the metaphor, then in years to come when the entire planet has been mapped for mountains and the infrastructure for additional methods of traversing it has been established, the advice may indeed be superseded by a finer tuned analysis, but as a beginning it is entirely pertinent.

In fact this project offers not just a one-off visit to the land of child dissociation, but three visits to three different 'patient-locations', conferring a little greater validity on any convergent findings. If the findings can alert therapists working with other dissociative children about what they may encounter and what preparations it may be wise to make, then this will be generalizable advice and possibly a prompt for further more specific enquiries.

4.4 Process Recording as a method for gathering 'Raw' Data

A process-recording is a detailed written account of the psychotherapy session, a narrative of 'enhanced' clinical notes in which the subjective experience and thoughts of the therapist are included. The potential flaws of such a method of gathering material for research are precisely those concomitant with the human condition – subjectivity and the selective nature of memory, with the danger that 'Process notes seem to present primary data but rarely do…Observation is conflated with inference' (Klumpner & Galatzer-Levy 1991 p. 727 cited by Midgley, 2006 p. 128).

The relative merits and disadvantages of using audio- or video-recording in psychoanalytic work are discussed more fully elsewhere (Midgley, 2006 pp.128-130; O'Shaughnessy, 1994 p.943). It is acknowledged that whilst such recording might capture certain 'true' aspects of a psychotherapy session, for instance who said or did what and in what sequence, other keys aspects would be missed, for instance the transference and counter-transference experiences. Furthermore, for the psychoanalytic research project, the 'clinical facts' we wish to explore cannot be divorced from the person of the therapist – 'it is evident that as analyst I both observe and, through fallibility or understanding, contribute to making the clinical facts what they are' (O'Shaughnessy, 1994 p.946), so that machine recording might actually diminish rather than enhance the quality of the data gathered. Nevertheless electronic recording methods are now increasingly used, sometimes alongside therapist process recording, as one method of data-gathering in the ongoing large scale study of child psychotherapy sessions with 540 depressed young people participating in the IMPACT[9] Study and as a supervision aid throughout the roll out of IAPT[10] trainings. However electronic

[9] Improving Mood through Psychoanalytic and Cognitive Behavioural Therapy
[10] Improving Access to Psychological Therapies

recording was not a viable option for my work with Kayleigh, Frank and Robbie. Even if the logistical problems of setting up finely-tuned equipment at three different venues could have been solved, the likely effect of a 'third eye' on both the children and myself could not fail to be distorting for children who had been unduly intruded on and who had become hypervigilant. The dangers are similar to those discussed above in relation to Frank regarding how knowing about a therapist's interest may unhelpfully direct the course of free association away from being truly 'free' (4.2 above); the physical presence of recording equipment is arguably more overtly present and additionally would have to persist for every session across the research period.

In order to diminish the inaccuracies inherent in process recording as a method of data collection, I adopted the following 'rules' to promote consistency and clarity:

- **The written record was to be made within three hours of the session occurring, where possible immediately after the session.** In actuality this was achieved in every instance except one where a domestic emergency necessitated making the recording the following morning.
- **The general brief was to record all events, verbal, gestural, expressions, actions, exterior 'noises off' and so on as observed and recalled by the therapist in chronological order.** This was achieved in all the recordings that form the analysed corpus of data, by excluding two sessions that were inadequately recorded. As an experienced child psychotherapist the exercise of process recording is familiar and well-practised; it is the method begun with pre-clinical infant observation, and which continues throughout clinical training and post-qualifying supervision. It is important to note that I am not claiming I achieved an objective *factual* record here, but I am claiming I gathered a full subjective record of session events *as observed and recalled by myself as the therapist.*
- **The additional brief was to record, in indicated form, all thoughts, feelings and internal interpretations experienced by the therapist.** To keep a clear distinction, all subjective material was delineated by an abbreviation (e.g. 'CT:' for a Counter-transference experience or 'H/S' for a hind-sight thought occurring within the session but after the event that prompted it.) or by a narrative phrase (e.g. 'I wondered to myself' or 'I felt unexpectedly confused and sickened') indicating the status of the phenomenon described.

Gathering data for research analysis in this way has perhaps one further element which could be considered either an unhelpful distortion or the useful beginning of 'intuitive induction' (Dreher 2000, p.25 cited by Midgely 2006, p.138). If the researcher and the recording clinician are one and the same, as in this project, then it is unavoidable that no matter how much attention she may be paying to ensuring a clear and complete narrative, the enquiring *thematising* part of her mind can hardly be 'switched off' or entirely put to one side. Just as the making of process notes for clinical supervision necessarily involves a self-supervision, so that material is being recorded to be brought for discussion but also inevitably re-appraised, reconsidered, reformulated by the therapist in her own mind before that discussion occurs, so the researcher, making notes to compile a corpus of data, cannot help but begin to notice frequently occurring phenomena or patterns between events. A formal analysis will occur at a later stage, under the direction of an established systemic and explicit methodology, but an informal analysis, under the direction of a clinically experienced and curious mind, has already begun.

4.5 Selecting a Sample

Psychotherapy is a relatively long-term treatment and process recording produces a detailed and lengthy tranche of data such that analysis of the entire corpus would be prohibitive for a lone researching therapist. A decision must therefore be made about which sessions to select for analysis to make the task manageable whilst sacrificing as little useful data as possible.

From a collection of some 30-90+ recorded sessions for each participant, a run of 10-12 consecutive meetings was selected, starting within the first six months of the therapeutic work and including as additional to this core body of data extra relevant notes, for instance where a session had been curtailed or cancelled through illness or a therapeutic phone call had been made within the sample period. Clearly this is a *purposive* rather than *random* sampling strategy and has two key components: firstly portions of data were selected from *early on* in the participants' therapy, and secondly a decision was made to select a tranche of *consecutive* sessions rather than an alternate, spaced or random selection.

The decision was made to focus attention on the first portion of treatment because the investigation included a directed enquiry into how such children present in psychotherapy: I was aware that should my patients begin to recover then the very symptoms I was hoping to capture and explore should be likely to occur less frequently – for instance more reciprocal co-consciousness between Kayleigh and *Priti* could be expected to reduce amnesia for *Priti's* escapades (code **Am - amnesia**), an improved sense of safety and acceptance for or between Frank and *Ben+Ben* might reduce the disparity of their cognitive abilities (code **Va** –varying capacities). The first portion of the treatment was judged, therefore, likely to be the most fruitful in this regard. Such a strategy also conferred the benefit of reducing the risk of having incomplete data sets because of drop-out from treatment or interrupted treatment, which might happen if, for example the sampling strategy involved analysing one session every six weeks across a full two years, and of allowing the data gathering to complete and the research to go forward whilst the childrens' therapy took its own journey. A further benefit is that in selecting data from *the same portion* of treatment for each participant one aspect of participant variability is diminished; the participants' ages, gender, life-stories were unavoidably diverse, but this strategy could remove potential variability arising from symptomatology at different stages of treatment.[11]

The decision was made to use consecutive sessions because the investigation hoped to explore how the presentation of dissociative children prompted alterations to technique by the therapist. It was anticipated that this was most likely to be illuminated by detailed 'blow-by-blow' sequential material, approximating to a full narrative, and that action-reaction or cause-and-effect correlations might be more clearly discerned where no sessions were 'left out' (as they would be with a spaced or random sampling strategy). In addition this was likely to afford a better opportunity for the influence of the specialist supervision to become apparent as the therapist discussed the treatment and then chose to alter technique across the weeks selected.

4.6 Selecting a method of analysis

Child Psychotherapists are rigorously trained to be adept at analysing what transpires between humans with an intimate, minute, micro-lens. We begin with infant

[11] Though undoubtedly variability of symptoms across treatment would make an illuminating future research project.

observation, continue with a fine self-examination in our own psychoanalysis, embrace being up close and personal when working with our intensive patients, and qualify by writing a 10,000+ word paper about our work with *just one child*. Once qualified, we are likely to start working life in a multi-disciplinary environment where we must wave the flag for 'devil in the detail' of the child's presentation or intimate family dynamics. That is to say, we are skilled at searching for meaning *within* a 'data item'. However a subjective narrative analysis of our work is vulnerable to the criticism of a lack of rigour. To improve the rigour of our analysis requires a systematised approach that diminishes the subjective influence of the person of the researching therapist and can facilitate reasonable and evidenced hypothesising about the pathology of more than just one individual. Applying a systematic method of analysis makes way for generalization from the micro to the macro driven by measurable observed phenomena rather than untestable theorising.

The challenge here was how to search for meaning across an entire 'data set' made up of hundreds or thousands of data items, some 60,000+ words. How could this be achieved?

4.6.1 Thematic Analysis

Formal systemised research into the practice and achievements of child psychotherapy is relatively recent. In response to a clinical training which now includes a distinct compulsory research component, and to a professional climate in which the unique contribution of a psychoanalytic child psychotherapy approach must be evidenced for our survival, Grounded Theory (GT), pioneered by Glaser and Strauss(1967), and reworked for modern times by Charmaz, (2006) has emerged as a dominant methodology in attempts to investigate data composed of the records of therapy sessions with children. Anderson (2003, 2006) and Midgley (2004, 2006) further make this case and examples across the last decade continue to accrue across a range of psychoanalytic interventions from the intimate mother-infant work of Reid (2003), to the once-removed consultative work of Evans (2013) with SENCOs in schools.

Thematic analysis (TA) is very much from the same stable as grounded theory, easily sharing description as a systematised method of analysing qualitative data about human behaviour in a potentially meaningful and illuminating way. Fieldwork samples of

social communication usually via observations, conversations, video or audio-recordings, are converted into a form in which the elements can be re-scrutinised and recurrent phenomena emerge. These are then recursively re-analysed in a systematic way to allow further correlations to show themselves and be grouped into ever more substantial and, hopefully, substantiated 'themes'.

However TA is somewhat freer than GT of a central goal of generating theory and allows the research to demonstrate *what is present* in the data as a meaningful finding. Thematic analysis attempts transparency. The researcher is charged with declaring his or her own interest and acknowledging the decisions made in the pursuit of data extracts pertinent to the question he or she is investigating. Thematic analysis makes no apology for embracing the constructionist perspective that though there may be clinical facts of interest (O'Shaughnessy, 1994), and patterns within a data corpus or a data set that can be usefully identified and explored, these cannot be assumed to be presenting themselves outside of the context of observation by an interested mind. Braun and Clarke (2006) helpfully quote Ely who asserts: 'If themes 'reside' anywhere, they reside in our heads from our thinking about our data and creating links as we understand them' *(*Ely, 1997).

Champions of this form of qualitative investigation might criticise an orthodox Grounded Theory approach with its claims of an approximation to objectivity, arguing that we cannot leave our theoretical assumptions at the door as we come to apply our minds to analysing clinical data, and that despite our best conscious endeavours these are bound to seep through to contaminate what we observe, what we notice and do not notice, what we suspect is causally related and how we determine evidence for this[12]. Traditional Grounded Theory as it was originally designed (Glaser and Strauss, 1967) aims to generate theory from phenomenological evidence, hence the purists' injunction against a thorough knowledge of relevant literature until *after* the analysis is largely completed. Within GT there is an exhortation for the researching analyst to free herself from all prejudicial assumptions and associations, but in reality this is not possible, especially for research questions like that of this study which have inherent theoretical assumptions *built in.* Thematic analysts would agree with O'Shaughnessy's (1994)

[12]To a great extent these are the same set of arguments analysed in our discussion of the subjectivity of single case study and process recording methodology.

reference to the philosopher Nagel's thinking that whilst undeniably subjective, every observation is nevertheless at least always 'a partial view from somewhere' as opposed to being 'The View from Nowhere' of his title (Nagel, 1986). However Thematic Analysts would add the essential imperative that the researcher must be keenly aware of her 'somewhere' and that it must be transparently declared from the start.

In the spirit of such honest declaration then, what was I looking for when I approached the data I had gathered and what assumptions had I already made?

4.6.2 Theoretical Assumptions

1. That psychoanalytic child psychotherapy is likely to be helpful for these three emotionally disturbed children and young people. The participants of this study were not selected on the basis of their condition and then randomly assigned a traditional treatment, a 'new' treatment or indeed no treatment. All were in psychotherapy with me because a mental health professional had formed the view that this sort of treatment was likely to be helpful and referred to me in each setting. Furthermore I assessed all three myself and concurred with the referrers' views that psychoanalytic work was likely to be beneficial otherwise I would not have recommended weekly sessions and embarked on the venture with each one. At the point of accepting the three into treatment, only Kayleigh had a formal diagnosis of a dissociative condition, but I assumed that all were likely to be helped by our work together to some degree, that is towards settled less distressed states of mind in which they could better fulfil their potential 'Lieben und arbeiten' - 'to love and to work' (Comment ascribed to Freud, by Eriskon, 1950 p.256).

2. That psychoanalytic child psychotherapy is here best described as an intervention based on the play therapy technique of Melanie Klein in the cases of Frank and Robbie, and on a modified adolescent version of the same when working with Kayleigh.[13] This is a fundamental assumption because the question of what changes to technique I found I needed to make are a central component of the investigation. Klein's *Psychoanalytic Play Technique* (Klein, 1955) rests on the cornerstone of the persistent identification and interpretation of the most urgent anxiety.

[13] See Shedler, 2010, for a helpful description of seven distinctive features of psychodynamic psychotherapy as collated via a search of studies using a manualised version of the same.

Re-reading her description of how she arrived at her conviction I find a Klein who is kinder and more self-questioning than I had credited. She describes a young boy, 'Fritz', whose anxieties only seem to increase in the face of her interpretation, but only arrives at a view that persistence is warranted after consultation with her supervisor (Karl Abraham) and an eventual diminution in the child's symptoms (ibid. p.123). She discovers that recognising and interpreting the negative transference and connecting this with the earliest object relations is key. In addition Klein is clear that the need to 'keep in step' (ibid. p.128) with the child's emotional state, to neither show encouragement nor disapproval, necessarily prohibits using any 'educative or moral' influence (ibid. p.129).

3. That dissociative disorders do not just arrive a priori from congenital or inherited weakness[14] or some other independent source, but are causally connected with distressing emotional experience. I came to this investigation as a qualified child psychotherapist with a body of theory about how minds work tempered by over 20 years' of experience of working with distressed and disturbed children. As the analysing researcher I would have to declare that I was not open-minded to a potential discovery that the two are not related; standing on the shoulders of historical figures such as Janet, Fairbairn, Ferenczi, and in line with the most recent research by Putnam, Perry, Liotti, Lyons-Ruth, Schore, and others, I accept the merit and evidence of the theory that DID and OSDD are drastic responses to the debilitating sequelae of trauma (see Chapter 2 for a fuller account). There is already an assumption here that whether as by-products or attempts to manage the psychological pain, or via some other correlation, the two are related, that an unconscious level 'though this be madness, yet there is method in't' (Shakespeare, 2006, 2.2:195).

4.6.3 Specific Assumptions:

In her argument that Grounded Theory is well suited to research within child psychotherapy, Anderson pares the value of any investigation down to the simplest of questions: *Was anything new found?* (Anderson, 2006). However for this investigation, a discovery of the new was not only a hoped-for conclusion but also the starting block.

[14] This was the erroneous correlation cited by the fledgling psychoanalytic community at the turn of the century to diminish the work of Pierre Janet, see Ellenberger, 1970, Mollon, 1996 pp:29-40, Van der Hart and Dorahy, 2009 p.14 for further discussion of the history.

As I elucidate in the Introduction (1.1 above) the wording of the investigation points to two phenomena that I had already recently 'discovered' for myself:

1. First that DID and OSDD really exist as pathological conditions in children and young people and
2. Second that unmodified psychoanalysis applied by this particular clinician did not seem to produce much healing

It was from these standpoints, then, this 'somewhere', that I started in on the endeavour of a systematic thematic analysis of my case material. I aspired 'to boldly go' (*Star Trek,* 1966) into the field of the process notes of sessions with dissociative children against a backdrop of two 'knowns' concerning the reality of DID in some child patients and its apparent insusceptibility to some aspects of traditional psychoanalysis, under the theoretical assumption that DID proceeds from complex trauma overlaid on disturbed attachments and with a declared interest in the 'unknown' of the prevalence and type of moments where I had stepped away from a more orthodox psychoanalytic orientation.

Chapter 5: INITIAL FINDINGS

5.1 Phase 1 – Findings from the 'Familiarising Re-read'

The first approach to the material is a broad re-reading Braun and Clarke term 'familiarising yourself with the data' without any detailed recording or analysis. The mind is encouraged to take in the whole picture, to let the data 'flow over and into consciousness' without immediately schematising or coding (Braun and Clarke, 2006 p.87). This initial untrammelled appraisal is well matched with the psychoanalytic mindset which 'consists simply in not directing one's notice to anything in particular

and in maintaining the same 'evenly suspended attention' in the face of all that one hears… the rule (is) of giving equal notice to everything' (Freud, 1912 p.112).

Of course this is far from 'simple'! In the consulting room the data is the total communications from the patient - verbal, creative, behavioural, body posture, and the effect all these may have on the therapist, and here the data is the corpus of process recordings being re-read at some temporal distance from when they were originally written. This initial approach might also be understood as an attempt to privilege a 'right-brain' reception of what the data have to offer, receiving the words not just at an intellectual objective level but also '…listening and interacting at another level, an experience-near subjective level, one that implicitly processes moment-to-moment socioemotional information at levels below awareness' (Schore, 2003 p.52).

Attentive and thorough-going reading is time-consuming and not immediately productive: a potential list of initial themes is all that can be hoped for as an observable outcome. The need to resist the pull to rush on to explicit selection and coding may have something in common with the need to resist the pull to rush on to premature interpretation in early psychotherapy sessions. There is an exhortation to 'be with' the data as there might be to 'eschewing memory and desire' (Bion, 1962 p.272) in order to attentively 'be with' a patient. Braun and Clarke are emphatic about the importance of this first methodological phase within a thorough thematic analysis: 'It is, therefore, tempting to skip over this phase, or be selective. We would strongly advise against this, as this phase provides the bedrock for the rest of the analysis' (Braun and Clarke, 2006 p.87)

Braun and Clarke describe this initial read-through as an 'immersion' in the data, one in which the reader is active and necessarily seeks out 'meanings and patterns' (ibid. p.87). This is also the phase of the research in which, if necessary, transcription would be carried out, so in this study the re-read was used to actively organise and delineate the data sets. Each set of session notes was robustly anonymised and a password-protected list of consistent pseudonyms created.

The brief for this initial reading might be the instructions 'notice what these children do that is different (from children who are not suffering dissociative symptoms)' and

'notice what you yourself do differently (from when you are working with other children)'. Using a computerised word processing system that allows the creation of comments in a parallel vertical field, phenomena which were anticipated to be of significance could be noted within the material notably but not exclusively along these two axes of observation. My observations had the quality of 'pencil notes in the margin' but necessarily grew into a collection of repeated topics or themes listed in full in Appendix 5.1.

5.2 Phase 2 – Generating Initial Codes

Here I was looking to create a usable list of 'the most basic segment(s), or element(s), of the raw data or information that can be assessed in a meaningful way regarding the phenomenon' (Boyzatis 1998 cited by Braun and Clarke 2006 p.88). These needed to reflect *both* the nature of my investigation *and* what was observably available in the data set. Here I had to attempt to make a marriage of the *subjective* that is the field of my enquiry and the focus-biased mind I necessarily brought to the research process, and the arguably *objective* which is the process recording notes of sessions made several months/years previously[15] and before this particular investigative lens was in play. The coding is therefore both 'theory/enquiry-driven' and 'data-driven'.

On conducting a further examination of the broad sweep lists compiled from the first read, two loosely grouped sets of meaningful phenomena emerge: those that relate to the patient's presentation – for example, amnesia, connectedness, varying capacities, issues of agency and identity, the parental mindset revealed, a sense of authenticity, and those that relate to the therapist's technique – including the dilemmas of accepting or resisting abuse, managing fabrication, the attitude to dissociative identities and to their integration and so on. In addition there are several other notable aspects such as how and when the therapeutic work was internalized (Kayleigh), the therapist's intervention to calm (Frank) or metaphorical 'method in the madness' (Shakespeare, 2006, 2.2:195) (Robbie). Whilst these last three were not common and almost wholly present only for one specific child, the decision was made to retain these 'other' features that might prove to be missing links or prompts for future investigation. This is permitted within a

[15] This is more certainly the case for Robbie and Frank, who notes I had written several years previously, whereas Kayleigh's were in reality just a few months old and the nature of my investigation much more firmly delineated.

thematic analysis approach at this stage, since significance is apportioned not solely on the basis of prevalence, frequency or some other quantifiable measure, but rather on whether 'a theme captures something important in relation to the overall research question' (Braun and Clarke, 2006 p.82). Retaining these might also prompt a deviant case analysis in subsequent discussion.

Additional phenomena for which additional codes are required may emerge of course, but a set of initial codes are necessary for beginning the identifying and collecting process. The set of codes emergent from Phase 1 are tabulated below. The groupings are not determinant of correlation or relationship and are consciously 'held lightly'. The methodological directives at this stage are firstly to include context within the portions coded as this may be required to make sense of the data group later, and in addition, to code inclusively in terms of allowing any data item as many codes as it befits, and finally to be generous in using as many codes as possible (ibid. p89). In the event this last instruction was tempered for fear of creating a scattered and diverse tranche of coded material that might necessitate an unhelpfully complex analysis. There is a limit to the number of potential codes the ordinary human brain can keep in mind whilst appraising and re-appraising written material; for this project a goal of somewhere between ten and twenty codes was judged to offer a reasonable balance between the conflicting demands of capturing the fullest picture and being able to keep the list workably in mind.

Code	Name	Definition
Patient - features potentially related to dissociative symptoms		
Am	Amnesia	It is apparent that something has been forgotten, or the child talks about something forgotten or play/dream/narrative theme of forgetting
Va	Varying Capacities	Inconsistency in cognitive, creative, verbal or other capacities, where this becomes apparent in the material content or the process of the child's behaviour towards the therapist, also where the child talks/plays on the theme of varied abilities
D	Connectedness / Disconnectedness	There is a notable moment of meaningful association between ideas or agents (therapist and child or two characters in a play scenario etc.) or the significant absence of such meaningful association where it would be expected

Id	Identity	There is material relating to the child's identity, to dress or clothing or appearance**,** the nature of transformation, also to joy at being specifically noticed or at having a 'real' drama/life event to relate
Pa	Parental Landscape	The child's material, both content of discourse, play, etc. and the process of transference communicate about their internal working models of adults in positions of caring for them
R	Responsibility	The child takes responsibility when something not his/her fault, the child erroneously ascribes responsibility to another, there is a lack of appropriate sense of agency (hypo-agency), there is omnipotent phantasy in evidence (hyper-agency)
C	Credibility	The child is preoccupied with whether others believe them, the child expresses not feeling 'real', the child presents self in an inauthentic manner or the opposite - moments of clear authenticity
AR	Alter Relations	The child communicates explicitly about how the alters relate to each other + the host/ ANP personality, how each does or does not take control and so on.
Therapist - features potentially related to technique		
F	Managing Fabrication versus Reality	Therapist experiences some work/struggle in speaking to material which is fantastical or questionable + is being claimed by the child as 'real' rather than imaginary or pretend play
Al	Attitude to Alternative Identities	Therapist shows acceptance / encouragement of alternative dissociative identities, the therapist conveys that these identities can be useful as informants or as parts of the child's self, conversely the therapist encourages the child to 'act their age' or 'be sensible'
In	Attitude to Integration	Therapist or child refer to what 'getting better' or recovery might mean, therapist or child speak about integrating or fusing dissociative identities, therapist or child speak in other ways about the future of those identities
O	Organising	Therapist records the desire to organise or the action of verbally /physically organising the child, conversely where chaos is noted but allowed as an important communication
Ps	Psychoeducation	Therapist gives 'real world' information about dissociative symptoms (**PsD)**, about sexual/reproductive matters **(PsS)** or about other matters **(PsO)**
Vi	Resisting Abuse	Therapist resists, refuses or limits involvement in an activity/exchange initiated by the child with elements of collusion or abuse, conversely the therapist is willing/content to be involved as a victim
Other - features that appeared for only one participant in initial read		
e	Ethics	Matters relating to seeking consent and ethical considerations
i	Internalisation	Evidence that something has been internalised from the therapeutic work and / or indications of how
r	Risk	Material in which suggests that dissociation is stabilising and disclosure (of abuse) risky

m	Method in madness	Apparently chaotic material has elements of impressive sense / wisdom

Table 5.2 Initial Codes

Every process recording from each of the 30 sessions was then finely re-scrutinised to note every incidence of all the codes and the extracts labelled for each code using a commentary software tool. During this activity two new codes were added to the list, a patient related code of **S:** 'switching' defined as 'the therapist observes a distinct sudden change in the patient's mood, state of mind or presentation, or the patient and/or therapist talks or plays on a theme of such changes' and an additional code of X – 'miscellaneous' for a significant therapy event that bore retention but did not fit any other code.

5.3 Phase 3 – Refining initial codes to candidate themes: making judgements about what to exclude

In this phase the active agency of the researching clinician is openly directed, she must 'search' for themes. In traditional scientific parlance the selective enquiring mind of the investigator is not a *contaminant* but an element of the experimental *apparatus* to be applied to identify and correlate. However the close quarters comprehensive re-trawl through the data set necessary for the comprehensive application of the initial codes in Phase 2 had made me aware that although my interests might be evenly spread, the presence of the features of my interest, especially in terms of the therapy technique, appeared more patient specific. I was concerned that my subjective interests had highlighted features that transpired to be neither common to all three nor frequent, and perhaps only loomed large in my own mind under the emphasis of my anxieties about how to work effectively with such young people. I was aware that:

> From a research perspective, the danger with the traditional method of selecting and interpreting material within the clinical case study is that episodes that tend to fit with one's own theoretical preconceptions tend to get emphasised, while those that might contradict such an interpretation are simply ignored.
>
> Midgley 2006 p.132

I therefore wanted to quantify how and with what frequency my identified phenomena of interest occurred across the work with all three. For instance, following the coding

application of Phase 2, my sense was that managing to avoid collusion and becoming a victim (**Vi**) appeared to be at its height with Frank, whereas psychoeducation of all kinds (**PsS**/**PsD**/**PsO**) was prompted most regularly with Kayleigh, but did my process notes confirm this? My hope was that a simple quantitative analysis would illuminate which phenomena were prevalent and perhaps also serve to direct my subsequent enquiry towards themes most richly evidenced in the data set[16].

To do this the frequency of each code was counted across the data set for each participant to give a crude figure which could be compared both between codes and between the three children. These were then expressed as a percentage of the whole set of codes for each participant and for the whole data set. As I had rated coded phenomena as they appeared in the text, without limiting or equalising the number across the three, there were unsurprisingly a different total number of occurrences of all phenomena for each participant from the ten utilised sessions - 218, 251 and 287 respectively. Given that I wished to understand which of the identified phenomena occurred significantly across the entire participant group, it was important to guard against an item being included or excluded due to the discrepancy between the size of the data sets for each. For instance the coding **Id** for issues of identity occurred almost three times as much for Kayleigh as for Robbie and hardly at all for Frank, but Kayleigh's total codes were some 30% greater than Robbie's so had this skewed the results to make identity issues appear more frequent across the entire set than they actually were? The same sort of question could be asked about the exclusion of the coding **Va** for Varying Capacities: had the fact that these occurred most in my analysis of Robbie and Frank's sessions, data sets of less total codes than Kayleigh's, diminished the perceived significance overall? To determine whether or not this was the case involved a fine comparison of the weighted and unweighted frequency of each code, the detail of which is summarised in Addendum 5.3.

The results were reassuring: crude or adjusted, once rounded up to whole percentage points, the frequencies for each coding were the same except for three codes – **Pa** Parental Landscape (12/13), **PsS** Psychoeducation around Sexuality (5/4), and **Vi**

[16] It must be acknowledged that analysing the data in relation to the wide differences in age and the gender of the participants was not possible with such a small sample, and that these differences are likely to influence the variation in the findings.

Resisting Abuse (10/11), and even in these three only by one percentage point. This indicated it would be reasonable to make judgements on what codes to pursue going forward using a low-incidence cut-off rule. Even though frequency *per se* is not a determinant of significance within the thematic analysis methodology some features needed to be ruled out in order to delineate a manageable amount of data to analyse in greater depth.

The table below sets out the frequencies for each participant as a percentage of all coded extracts for each in turn and then as a total, together with three different exclusion criteria:

Coding	F	K	R	Total	Exclusion		
					Total≤3%	2 at <2%	2 at ≤2%
Patient							
Am Amnesia	3	4	7	5			
Va Varying Capacities	4	2	4	3	✓		
D Connectedness	8	5	18	10			
I Identity	1	12	5.5	6			
P Parental Landscape	16	8	14	13			
R Responsibility	4	9	11	8			
C Credibility	1	9	0	4		✓	✓
AR Alternative Identity Relations	3.5	8	4	5			
S Switching	7	1	5	4			
Therapist							
F Reality v. Fabrication	6	1	0	3	✓	✓	✓
Al Attitude to Alternative Identities	5.5	6	1	4			
In Attitude to Integration	2	4.5	0	2	✓		✓
O Organising	5	6	11	7			
PsD P.E. DID	0	4.5	0	1	✓	✓	✓
PsP P.E. Sexuality	2	11	0	4			✓

PsO P.E. Other	2	2	0	2	✓		✓
Vi Resisting Abuse	19	2	11	11			
Other							
e Ethical/Consent	0	1	0	0	✓	✓	✓
i Internalisation	1	1	1	1	✓	✓	✓
r Risks of disclosure	7	0	1	3	✓	✓	✓
m Method in madness	1	0	3	1	✓	✓	✓
X Miscellaneous	1.5	1	2	2	✓	✓	✓
Total	99.5	98	98.5	99			

Table 5.3: Coding Frequencies as percentage of total codes for each participant

The three potential exclusions applied here are:

1. An exclusion of all codes that occur with total adjusted frequencies of ≤3%.
2. An exclusion of all codes where the frequencies for 2 or all participants are <2%
3. An exclusion of all codes where the frequencies for 2 or all participants are ≤2%

Additional 'Other' codes - e, i, r, m, X. Applying the exclusion it can be seen immediately that the phenomena collected under the 'additional other' title, are excluded under each of these applications and so could legitimately be put to one side as insufficiently frequent to bear further recursive investigation here in the interests of attending comprehensively to the more substantial patient-centred and therapist-centred collections. From this group only Frank's expressed concern with the risks associated with disclosure (**r)** individually reached any percentage over 3, the majority were ≤1%. Whilst reticence to disclose is understandably not uncommon in young people who have experienced chronic abuse and particularly likely where psychological survival strategies like DID have a goal of keeping things hidden from internal and external view, in this study it did not occur with sufficient frequency *across* the participant set to warrant further systemised scrutiny.

In terms of the two main collections, patient-centred and therapist-centred, Application 1. also indicates that the codes for Varying Capacities (**Va**), Reality versus Fabrication (**F**), Attitude to Integration (**In**) and two of the Psychoeducation (**PsD** and **PsO)** categories are present at ≤3% insufficiently frequent for inclusion.

Va - 'varying capacities': The low incidence of this feature was unexpected. Before the analysis, from clinical practice, I would have considered this to be one of the distinguishing characteristics of dissociative children, and something which can potentially confound the therapeutic process. Experience of consulting to and supervising other child psychotherapists working with dissociative children confirms this (admittedly anecdotal) view. Given the potential interest to practitioners, and as the coded extracts occurred with similar incidence across the three participants, therefore not hitting the bar for exclusion under applications 2. and 3., the decision was made not to exclude the extracts from further analysis at this point.

F - 'reality versus fabrication': Although the total incidence was the same as for **Va** 'varying capacities' at just 3%, a different decision was made in this case, namely to proceed with exclusion of the **F** coded extracts from any further analysis. Whereas **Va** 'varying capacities' was of low incidence, this was evenly spread and not skewed by an anomalous presence for just one participant. By contrast extracts coded for **F** 'fabrication versus reality' code was only present to any significant degree in Frank's session material. This decision to action the exclusion is backed up by applications 2. and 3., with the frequency of **F** also meeting the '2 participants at ≤2%' and most exclusive '2 participants at <2%' applications.

Despite their low incidence, a strong investigative interest remained in both the **In** 'attitude to integration' and **PsD/PsO** 'psychoeducation' themes since these have a direct bearing on traditional child psychotherapy technique. This conflict of 'exclude as infrequent' versus 'retain as highly pertinent' was a prompt to find creative ways to retain these extracts, which **are** discussed in the following section 5.4.

C – 'credibility': This feature occurred so regularly in Kayleigh's material that the total frequency made 4% and was therefore not excluded by application 1. of ≤3%. However credibility issues are actually present in only two of Frank's sessions and in just one isolated extract for Robbie. The other two applications reflect this and both indicate exclusion of the C extracts. Kayleigh was preoccupied with others' response to her disclosures of sexual abuse / assault and with whether family, friends and teachers believed her dissociative experience or considered her to be a manipulative 'attention-seeker'. From experience with other dissociative young people 'being believed' is often present as a recurring theme in their psychotherapy, both around the matter of familial

sexual abuse, and around the lack of understanding or 'belief' in the diagnosis itself. However, given that the issue emerges clearly here only for one of the three participants with any recurrence, and there is certainly sufficient other common material to explore, it does seem reasonable to make a decision to exclude the C 'credibility' coding from further analysis in this particular investigation.

5.4 Phase 4 - Refining candidate themes, merger and subsetting

5.4.1 Merger

Psychoeducation (**Ps**) emerged as a diversely present therapist feature, a major axis of intervention for Kayleigh, mildly present for Frank and not at all for Robbie, so in terms of frequency alone it should be excluded. In terms of the project however, it was judged important not to let this phenomenon go; child trauma specialists emphasise the importance of psychoeducation concerning both the nature of abuse and the effect of trauma on the mind (Silberg, 2013 pp.62-69, Struik, 2014 pp.63-80) and the use of educative interventions has historically been an area of controversy. If possible I did not want to foreclose the possibility of examining the extracts in finer detail. The solution was therefore found to merge all three **Ps** categories into one which brought the percentage for Frank beyond all the exclusion zones and the theme could be legitimately retained.

Since the code **In** 'Attitude to Integration' was also relatively infrequent and statistically only to be retained if the most inclusive cut-off were applied, consideration was also given to merging this code with the related **Al '**Attitude to Alternative Identities' code, since this also notes extracts with themes of the therapist's attitude to uniquely dissociative symptoms. However a recursive examination of the two showed that only one extract was in fact coded for both and the content of each was distinct. In this instance a merger of codes would make for a less coherent theme. Just as for **Ps** 'Psychoeducation' the **In** code identified therapist interventions which may be counter-intuitive (the promotion of or stalling of integration) and are particular to the field of study in terms of working with dissociative children. Apart possibly from work with psychotic children, the therapist's attitude to the integration of self states is unlikely to be an issue with other non-dissociative patients, where the illusion of a unitary sense of self is in the ascendent, no matter how anxious, unhappy or oppositional that self may be. In the event it was judged that forcing a merger in order to marry a rigorous exclusion with the retention of an important theme rather worked *against* the spirit of a

curious exploration, but the distinctive relationship of the theme to dissociation nevertheless justified retaining the **In** code in its own right and keeping an open mind about its place in the overall schema.

5.4.2 Sub-setting

Excluding all 'additional other' codes, plus **Fa '**Fabrication versus Reality' and **C** 'Credibility' leaves two main sub-sets of 8 patient and 5 therapist themes. A recursive assessment of these judged that the themes do cohere sufficiently within the two groups and bear focused analysis, but also noted temporal and thematic parallels across the two sets. A temporal parallel is one where the incidence of themes appears to correlate, say, for instance between extracts coded for the therapist-organising theme and those for patient-amnesia or patient-switching appearing in proximity within sessions or in consecutively adjacent sessions. It is unfortunately beyond the scope of this study to apply an analytic tool that might statistically calibrate such correlations, although others are pioneering this sort of work in which child-therapist interactions can be tracked across a period of therapy (see Goodman, 2015 in press). A thematic parallel is where two identified features relate to the same overarching theme, the most obvious example being the patient-theme **AR** 'Alternative Identity Relations' with the two therapist themes **Al** 'Attitude to Alternative Identities' and **In** 'Attitude to Integration'.

5.4.3 Candidate Themes following merger and sub-setting

Coding	Frank		Kayleigh		Robbie		Total % within subset
	No.	%	No.	%	No.	%	
Patient							
Va Varying Capacities	10	8.5	6	4.3	9	6.0	**6.3**
S Switching	17	14.5	2	1.4	11	7.4	**7.8**
Am Amnesia	8	6.8	11	7.9	16	10.7	**8.5**
AR Alternative Identity Relations	9	7.7	24	17.1	8	5.4	**10.1**
I Identity	2	1.7	34	24.3	12	8.1	**11.4**

R Responsibility	10	8.5	26	18.6	23	15.4	**14.2**
D Connectedness	20	17.1	15	10.7	39	26.2	**18**
P Parental Landscape	41	35.0	22	15.7	31	20.8	**23.8**
Patient total	117	99.8	140	100	149	100	100.1
Therapist							
In Attitude to Integrat'n	5	5.6	13	12.1	0	0	**5.9**
Al Attitude to Alternative Identities	14	15.7	17	15.9	2	4	**11.9**
Ps Psychoeducation	10	11.2	53	49.5	1	2	**20.9**
O Organising	13	14.6	18	16.8	23	46	**25.8**
Vi Resisting Abuse	47	52.8	6	5.6	24	48	**35.5**
Therapist total	89	99.9	107	99.9	50	100	100

within these rationalised groups gives the results tabulated below (Table 5.4) which are the candidate themes.

Table 5.4 Table 5.4 Candidate Themes following review

These two subsets of features can also be expressed as pie charts, giving a visual representation of the frequency of each theme within its group:

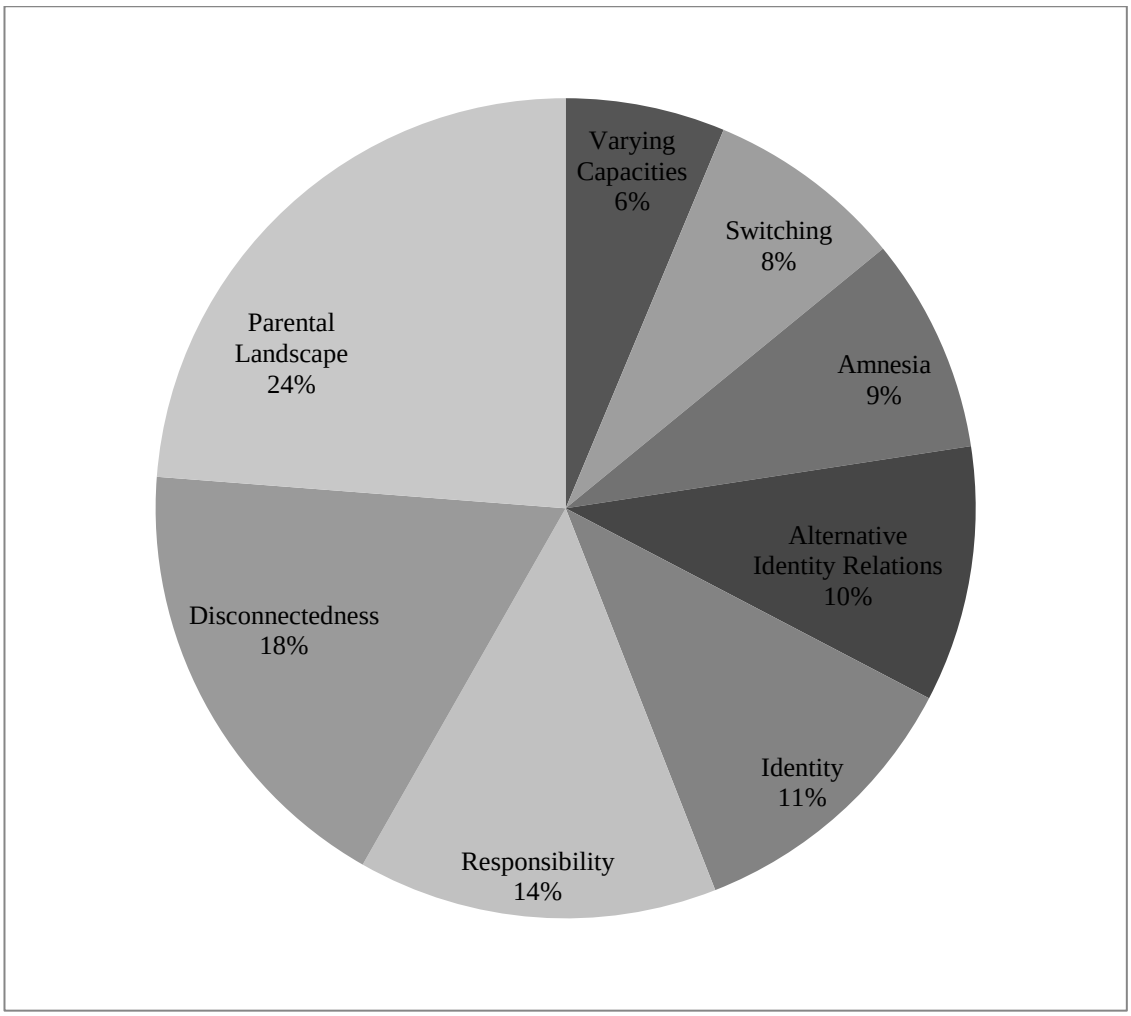


Chart 5.4a Pie Chart of Patient-related themes

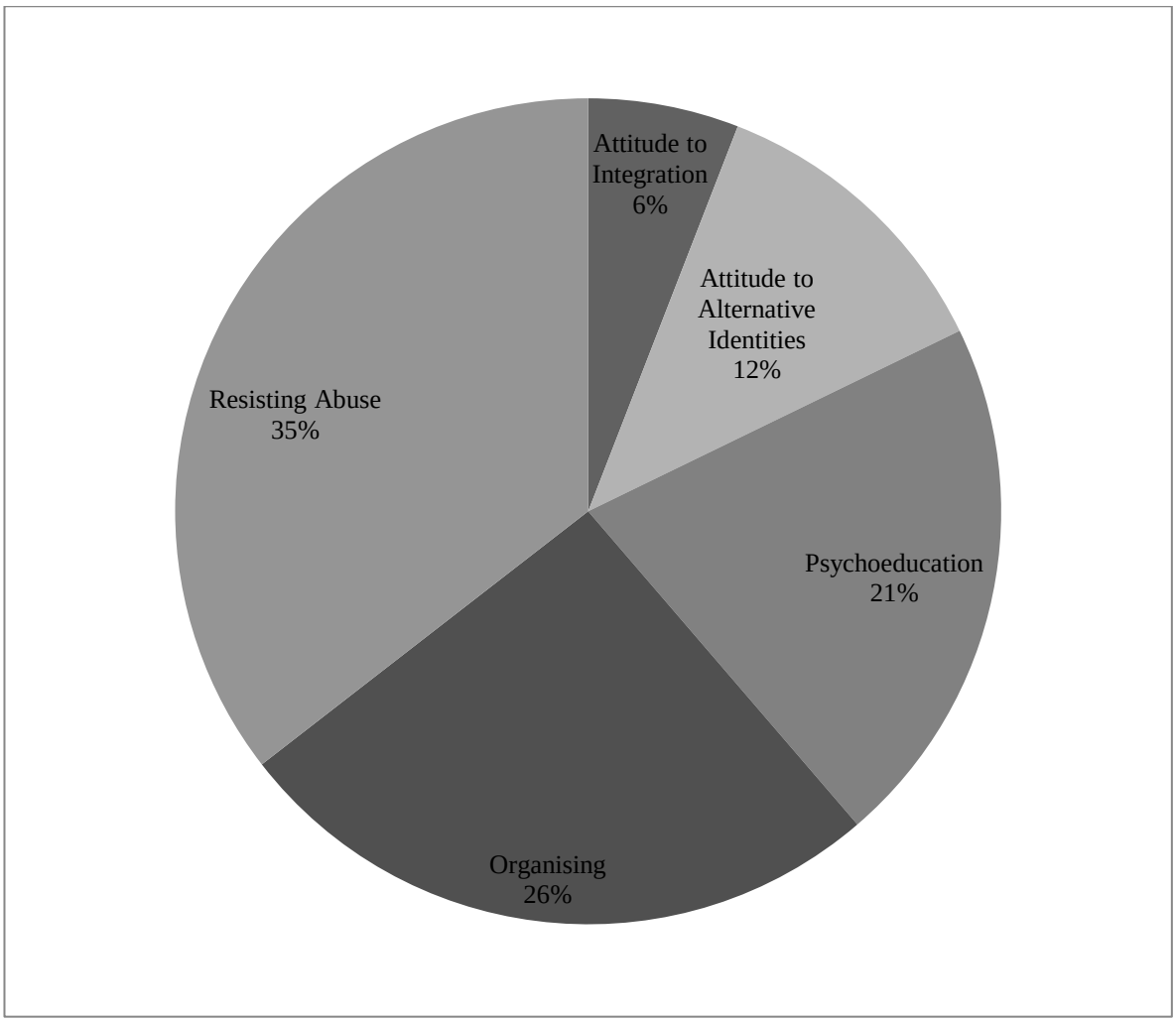


Chart 5.4b Pie Chart of Therapist Related Themes

5.5 Summary

These first four phases of the thematic analysis have been applied to execute a thorough trawl of the raw material in order to discover what themes exist and to capture the frequency and detail of these. Refinements have then been made directed both by the mathematical realities and by the declared research interests of the investigation. The result is distinct two groups of themes which cohere internally in terms of the person to whom they relate – patient or therapist, and which may have varying degrees of influence and correlation both within and between the two groups. In the following two chapters each theme is analysed in fine detail, by gathering and re-scrutinising all extracts coded in the same way. This allows an exhaustive overview of every instance noted of a particular theme so that patterns and trends can be identified, illustrated and discussed.

Chapter 6: REVIEWING AND ANALYSING PATIENT-THEMES (Phase 5 part 1)

6.1 Varying Capacities

Va: Varying Capacities - *inconsistency in cognitive, creative, verbal or other capacities, where this becomes apparent in the material content or the process of the child's behaviour towards the therapist, also where the child talks/plays on the theme of varied abilities.*

There has been some very fine research directed at evidencing physiological variations consequent on one individual switching into different self-states. Amongst other studies, Reinders at al monitored a group of adult women with DID in both their ANP and EP states to measure their psychobiological responses to audiotapes describing both neutral and traumatic memories (Reinders at al, 2006). Across both subjective emotional and sensorimotor domains and the neural pathways that mediate cardiovascular and regional cerebral blood flow this study found that the EP states showed significant changes in responding to the traumatic scripts, whereas ANP states, who did not recall the traumatic memory as a personal event, did not show these changes and expressed a different affective reaction.

Whilst analysis of physiological internal variation was clearly not a possibility in this study, I could, from the start, readily describe each participant's varying capacities as they were revealed in our work together: Robbie's collection of nursery-level painted splodges in contrast to the remarkable precise pencil drawings of dragons or monsters he could produce when in 9/10 year old mode, Frank's sharp memory during repeated games of 'pairs' contrasted with *Little Frankie*, *Ben+Ben* or *Vanessa'*s enthusiastic but undeveloped or impaired recall, Kayleigh's keen and sophisticated verbal appreciation of literary narrative contrasted with her stumbling delivery and limited vocabulary when *Priti* was not in agreement with what Kayleigh wanted to tell me. As a therapist these experiences were arresting in terms of the reality of how definitively and completely aspects of the whole self's capacities may be inaccessible when a child employs dissociative defences. However objectively **Va** 'varying capacities' did not feature as highly as other coded patient themes in my process recordings of the sessions of my participant patients - it was *less* present in the data set than it was in my mind.

Broadly the children's awareness of impairment to their cognitive talents evoked complaint for all three who expressed frustration and confusion by being markedly less able at some times than at others. Robbie *wanted* to paint or draw more precisely (R 4:4, 9:8, 9:12) Frank as his other identities still *wanted* to beat me at 'Pairs' (F 2:7, 2:8), Kayleigh powerfully *wanted* to let me know what was going on in her mind and, when *Priti* was not 'blocking her mouth', she had more than the requisite verbal competency to do so. For instance she finds eloquent words for her experience of how being sexually abused by her stepfather affected her sense of herself in the world:

However Kayleigh then discovers this for herself and says 'I was not innocent after that'. This part of her conversation feels serious and sad, the elements of something being ruined in her or for her, and deprivation are around… Kayleigh exclaims with heartfelt exasperation 'Yes, I became different then, I was never the same again, I was different from everybody else, I mean I know it has happened to lots of people and I don't mean to offend them, but I became different from then on, I became an anomaly.'

Kayleigh 1:7

Yet when trying to let me know what *Priti* is saying she stumbles and stammers, her articulate verbal delivery about these aspects of her self is unavailable to her when *Priti* is 'at the control panel' (K 9:22), because *Priti* does not want these things shared; at these moments *Priti* has access to the 'organ of attention' (Meltzer, 1992 p.118) and is observably offering resistance to object-relatedness and recovery in the manner of a pathological organization (Rosenfeld 1971). However an infantile Robbie, Frank-as-Vanessa or Kayleigh-as-Priti simply *could not* achieve their goals no matter how hard they tried because precise eye-hand coordinaton, or detailed visual memory, or articulate verbal delivery were unavailable to the present self-state.

What the collection of **Va** 'varying capacities' extracts do illustrate however is that some children may develop an overlap between the dissociative and more deliberate and conscious engagement of alternative personality states which are not only triggered *in extremis* but also used to navigate more ordinary psychological challenges. This was particularly true of Frank, where a present defensive function could be observed as in the following example where *Vanessa* is engaged to help Frank 'cope' with confusing or distressing thoughts:

Suddenly he is quiet and reaches for the 'let's talk about sex book'. I reflect to myself on how unfortunate a title this is for Frank though it is unclear whether he can read it. Frank spends some minutes looking through this book slowly and almost methodically. There is no giggling or gleeful smiling to himself. After a minute or two I say that this is a book about ordinary sex, about healthy sex. Frank does not respond but does seem to be trying to read it for himself (Perhaps I could have commented on this though I was mostly trying to give him some room) After some minutes I say that it's hard for me to tell if he's just having a look through or if he's looking for something in particular. A minute or two later I say that I can see he's looking at the page about being born. He remains on this page for some further seconds, then carefully closes the book and puts it back, taking the other book on the human body from the shelf. He says something about wanting to see the picture of the baby. I ask if this is a baby inside or a baby outside, Frank is clear 'inside'. He locates another picture of a baby inside a pregnant woman in the second book and asks me 'What does that say?' about the word 'vagina' I say that I think he can read this word, but that he finds it exciting when I say it. Frank says 'No I can't I' dumb' He studies the picture further and says in his disabled voice 'I ont oo otak it' which I repeat as 'You want to attack it?' 'I want to look at it' Frank corrects me. I acknowledge this, the idea of the baby inside is very interesting to him. I am forming an interpretation about him wanting perhaps to be a baby inside, but I do not get mental space or airtime to do so. Frank then says in his own able-minded voice 'Vagina' and closes the book and puts it away.

Frank 9:10

There appears to be a high degree of co-consciousness here - Frank is able to 'translate' *Vanessa's* 'disablese' into intelligible speech when it is clear I have misunderstood him. This exchange has particular context; earlier I had set a firm boundary with Frank when he made salacious sexual comments about my clothing and tried to touch me, which is likely to have helped him feel reassured that I would not get 'carried away' with him and could keep my own sexuality out of the room. I had also made an interpretation when he had previously switched to *Vanessa* about how being disabled is a way of protecting himself from having to think about painful things. So here is Frank exploring or even achieving insight about the conflict between a part of him which wants to understand 'I want to look at it' and a part of him which needs or has historically

needed to become ignorant 'No I can't I dumb' ? This is complex but ordinary psychoanalytic territory. Indeed in this excerpt it seems that although I can barely keep up in the moment, my previous comments and *Vanessa's* appearance actually help Frank to stay with the difficult encounter with a pregnant female body, and ultimately to be able to read and to speak the word 'vagina' for himself.

If a child is in a safe environment and is engaged with therapeutic help then the co-consciousness evident in such use of their dissociative identities can be a help towards recovery. Identifying and 'getting to know' alternative voices or personalities is advocated as a key component of treatment for dissociative children. Siberg's EDUCATE model includes specific approaches to enable the child to understand and claim what is hidden, (Silberg, 2013 pp.76-95) and these may be accessed via a variety of means (drawing, small world play, sand tray, letter writing (Marks, 2014). However without safety and therapy it is easy to see how the deliberate and conscious nature of their use of alternative identities could leave such children open to aspersions of being manipulative, malingering and even misdiagnosis as personality disordered or psychopathic.

6.2 Switching

S: Switching - *the therapist observes a distinct sudden change in the patient's mood, state of mind or presentation, or the patient and/or therapist talks or plays on a theme of such changes*

We all shift mood, attention, emotion, behaviour in response to both our own internal thought process and to events as they unfold around us. However people who have developed dissociative defences may be experienced and/or experience themselves as 'switching' suddenly and ostensibly inexplicably from one state of mind to another.

> For our purposes, we will define a state-change or switch as the psychobiological events associated with shifts in state of consciousness as manifest by changes in state-related variables such affect, access to memories, sense of self, cognitive and perceptual style, and often reflected in alterations in facial expression, speech and motor activity, and interpersonal relatedness.
>
> Putnam 1988 p.26

Of course these switches are not in fact random, whether understood as symptomatic of disorganised attachment responses or as part of a protective defensive system, but they

are unlike ordinary fluctuations in mood which can be causally traced with relative ease. Dissociative switches between states of mind or from one alter to another may be wholesale - 'lock, stock and barrel' and the trigger may be impossible to discern. Therapists aim to be skilled in analysing their clients' incongruent emotional responses in relation to past conflict, unexpressed anger, anxiety or loss, hitherto hidden trauma. However this approach is deeply hampered when there is so little obvious process or progression from one state to the next and when the child or young person has little or no awareness that a change has occurred. From working with Frank, Robbie and other dissociative young people I recognise Baita's description of her experience of being with a switching four year old:

> What triggered her switch? At this point I felt as if every word, every move, and every gesture of mine could potentially act as a trigger. It looked like a puzzle where some pieces had been lost.
>
> Baita, 2011 p.39

For the therapist these 'non-linear' shifts (Putnam, 1988, p.25) can be as though the child or young person has 'jumped ship' and has arrived in an entirely new landscape; the thread of the conversation she was just having with the child is not remembered and apparently no longer relevant, so she may need to immediately alter her own arousal and attunement, adjust her vocabulary, reestablish firmer or more flexible boundaries. Hopenwasser makes an inspiring case for transcendent 'dissociative attunement' in which she exhorts therapists to almost 'just roll with it', to 'listen to implicitly derived knowledge and at times to abandon the caution that accompanies reflection' (Hopenwasser, 2008 p.361) which she describes very tenderly:

> But throughout these shifts, there was what felt to me a remarkable attunement between us. There would be a window of perhaps 10 or 20 seconds during which time I could sense Francesca's imminent shift. There was no opportunity to pause and actually think. … I understood that Francesca and I were being in rhythm in a synchronized way moving through time. What might have appeared to others as misattunements were in actuality syncopated, synchronized shifts through multiple self-states, not unlike the improvisational yet coordinated polyrhythms I was learning in my musical studies.
>
> Hopenwasser, 2008 p.360

Although **S** extracts were identified for all three participants, rapid and repeated switching was only present for Frank and Robbie where it did indeed pose a technical challenge. Wieland's description of a child with mild dissociation presenting 'like an

infant or toddler who moves directly to extreme states of reacting' (Wieland, 2011 p.4) is apt for Robbie where my notes record:

The session is unremittingly hectic, involving me out of my chair many times to protect the toys or hover by the door to prevent him running out. Robbie's mood switches rapidly as he hops from one mode of operation to another, moaning to fury to a few moments of contrived sweetness.

Robbie 8:5

- or in more detail:

Robbie selects his painting of a butterfly, the copy is in two parts and he brings it to the table saying as though with resigned boredom: 'We could stick these together' I agree, simply: 'Yes, we can do this together.' but at once Robbie has an idea he likes better and gets excited 'Or we could cut them up and make a puzzle!' As he begins to attempt this task, one entirely within his intelligent-self capability, he shifts within seconds from delighted anticipation to general accusatory moaning: 'Where are the scissors… haven't you got any scissors?' then, on retrieving them from their usual place in his box a pitiful: 'Aren't you going to help me?' and finally an exasperated 'Oh it's too difficult!'. I do say that he is so cross today that it's hard for me to get anything right, everything I do is wrong[17]*. Robbie becomes furious and aggressive:'Shut up!' and then 'Shut up or I'll punch you!'. I say that he's trying to bully me into being quiet 'Yes, shut up!' Three seconds later Robbie smiles genuinely sweetly, a compliant cherub, and offers me a cut-up piece to position, speaking in a high-pitched little-boy voice to tell me 'You can do this one.' He continues elicits my help in sorting out the puzzle and is expansively pleased when it is done, announcing 'We did it!' This is a rare moment of expressed enjoyment of a cooperative endeavour.*

Robbie 7:8

The unconscious metaphor here is poignant: it appears that in order to cope Robbie has had the 'bright idea' of *cutting himself up and making a puzzle* in which the relationship between the parts is not immediately obvious. Extending the parallels further he then

[17] With greater experience I would be likely to make a less complete less challenging interpretation, possibly just echoing his frustration 'Oooh, this is tricky isn't it?'

offers me *a cut-up piece* just as at any given moment I have only an aspect of him, moany complainant, aggressive bully, intelligent schoolboy, or innocent infant.

Frank's rapid switching could be similarly discombobulating, so that attempting to stay mentally in-the-room with either Frank or Robbie could be like trying to stay in the saddle on a runaway pony, having to go with the ups and downs and the unpredictable changes of direction without any room to observe the surroundings or actually regain control, and where new features of the landscape might spook the animal all over again. Both Robbie and Frank were always on the brink of flight into a disconnected state, jettisoning one intense emotion for an alternative. But *flight* is not quite right, with its connotations of speedy but chartable trajectory, whereas switching has an inherent disconnect. Perhaps popular stories have this best - the **S** extracts have more in common with the tele-porting of Star Trek (*Star Trek,* 1966) or the Portkey transportation of Harry and his friends in Rowling's famous series (Rowling, 2000). Sinason makes the cogent comparison with familiar elements in fairytale narratives as a reflection of dissociative switches (Sinason, 2012 p.45) where a protagonist may suddenly find themselves in a different land, turned into an animal, or magically revealed to be royalty.

Kayleigh did not switch in front of me. *Priti* was around on occasion and certainly had an influence over the proceedings of our therapy conversations but generally I witnessed a struggle between the two rather than a take-over. However Kayleigh did speak to elaborate preparations she made each day in order to be able to 'make a quick getaway' by entirely changing her appearance in a way that my notes record reminded me of switching at moments of perceived threat (K 14:5). In this extract (quoted in full in section 5.53 below) she tells me that *she always has another outfit on underneath…so that she can just take (her original outfit) off if she needs to.* This could so easily be the description of switching, a practised preparedness to 'quick change' if things turn nasty. For a young child trying to navigate an unpredictable and abusive parental landscape this could be a vital skill indeed.

Clearly, though, Kayleigh is describing a conscious process whereas dissociative switching may be largely or partially unconscious. A further complication may emerge when a child or young person realises the various secondary gains of different alter

states and deliberately uses these to manage their social environment. During our work together Frank became increasingly aware of switching into his disabled mode when an idea became uncomfortable or confusing. Something of this kind appears to be happening in the excerpt below which was coded for switching:

Frank wants to play with the dog and vet's kit. He begs me to play too, I say that today I will not. He begs me 'Just once' and then 'why not' I say that today I want to be able to think about how he is playing. Frank is clearly cross about this and becomes loudly disabled, he rattles the lock and as I try to talk he shouts 'I 'ot 'istening!' ('I'm not listening!') I say that being very disabled is a way of protecting himself from having to think about painful things.[18]

Frank 9:9

Of the patient phenomena observed and coded, 'Switching' was the only additional feature added after the initial familiarisation as the sessions were coded line-by-line. On approaching the sessions to code them I noticed repeated incidents where switching occurred and wondered if under such a micro-lens any pattern or theme might become discernible between these moments and a painful state of mind. This is precisely what child psychotherapists learn to pay close attention to with their non-dissociative child patients - what is the psychological event which causes a breaking off from play, a withdrawal from emotional contact with the therapist, an escalation of an anxiety symptom and so on. Over time we might hope to be able to build a shared understanding with the child of the anxieties that cause them to habitually employ such a manoeuvre and to make room for alternative ways of coping.

6.3 Amnesia (Am)

Am: Amnesia - *it is apparent that something has been forgotten, or the child talks about something forgotten or play/dream/narrative theme of forgetting.* The selected extracts which comprise the data group of items coded for Am: Amnesia are a mixed bag. On reflection my working selection criterion appears to be an extended definition and includes any item containing elements relating to memory so that I have coded

[18] With hindsight it would have been more accurate and potentially more helpful to have made the comment that *today* he is using (alter) Vanessa, or using his ability to be like Vanessa to help him get away from my expectation that we should try to use our time to *think* about things together rather than just play.

items where aspects were notably *remembered* as well as notably *forgotten*, and included my own forgetting as well as that of the children. Four recurring themes emerge that bear closer examination - amnesia and memory related to traumatic events, pervasive forgetfulness, secondary 'forgetting' and a forgetfulness on the part of the therapist.

6.3.1 Amnesia and Memory for Traumatic Events

Kayleigh's struggles with her memories of sexual assault provide examples of how storage of sensory and affective information may be altered during traumatic experiences and can compromise recall after the event. In her re-telling of the first sexual assaults, aged just 8, Kayleigh can provide a coherent narrative which is likely to have been further stabilised by the criminal investigation that followed. However the subjective salient features are sensory '*I remember that we had a carpet on the stairs that was all worn on the front from Harvey (puppy) and it was really smelly'* (K 11:21) or *'Kayleigh then launches into a blow by blow account of the abuse with Anthony, but concerned that she cannot remember exactly what music was playing when he asked her to dance at the party, telling me 'But if you know 'Ibiza club hits 12' then it's the second track on that!'* (K 9:17) and post-hoc affective *'Kayleigh berates herself again for 'not knowing' , her memories of the abuse are peppered with these guilty self-recriminations* I should've known *and* if only I'd known what sex was *and seem impermeable to my assertion that an 8 year old could not be expected to understand such things.'* (K 9:18). Sense impressions that are largely irrelevant to the actual traumatic events are retained in sharp relief many years afterwards - the smell of the carpet, the particular music playing, with qualities that suggest hyper-arousal, all senses primed but not selective, rather than attempts at dissociative comfort. Kayleigh's preoccupation with her guilty and shameful feelings, whilst painful, also suggest to me that she did not powerfully dissociate during this experience but continues to try and 'work over' what occurred - she is emotionally connected with her coherent internal story.

Kayleigh's memory for the second sexual assault, which was both a much more violent event and suffered whilst quite on her own, is much more compromised, which caused problems for the criminal investigation and was partly why Kayleigh eventually withdrew her allegation against David. Again she remembers sensory memories such as

the rough bark of the tree hurting her back and seeing a glowing moon in the night sky but these appear as 'flashes of memory' within a narrative that has whole portions missing. Kayleigh cannot recall the (presumably) much greater physical pain associated with her relatively serious sexual injuries and can remember nothing about how she found her way home that evening. Guilt and self-recrimination are present in Kayleigh's affective description of this event but focused on a relatively minor detail which even she questioned 'I kept thinking that I had (friend) Crystal's leather jacket on and it was getting ruined. I kept thinking she'd be cross with me. Why was I worried about that?!' (K 1:14).

6.3.2 Pervasive Forgetfulness

All three participants failed to remember diverse aspects of their own and our shared therapeutic life together despite showing impressive detailed and precise recall for other items, a disparity which demonstrated that the impairment was not a matter of pervasive cognitive deficit. For Kayleigh this occurred mostly via an inability to recall whether she had already told me something or not, but for Frank and Robbie the forgetting was repeated and pervasive. The outrage or confusion which accompanied a challenge that subjective memory and objective reality might not be matching up were testament to the authenticity of their amnesias. For instance:

(*On) returning to psychotherapy after a short break Robbie takes some moments to leaf through his growing collection of artwork, not recognising one of his well-executed drawings which he then waves in front of me demanding 'Whose is this? What's this doing in here?' as if I, always an inadequate therapist, have allowed a 'foreign body' to invade his things. The picture is actually one of my favourites as it is imaginative and playful. He appears entirely disconnected with the part of himself that took quite some time and energy to create it and quickly reaches an interpretation that something has gone awry in the external world rather than within his own mind. He jettisons the offending picture over his shoulder only to be brought up short when he encounters another, almost identical in style in the pile of papers. 'Oh!' Robbie exclaims in clear surprise, then solving the dilemma of a picture which he now sees* might *be his with 'Well it matches this one so I suppose it can stay.'*

Robbie 1:1

Later in that same session Robbie remembered in micro-detail what was stored inside a margarine tub he had bound with tape from several weeks previous to the picture.

Psychoanalysis understands what is forgotten as significant in the interplay between internal dynamics, the ongoing repressive compromise between drive and defence (Stern, 2009 p.655) but despite close observation across many months, most of both Frank and Robbie's memory losses never resolved into forgetfulness within which meaning could be discerned. We can speculate that multiple losses of connection like these are apparently 'random' because they are symptomatic not of the avoidance of specific symbolised internal anxiety, trauma or emotional conflict, but of a disorganised and disorientated *forgetful* brain. Is it possible, following our growing understanding from attachment and neuroscience research (see section 2.2.2 and 2.2.3 above) that both Frank and Robbie had incomplete vertical and horizontal brain connectivity, which is to say that much of their experience remained 'unformulated' (ibid. p.658) with the consequence that their memory is organically and permanently compromised, full of dissociative gaps?

6.3.3 Secondary 'Forgetting'

On one or two occasions it was clear that Frank had employed semi-volitional forgetting because he did not want to think about something difficult, for which a 'jog' could restore his memory, but only if he was willing and presumably if the memory was not associative with extreme prohibitive anxiety. Observing Frank closely I could see that he was not *pretending* to forget on these occasions, but rather he was more deliberately *doing a forgetting thing* to himself, like a child might learn to sing a song to take their mind off something or to daydream about football in order to mentally escape a detested maths lesson.

Following a conversation about his going into an older boy's room at night, I ask him whether he can tell me something about the conversation he had with Dr. Pullinger a few days back? (Dr. Pullinger is the child psychiatrist he had sexually propositioned at his last consultation, but I do not introduce this explicitly). Frank looks very confused 'What are you talking about?' He is so spontaneously mystified that I wonder if I have got it wrong, was it Dr. Pullinger? Does Frank even know that the doctor of course told the staff? Frank is very able to ignore, distract or tell me to shut up, but now he

engages with genuine puzzlement 'When did I talk to a doctor?' I find I am doubting myself, but I persist 'I am asking you about the conversation you had with Dr. Pullinger about sex.' Frank's posture changes, he shifts his weight with a small but discernible swing of one hip and a lopsided knowing smile 'What sex?' he asks slyly, going on to remember the exchange.

Frank 6:4

Frank had got 'good at forgetting' and when necessary was unafraid to use such a skill to smooth his path; indeed he is so convincing in this extract that I doubt my own memory. It seems likely that the pain, shame or excitement of recalling the conversation with Dr. Pullinger was not something he wanted, quite possibly unconsciously, and he could easily function in a part of him that 'did not know' about those events by mentally putting them to one side. One could speculate that this is the corollary of the experience of intrusive thoughts in which children complain that they *cannot stop* thinking about something, and we can imagine how useful such an ability might be in an abusive household. However at my persistence and explicit reference to 'sex' Frank appears to give this up and slides into a part of him that does know, indicating that the amnestic barriers between knowing and not-knowing about this event are not impermeable.

This seems to me neither surprising nor particularly concerning. Human beings are, in evolutionary terms, consummate tool makers, creative in bending the resources available to the most pressing survival needs. There have been many occasions now when I have had to advocate for the possibility that dissociative children and young people are as likely to use their quirks, coping strategies and weaknesses to good effect as any of the rest of us, and argue that this does not mean that we cannot reasonably re-diagnose them as 'malingering' just because they are willing to manipulate us to their own advantage using dissociative skills forged in adversity. It is an understandable complaint of those caring for violent children who then declare that they cannot remember the punches an abusive alter threw earlier that day, that selective memory is at play in a rather convenient way. However just because children can sometimes apparently use dissociative skills at will does not preclude the possibility of their being largely and genuinely at the mercy of those same processes to their disadvantage much of the time. If Frank had had full control and access to the consummate memory skill

he could use to trounce me at ‘pairs’ he would undoubtedly have rejoiced in doing so every time we played. In reality *Vanessa, Little Frankie* or *Ben+Ben* would almost always interrupt to prevent him succeeding.

6.3.4 Forgetfulness on the part of the Therapist

The group of **Am** coded extracts draw attention to several moments where I experienced forgetfulness that struck me as unusual and left me somewhat dazed and confused. This can of course happen with many kinds of chaotic or oppositional children as well as those that powerfully project feelings of stupidity or sleepiness. However, closely observing my own internal state, there was a particular quality to this amnestic disorientation perhaps best described as a sudden ‘coming to’ in a new landscape with the question ‘How did I get here?’

I find I have now almost entirely forgotten the last ten minutes of the session. Is the baby material so traumatic and blinding that I have a small amnesia? Have I too had enough?

Frank 9:13

I am clearly in the grip of a ‘not-me’ experience here, perhaps under the influence of a powerful projection of dissociative forgetting and/or switching. Whilst I would have set out (paraphrasing Kipling, 2007) ‘to keep my head when all about are losing theirs and blaming it on me’, endeavouring to articulate and diminish the children’s fragmentation, it turns out that instead as their therapist, I sometimes ‘caught’ the amnesia with them. Baker writes eloquently about such moments in her paper ‘Dancing the dance with dissociatives’, delineating how important it is to examine such ‘not-me’ events for significant unconscious information: ‘we may conceptualise ‘the dance’ as in part a mutual enactment in the therapy which brings us a richer and closer understanding of our dissociative patients’ (Baker, 1997 p.217), telling us far more potently than with words ‘what it is like to live our patients’ lives’ (ibid. p.219). Here then was a very small dose of dissociative living for myself as Frank’s therapist, time spent (lost) in his shoes.

6.3.5 Is dissociative amnesia distinctive?

It is striking how varied the capacity for memory was in all three participants, so that intense hypervigilant storing and recall alternated with complete absences and memory items themselves that might be accessible at one session and then not at the next. Kayleigh worked very hard with her dissociative difficulties to restore an integrated unitary narrative. However for Frank and Robbie, episodes of forgetting exposed by a gentle reminder from the therapist were not generally greeted with the usual 'Ah of course, *now* I remember!' indicating that memory has been successfully prompted in a helpful re-integrative fashion. Instead when faced with the challenge of memory losses these tended to be dismissed, argued over or silently incorporated as if to deny the disparity. This is congruent with an internal dissociative landscape dedicated to the avoidance of anxiety-provoking or painful mental content, neither Frank nor Robbie were motivated to reach out for a less dissociative life, both functioned in their internal dissociative homes as though amnesia was just part of the furniture, sometimes useful sometimes just there.

6.4 Alternative Identity Relations

AR: Alternative Identity Relations - *the child communicates explicitly about how the alternative identities relate to each other and the host personality, how each does or does not take control and so on.*

Robbie showed no explicit awareness of his swiftly alternating mood states as distinct entities. He did once notably spend several minutes and a great deal of energy stuffing the beloved teddy and other soft toys inside two larger hollow soft dolls, exclaiming with joy when the compressed creatures burst back out again (R 4:11), but whilst this anarchic play struck a chord with my own experience of being with him - one of trying to endure the relentless bursting forth of his diverse and demanding states of being - any metaphorical significance was certainly lost on Robbie himself. However as, despite the anarchy, I began to build some understanding of what qualities he had invested in a tribe of imaginary objects and to give these credence by remembering their powers and being tender to their needs, some symbolic to and fro became possible between the various aspects of himself he had projected into whatever receptacles had recommended themselves for the role. Gradually, as we might hope for any young child in psychotherapy, symbolic interactions became an alternative to acting out, though these

remained very much a minority activity for Robbie. He sustained small play-acted scenes showing compassion to baby parts of himself lodged in the teddy, for instance by picking up the paint brush between his paws and 'helping him paint' (R 5:15) and allowed himself to share both good and evil roles in a sand tray drama 'I'm sand man as well as spiderman - I can be sand-man too!' (R 13:4), eventually incorporating the idea of a team who could together resist attacks 'You can't break our bones!' to get the job done (R 13:11).

By contrast Frank's alternative identities were fluidly in relationship with myself and each other with varying degrees of co-consciousness and he was often quite aware of using these different ways of being to manage stress, to bring him pleasure or get me to behave as he would like. Frank could be fairly said to be 'living as a group' who together took a stable approach to the challenges of interpersonal relating and each of whom could be more or less voluntarily called upon when the occasion demanded it as well as 'triggered' involuntarily when emotional stimuli were very intense. Unlike Kayleigh who divulged the details of her relationship with her chief alternative identity *Priti* against a tide of internal resistance, Frank was often able and willing to give me details about *Vanessa*, *Ben+ Ben* or *Little Frankie*, and seemed able to slide into each at will. Disabled *Vanessa* was particularly useful when it was expedient for 'the Frank group' not to know something or not to be challenged intellectually, she had learnt that being stupid lowered others' expectations, *Ben+Ben* were not only their own play-partners when bored or lonely but also very good at engaging others in play and certainly Frank's reports of his contact visits with his mother would suggest that he spent most of these as a much younger *Ben+Ben* version of himself. Similar examples are illustrated in the process material given in the sections on the varying capacities and amnesia extracts above (6.1 and 6.3). Over time we were able to make a book together of the 'vital statistics' of the group, with Frank contributing details about age, intelligence, gender, and 'how they feel about the sex stuff'. Unbeknown to me at the time this was intuitively close to the 'mapping' approach advocated by Kluft (Kluft, 2000) as part of an 'invitational inclusionism' of all the dissociative identities in the initial phase of a psychoanalytically based treatment (Kluft, 2009, p.608) for DID, and features in the programmes of Silberg, Marks and Struik with dissociative children (Silberg, 2013: Marks, 2014; Struik, 2014).

Although some survivors with DID find ways of living a productive and peaceful life 'as a group' 19 the mental confusion and memory losses that accompanied such a coping strategy for Frank are sufficient to judge it 'dysfunctional' quite apart from the huge irritation felt by all those caring for or teaching him. Very fine observation of how Frank used his dissociative identities suggests the chilling possibility that he may have had to manage a perverse collusive knowledge of shared pretence.

Later as Ben+Ben *he begs for me to 'guess' where a plastic bucket is buried. The bucket is large, the sand tray small so it is impossible to genuinely hide it. I refuse saying that this is a 'dumb' game (Frank and I have reached an understanding of the word 'dumb' which means a deliberate stupidity). I add that I could only play it if I pretended that he and I do not both in fact know where it is hidden but we do.* Ben+Ben *continues to fill containers in the tray but then slides into another state and at several points pulls a very contorted false smiling face. At first I am only able to remark that this is a horrible face, saying that Frank is not happy with me or in himself, yet he is making a smiling face. Later I am able to name this as a 'false smile'.*

Frank 2:13

It is one thing for a traumatised child to develop a part of the self that gets good at 'going dumb' on experiences that it is too painful to know about or where 'going dumb' protects the fragile ego of a caregiver by allowing him or her to feel like 'the superior clever one', but here *Ben+Ben* seems to be inviting me to 'go dumb together' with him. Frank's world of relating seems to include the possibility that a dissociative state may not be just what a victim develops as a consequence of abuse or neglect, but that a perpetrator could encourage or coerce dissociation in the child. It seems likely that the trauma approach of Silberg (2013) or Marks (2014) in which dissociative identities are accepted as having a broadly 'helpful' role would be hampered by this sort of perverse coercion, where coping strategies are openly bent to the will of the abuser too. With hindsight, though, perhaps my horror at his invitation as proof of an even more damaging more perverse dynamic is naive. If a child is being persistently exploited for adult needs then why should any part of the self be immune to abuse? Should I really be

[19] For a fuller discussion of DID sufferers who espouse living as a group see Alderman and Marshall (1998) especially Chapter 5 '*How to manage living with DID'*

surprised that for some children, possibly like Frank, even his defensive manoeuvres become 'grist to the mill' of his abuser(s)?

Kayleigh's alternative identity relations not only illustrate a more hopeful trajectory but also give a fine insight into how a dissociative young person may experience the relationships between their dissociative states. One of *Priti's* chief roles was to protect Kayleigh from being victimised, and another to be the socially confident one, the 'go getter' when Kayleigh felt unable to manage, but the power relations between the two of them were continually in flux. After asking me to explain the difference between a brain and a mind Kayleigh spoke movingly about how she had always visualised things inside her head:

Kayleigh goes on to describe the 'space ship' visualisation of how she understands her mind. She says that she thinks she has always had this, she thinks she had it even before Priti *was around to take over (the panel) and before the abuse (aged 8). She takes some time and uses gestures to explain that even though she knows its not actually the case (anatomically) and that her brain resides physically all the way down from the top to the bottom of her skull, she thinks of her mind as being at the very top of her head and then the next bit down - she gestures to incite a band across the level of her eyes - as being the 'control panel'.*

Kayleigh 9:22

Kayleigh's description is uncanny given what we are coming to understand about dissociative processes being initiated and mediated by brain stem and diencephalon (lower brain) structures' implicit responses (Schore 2009; Perry 2005). Kayleigh went on to elaborate that different parts of her could come down from the top of her head - her 'mind' to be 'at the controls', including an 'autopilot' setting for frightening situations in which it was not a good idea to fight, and that whilst sometimes she would allow *Priti* to take over, for instance when about to go to a party or in drama classes, at other times of high stress or distress *Priti* would just take over unbidden. Meltzer writes about something of this kind in relation to a fragmentation of the self in schizophrenia and how split off delusional systems take over, namely that '…the 'organ of attention' is highly prized and struggled over by the various parts of the self because of its direct access to motility…' (Meltzer, 1992 p.118). For Kayleigh these occasions of

involuntary ‘take over’, were when things could get troublesome and she could not then remember all that had gone on. However, most of the time, Kayleigh spoke about *Priti* co-existing with her ordinary self in relative harmony. *Priti* could function as a helpful internal older sister urging caution -

Kayleigh spontaneously brings Priti *into this and tells me that* Priti *said to her ‘You don’t have to tell her (a new friend) everything, just tell her what she needs to know’ I make something of this and point out how helpful* Priti *is being here, really acting to protect Kayleigh from the part of herself that might launch into giving all the details to someone she’s only just met.*

Kayleigh 6:7

- or encouraging Kayleigh to stand up for herself:

For one of the first times in our sessions Kayleigh spontaneously gives Priti’s *reaction of internal cheering when Kayleigh stood up for herself in the face of some verbal teasing about her mental health at school saying ‘Well done well done!”*

Kayleigh 3:12

Priti here is functioning almost as a supportive super-ego, encouraging and directing from the sidelines, however Kayleigh also spoke about having to limit *Priti’s* potential excesses, so that she *Priti,* then became an internal champion through whom aggression could be expressed but restrained:

Kayleigh relates how in this incident she (K) had to ‘hold Priti *back from punching them, because she was all ready to punch them so hard!’*

Kayleigh 3:14

Kayleigh was even able to outlaw *Priti* from coming on holiday to Thailand because she was so anxious at how far *Priti* might take things with the boys she was likely to meet following the trouble she had caused with Josh. Kayleigh and I worked hard to find a shared form of words which we could both use to describe their relationship, eventually arriving at ‘*Priti* is real but she does not have her own body’. Whilst sometimes it was clear that this limited *Priti’s* physical capacities:

K tells me that 'she (Priti) *couldn't have done anything anyway' not because she isn't strong but because although she can walk and can touch things, she can't really move them.'*

Kayleigh 1:17

at other points *Priti* clearly could take over entirely and was a fully physical agent in the world at large.

Fairly swiftly into our work together there were some signs that Kayleigh understood how problematic a divided self could be, voicing concern that an employer might not understand (K 9:14) and worrying that if she became a mother her children might get very confused (K 8:13). However her internal representation of *Priti* reveals how very 'real' and simultaneously 'not-me' she understood this other part of herself to be:

Kayleigh expresses compassion for Priti *saying she wishes she could get her out like 'with a plunger', gesturing the motion of a suction pump, and 'then put her into a free body'. Kayleigh goes on to muse compassionately about what it must be like to not have a body of your own but to 'be trapped inside someone else's head'.*

Kayleigh 8:11

It is easy to see how some children with dissociative voices or identities might easily construe their condition as one of spirit possession, rendering them vulnerable not only to a psychotic misdiagnosis but also to manipulation by unscrupulous or religious carers.

The clearly related themes of how the child therapist approaches dissociative identities and their attitude to the integration of these are discussed further in section 7.1 and 7.2 to follow.

6.5 Identity

Id: identity - *there is material relating to the child's identity, to dress or clothing or appearance, the nature of transformation, also to joy at being specifically noticed or at having a 'real' drama/life event to relate.* On gathering and re-scrutinising the **Id** extracts three connected themes were well evidenced**.**

6.5.1 The use of a 'second skin'

It is hardly surprising that issues concerning vulnerable or fragile identity should be apparent in the therapy sessions of children and young people who present with dissociative pathology. What emerges and recurs within the material from our three participants is a constructed, somewhat brittle sense of identity in which the 'second skin' (Bick 1968, p.484) of clothes or costumes fulfil a containing role. Esther Bick identified the concept of a 'second skin' following close observation of how young infants may develop a 'type of muscular shell' (ibid. p.486) when their parent is unable to contain the initially disparate parts of the baby's personality which 'in their most primitive form…are felt to have no binding force amongst themselves' (ibid. p.484). Bick's description of the cohering function of the actual caregiver in relationship with their baby is essentially similar to formulations that would come later whether this is the modulation of discrete behavioural states (Putnam, 1988 p.25-26), the organisation of neural systems (Perry, 1995 p.275) or intersubjective mentalising (Fonagy, 2002), all dependent on the active presence of an attuned parent.

For Kayleigh it was imperative that she 'looked right' if she were to interact with anyone, and this went beyond ordinary narcissistic teenage preoccupation.

Kayleigh gestures to her very short skirt smiling and I say that I have noticed she is showing a lot of leg. Kayleigh tells me that she 'cannot stand' her uniform, and so changes out of it every day before she even begins the journey home…she talks about how she hates the long skirt….she shows me that her uniform is stuffed into one of her bags and tells me that she never starts the journey from home in the uniform either, because of potential trouble from the people at her old school who might have a go at her and also realise where she goes to school now if they saw her in it. She tells me that she always has another outfit on underneath her school uniform, so that she can just take it off if she needs to. She describes this as a cumbersome but necessary way of managing, sometimes involving breaking her bus journey to go into a store and change. The whole suggests an accepted imperative of having to be able to 'make a quick getaway' or of being a 'quick change artist'….Kayleigh goes on to talk about how she like things to match, listing 'you know, the skirt to match with the shirt and the jacket,….and details about how her family will say to her 'oh stop making such a fuss, you don't have to look exactly matching all the time!' but she feels that she must - does

not even want to come downstairs to greet a visitor unless she has put the right clothes on.

Kayleigh 14:5-7

Kayleigh reveals some of her assumptions about identity here. Identity is related to trauma in her sense that, chameleon-like, it is important to be able to alter how she looks rapidly and completely in order to deflect the wrong kind of attention, and also to a thin or fragile internal sense of self that requires the external skin of what she is wearing to 'match' in order for her to function socially. Both these assumptions may be consequent on a dissociative internal landscape formed when a younger Kayleigh had to shift her approach to parents or peers in order to keep them sweet in attempts to elicit the 'right' kind of attention and deflect the 'wrong' kind.

From Frank's material there is only the one coded item which is detailed below (F 11:4-5, section 6.5.2) though he too used a number of 'props' to help him inhabit various personae, on occasion purloining my bag or arriving with a stolen headscarf in order to mince about the room in camp parody of a sexy woman. Robbie's preoccupation with the potential of 'suits' to transform his identity, literally the donning of a 'second skin', account for over 50% of the Id items from his material. His fascination with the perceived power of super-hero/villain costumes is discussed in greater depth below (section 6.5.3).

6.5.2 Shared delight in emphatic 'islands' of identity

Perhaps more hopefully the session material also threw up repeated examples of attempts to share delight about signifiers of identity. For Frank this is a moment of pride in a new pair of trainers he has been given:

Frank appears at the other side of the hall with a shy smile. As he crosses the hall to the therapy room I notice that he has new red trainers on. These are far more flashy and expensive than anything he would normally have, and Frank is not at all the sporty type. I say 'Hello' and Frank glances at me, coy but innocent as though pulled between behaving entirely normally, as if nothing of significance is happening, and yet also wanting to look to see if I have noticed the shoes and am going to look at him differently now. Frank sits down and at once tries to tie the laces. This feels sweet rather than

ostentatious. I say with some quiet reflective admiration that I can see he's got new shoes on. 'Yes' Frank replies with content pride, a rare uncomplicated response. Frank persists with trying to tie the laces which are too short to manipulate very easily. He tells me 'They are Nike, very expensive.' I smile and comment that they are a very bright red, 'Yes' says Frank, very satisfied. I ask where he got them? 'Craig[20] *gave them to me,' Frank tells me with obvious pleasure and then, with a little nervousness 'I thought I'd wear them to show you.'*

Frank 11:4-5

Perhaps rather poignantly there would be nothing remarkable in this exchange were it not for the normal context of Frank's sessions in which little is coherent let alone simple.

Work with Kayleigh produced many such moments. For instance she always arrived in the waiting room with at least two over-stuffed carrier bags which seemed to serve both as an additional indicator of her presence and as a metaphor for arriving with so much 'emotional baggage'. She quickly took up my observation and enquiry about these and volunteered her own observations as a way to make contact with me about what sort of state she had arrived in, reliably smiling with pleasure at the evidence of my interest:

Kayleigh arrives early at the clinic, she smiles easily as I go past to set up the room, and then comes with a broad grin saying 'I've got loads of bags today' as she follows me to the room.

Kayleigh 3:5

When it is time to come she hears me at once and immediately, picking up two bursting bags, announces 'I've not got as much stuff today, not so many bags' with a teasing grin.

Kayleigh 6:1

These exchanges *felt* delightful and unexpectedly innocent for myself as the therapist too, as though I were a parent intuitively engaged in reflectively confirming a young child's burgeoning discovery of 'who I am'. For Frank this might be something like

[20] Craig is a member of staff, there is a culture of passing on unwanted clothes etc. in Frank's children's home though not usually something so glamourous.

‘We both enjoy you being a boy feeling proud of his great trainers’ and for Kayleigh ‘Yes, we both know that you are someone who comes with bags of stuff!’. In Fonagy’s terms could this be the re-emergence for Frank and Kayleigh, who now find themselves engaged with the safe attentive non-frightening mind of their therapist, of their biologically pre-prepared capacity for intersubjective metacognition (Fonagy, 2002 p.79), a mentalising which momentarily undoes the disaggregating effects of dissociation and which is, poetically, ‘giving back to the baby, the baby’s own self’ (Winnicott, 1967 p.33)? Both Frank and Kayleigh delight in our minds uniting around looking at and describing a very concrete aspect of their self, a boy-with-great-trainers or a girl-with-stuffed-bags. These identity-building communications are not sophisticated, illuminating or finely interpretive but they are powerfully affectively attuned and surely mediated by our emotional right brains in the way Schore asserts is at the heart of regulating and transference exchanges in the consulting room (Schore 2003 p.43). As Bromberg has it ‘it’s not the linguistic content but the emotional content that teaches her she is understood’ (Chefetz and Bromberg, 2012 p. 181), and it is this sort of repeated resonant understanding that builds the sense of self. In her tender paper concerning ‘the little creature in the corner’ Richardson refers to such shared interest as an important element of Supportive Companionable relating (Heard and Lake 1997) and is clear that these moments are ‘not an updating of internal working models as such but *the construction for the first time* of a benign representational model of caregiving and care seeking’ (Richardson, 2002 p.155 italics mine). Building on Kleinian concepts Alvarez too argues that therapeutic work with deprived and abused children necessarily involves paying attention to a *‘lack of development of the good self and the good objects’* (Alvarez, 2012 p.74 italics in original), and advocates that a therapist actively articulates the ‘pleasure, safety and delight’ between therapist and child:

> ‘When we are working with seriously deprived children whose external objects have been unable to receive these loving projections, we often get a sense that the children have given up and we have to work, as it were, from both ends: that is, from the problem of the inhibition of the child’s love or failure of his trust, and from that of the internal object’s incapacity to like or care for the child.’
>
> Alvarez, 2012 p.74

Kayleigh’s relief in sharing signifiers of identity extended beyond her ‘second skin’ of costume (11:2, 14:5-7, 15:2-4), or a formal diagnosis (2:12) or reaching a milestone birthday (2:2) to showing great satisfaction in telling me about moments which clearly felt emotionally authentic to her. She is pleased to be feeling something genuine, an

emotion she can name and, perhaps most importantly, *for a reason that others accept*. When telling me about the distress caused by her liaison with a young man who turned out to be already married for instance:

Kayleigh smiles 'I know' but bumbles happily on telling me that she has mixed feelings about him now, whereas he seems to think everything should be ok between them. She expresses some heartfelt anger about her sense of being deceived but again moves on from this and instead tells me several times that she 'has had a very emotional day' with almost conspiratorial pleasure. I reflect as I have so often to myself that she is so relieved to find herself to be having real identifiable *emotional responses. Within the room, the distress is real, the excitement is real and so is the enjoyment of the attention that having these real problems / excitements brings from peers, teachers and myself.*

Kayleigh 6:6

Kayleigh finds it satisfying, almost wonderful, to experience a genuine emotional response to an event others witness. Robbie's material offers a similar example:

Robbie yawns and says that he is tired. There is a small pause before it is as though a light bulb has gone on, he has remembered something important, and he announces emphatically 'VERY tired!' with a dramatic irritation. It is clear that there is a story to tell, I ask why he is tired. Robbie exclaims in a louder angry explosion 'Because Matilda (younger sister) kept me awake. She's supposed to be sleeping in the night room but she keeps putting the light on in the hall so I can't get to sleep!' I agreed that this sounded very frustrating, not to be able to get to sleep when he needs to. 'Yes it is.' Robbie answers with solid satisfaction.

Robbie 8:3

Robbie's angry state is usually free-floating, incoherent, punitive and rapidly abandoned for his sweet-toddler or moany-toddler incarnations. Here he conveys a sense of emotion causally linked to an event which, as for Kayleigh, others have witnessed; Robbie is very pleased to be sharing a narrative about himself in which he is 'right' to be having the feeling he has authentically experienced, and he is also pleased that I have heard and understood it in a similar way. This is a brief moment in which his inner and

outer worlds match up, and Robbie appears to feel his 'self' is confirmed, the 'me-which-is-justifiably-angry'.

There is an important technical difficulty to watch out for here when working with dissociative children, or indeed with allied groups such as those with emerging personality disorders or emotional intensity disorders in which the sense of self can be equally fragile. Identity can become all too easily constellated around dramas into which others get drawn to try to ameliorate or manage risk. Where a sense of self in the other's mind is only keenly felt when risky behaviour makes that other take action, a thin sense of identity can become fixed to this sort of cycle, and there is a danger that the therapist's understanding is incorporated as collusively confirming rather than challenging the behaviour. With Kayleigh the key seemed to be to not only offer the attuned interest and reflective confirmation of her 'self' as she discovered it, but also to gently analyse her felt satisfaction at being noticed and recognised and to connect this with what she had missed out on:

Following a conversation in which I am clear that it would not be right for her to have an actual romantic relationship with her male teacher, I…say that this is reminding me of the things we talked together about last time, the ideas I shared with her about how little girls, toddlers, are often the 'apple of their Daddy's eye' and flirt with them in a very safe non-sexual way, ideas which (I remember aloud to her) she was intrigued by and found quite new and unusual. During this I too find myself reconnected with the conclusion we arrived at together, and remember to her our idea of how lovely it is to feel herself to be this male teacher's favourite, and how especially lovely this is for her because she has had so little love from any Daddy person in her life. Kayleigh beams.

Kayleigh 2:5

6.5.3 The nature of identity and transformation

Items from Robbie's material coded for **Id - identity** illuminate the adhesive and overly concrete nature of his thinking, in which symbolism veered more towards symbolic equation (Segal, 1950, 1979). In this vein Robbie regularly revealed his conviction that lathering an object in paint would transform its identity whether this was an inanimate object like a toy bus (11:6) or his own hand (4:8), and behaved as though making and adopting a costume would confer all the powers of the character, for instance that a pair of cardboard tentacles and iconic black spectacles will turn him into 'Dr. Octopus' with

the implication that I will have to 'watch out!' (8:13), i.e. that he will become genuinely dangerous to me once he has these accoutrements. Robbie seems to conceive identity shifts as 'non-linear' much as Putnam described the shifts between infantile behavioural states (Putnam, 1988 p.25), viewing this aspect of what should be play through his own uniquely dissociative lenses.

Robbie's internal assumptions about transformation of identity also showed in his language; he did not use the conditional words to create an 'as if' description, but instead spoke about *making myself into Spiderman* (4:8) as if no pretence were involved:

Robbie says clearly as he enters the therapy room 'I am Spiderman'. I ask what he means when he says 'I am Spiderman' ? 'Not you, me!' Robbie replies emphatically showing a verbal confusion of person. I say that I understand he means himself, that he *is Spiderman. Robbie says 'Well I'm waiting to sew a suit.' as though this is, obviously, all that is required. I say he's waiting to sew a suit and then he will* look *like Spiderman. I am fishing a little here, wondering how much fantasy and reality he can distinguish. Robbie goes on 'Well I will still need the webs, I need a spider to bite me and a make a mark and then I will have webs'*

Robbie 1:7

Howell elaborates that dissociative minds can be:

> …especially plagued by difficulty in grasping the subjunctive as a mode of thinking about the self and other. One way of understanding this is in terms of the lack of intercontextualisation of alternate perspectives and realities that can be simultaneously compared, because trauma can strip away the sense of context
>
> Howell, 2005 p.100

Robbie seems so caught up in his own internal equivalence of 'I, Robbie, am Spiderman', that he does not hear the reported speech of my first question and mistakes my meaning, jumping to a conclusion that I am challenging him or being very stupid. Much more significantly though Robbie does not use the future conditional to inform me about a pretend or possible transformation, 'I would need a spider to bite me and make a mark and then I would have webs' but instead uses the future definite verb 'I will…' to tell me about a certain transformation of identity. Robbie could not shift with permeable fluidity between playing and reality and this showed in how he spoke was about his play intentions: 'In the language of trauma…the symbolic in unavailable and …literal thinking prevails' (Sinason, 2012 p.42) Robbie's speech and behaviour suggest

that he could not symbolically enjoy inhabiting the character of Spiderman in his mind or in imaginary play, he could only aspire to Spiderman's heroic superpower by literally becoming Spiderman.

6.6 Responsibility

R: Responsibility - *the child takes responsibility when something is not his/her fault, the child erroneously ascribes responsibility to another, there is a lack of appropriate sense of agency (hypoagency), there is omnipotent phantasy in evidence (hyperagency).* This code appeared more frequently than I had anticipated, although a closer re-reading of the items collated suggest two parallel sets of phenomena, the first set of items concern a theme of agency - a marked presence, absence or conflict in the self's power to act, and a second set, notably from Robbie's sessions where responsibility for troublesome events was wholesale projected into myself.

6.6.1 Projection of responsibility

This second set of items merits brief description but is not essentially dissociative in dynamic and the items have much more the character of a spontaneous habitual projective evacuation into myself of moany-Robbie's unwanted feelings of failure, for instance when his painting went wrong (R 1:2, R 5:16), of disappointment, for example at having to wait for paint to dry (R 6:14), or of physical pain, such as when he fell off a chair whilst trying to do a trick (R 13:9).

Robbie holds the teddy in one hand as he paints with the other. He references the teddy repeatedly and tries hard to faithfully reproduce the shape and colours, largely successfully until he…does not wash the brush so that the yellow paint becomes brown. He is furious and throws the paint brush on the floor marking the Halloween picture. He moans and complains at me and I say he is talking like this is my fault, like I have made a mistake or ruined his picture, but he is the one who did not wash the brush and got the paints mixed up. 'No it's your fault you did it!' I say that he does seem to want to make it my fault. 'Shut up you knob!'

Robbie 5:16

My counter-transference feelings, which I did share with him when I could, sometimes with quiet humour, were of being cast in the role of a 'bad servant' (R 6:12, R 13:23),

always failing in my duties of care out of meanness or laziness against a standard which he set of almost telepathic anticipation of his needs (R 4:3). We could understand Robbie's behaviour as an attempt to escape from uncomfortable feelings of vulnerability and inadequacy by lodging them in myself and subsequent feelings of being persecuted by dependence on such a hopeless impotent therapist. My therapist-centred interpretations emphasising what I was to feel and how justified he felt in castigating me led to some small moments of insight for Robbie so that after some weeks he was able to let me see, by his knowing smile, that he understood *he* had indeed made the paint marks on the door despite his apparent denial (R 5:10) or *himself* deliberately damaged the exercise book he was complaining was ruined by me (R 13:21). However these exchanges are neurotic at base and familiar to many therapists trying to engage children who have experienced inadequate early care, the territory is hostile but the child demonstrates a fundamentally organised approach to engaging them albeit as a deprived victim who can never be rescued or satisfied.

6.6.2 Confusion over Agency

More pertinent to an investigation of dissociative phenomena were **R** items relating to a theme of agency, largely from Frank and Kayleigh's material. Most striking were a substantial group of extracts that exposed their difficulty in knowing what they should or should not take responsibility for and when it was ok to take initiative or not. For instance both spontaneously apologised for how they arrive when it is raining outside:

Kayleigh exclaims 'And I'm really wet - sorry about that!' I acknowledge this with my expression… She does not in fact look terribly damp and I am struck by her apologising for something which a) I am unlikely to mind and b) is beyond her control. It reminds me of how she speaks about the abuse from Anthony when she was 8, berating herself and saying that she 'should have known, if only I'd known'

Kayleigh 6:2

Frank comes to the door apologising for wearing his coat saying 'It's because it was raining and I didn't want to get wet.' (Of course this does not really require an apology, I am not someone who has ever minded the wearing of a coat!)

Frank 12:3

Both seem unable to reach a reasonable expectation that I would not see the rain and their coping with wetness as their responsibility, but would naturally understand that 'The rain rains on the righteous and the unrighteous' (Matthew 5:45), that inclement weather is in no way their fault. In a similar vein Kayleigh presented at her appointment time with bad laryngitis (K 10:1), just to whisper a heartfelt apology for not being able to attend that week; she should have been in bed but she clearly felt the sickness was somehow her responsibility and that she needed to make amends to me.

Dissociative children, who have compartmentalised contradictory IWMs of themselves and others (Liotti, 2006, 2009) are placed in the confusing position of not being able to ascertain who should be responsible for what or even what they should be worried about. At base we might speculate that this occurs for children whose parents were unable to offer adequate contingent responding (Murray and Trevarthen 1985, Tronick, 2004) who therefore have not been sufficiently helped to discern what is pleasurable, what is remarkable and what is alarming.

Kayleigh then says in a rush that she knows 'other people have it much worse' and that she doesn't mean to be self-pitying. We acknowledge together how within her family making a fuss about something is often disapproved of, both her mum and her aunt can feel she is being histrionic, over-dramatic, self-pitying. I comment on how hard it is for her to know inside herself what it's ok to make a fuss about and want some comfort for and what she should just shut up about and try to forget.

Kayleigh 11:18

The deficit I am describing here is essentially a relational deficit, concerning not just learning about potential pleasures and threats in the material environment but also about how their attachment figure *thinks* about them and is likely to respond to and with them. What Kayleigh feels about an event is not matched by her mother and aunt's feelings about the same event, she is not validated. In the 'wet weather' exchanges above neither Kayleigh nor Frank show the developed fluid metacognitive capacity which might help each understand what might be going on in the mind of whoever they are with. They mistake my mind, failing to discern that they are in relationship with an attentive empathic caregiver, for whom no apology is needed. Fonagy is clear that dissociation and multiple voices are the opposite of mentalisation (Fonagy, 2002 p.79),

so when we encounter evidence of limited or absent theory of mind in our child patients' distorted assumptions about responsibility, dissociative pathology is likely to be not far behind.

In addition an adaptive dissociative turning away from relationship as a young child can leave a maladaptive legacy of not knowing what is dangerous and what the self must defend against in the present. Kayleigh berates herself for 'returning to the scene of the crime' in both episodes of sexual abuse, feeling that she must *'give them the benefit of the doubt'* (K 11:21); this seems pitifully similar to how an infant might feel when faced with approaching a caregiver who has hurt them 'I need them so much that maybe I should give them a second chance?'. This later leaves her unsure about her own responsibility in the events that follow because she re-approached the source of the danger in both her step-father and her ex-boyfriend.

Nowhere was this difficulty of judging how to relate and who is responsible for what more apparent than in the realm of sexuality. Both young people had been exposed to un-thinkable incomprehensible sexual experiences with caregivers that left a legacy of sexual preoccupation and inappropriate sexualised behaviour. Of the two Frank was far more 'in blood stepp'd in so far' (Shakespeare, 2005, 3.4:135) existing in a world he was convinced was populated by others who were similarly preoccupied with sex, whereas Kayleigh was able to use her sessions to explore her behaviour and to try to reach an idea of 'how things should be' (see the section on my use of psychoeducation with Kayleigh, 7.4 below). In the absence of this sort of help one of the solutions her conflicted mind employed was for *Priti* to function as a sexually confident go-getting aspect of herself, minus the disturbing traumatic back story, whilst her Kayleigh self could remain a compliant victim without her own active sexual desires:

I notice that Kayleigh is keen to avoid any sense that she might have desired or pursued Daniel (a boy the same age as herself met on holiday) and that she portrays all the on-going movement in their relationship as either coincidental or initiated by him. After some minutes I gently challenge her, observing how she seems to be saying 'It was nothing to do with me!' as though we must not think that Kayleigh herself might have contributed. This is particularly stark as Kayleigh describes that she 'had' to sit on Daniel's lap because there were no other chairs, and then 'had' to turn around to be

more comfortable as she was getting neck ache talking from this position. However, she continues, this involved straddling him and shortly after this they kiss. I point out to Kayleigh that actually people only really sit like this if they are sexually interested in each other, we do not often see people sitting like this in public, it is a very intimate way to sit. Kayleigh responds with authentic interest - she is genuinely intrigued by this idea of mine. I comment that it is as though she wants us both to think that all the sexual feelings are in Daniel and not in her.

Kayleigh 8:12

Kayleigh is engagingly concerned to imbibe from me how things *should* be done in romantic relationships and then eager to let me know when she has put these into practice, for instance sending an ex-boyfriend a 'low-key' message in order not to be felt to be putting pressure on him (K 11:5), but the effect is almost of 'relationships by numbers'. Kayleigh-as-Kayleigh has no internalised coherent system for managing intimate relating other than a template in which she is wanted for serving the sexual needs of the other, for her 'assets' (as she describes her breasts, K 6:16) rather than her 'self', it is not obvious to her what initiative she can or should take, so instead she consciously tries very hard to 'get it right'.

In addition the **R** collection contains many extracts in which Frank asks for permission to do something that I feel he does not need permission for, such as playing in the sand (F 2:8) or playing a game of cards (F 5:4). Sometimes this is done as *Little Frankie* (4:13), sometimes as *Vanessa* (F 9:3), and sometimes as his apparent self (F 7:4-5). Why does this not feel innocent like it might with another child, why does it not become a constellation of 'delight in identity' like Kayleigh's overstuffed bags do (see section 6.52)? Instead I feel irritated, it is false, underhand. The coded item below may offer a clue:

Frank asks if he can play in the sand. He glances at me with a smile which conveys that we both know that he does not need to ask permission. I say this to him - that he asks even though he does not need to. Frank says in his ordinary voice, pleased, getting down to the business of play, and metaphorically rolling up his sleeves 'Time to make some pancakes!' and then in Little Frankie's *voice 'Cakey-wakey cakey-wakey.' I narrate this.*

There is a *knowing* attempt to abnegate responsibility here, to foist this upon me, so that my counter-transference is of being made to take responsibility for something I am not in control of, and that somehow by simply being asked and not refusing I cannot then complain about what transpires. How like the experience of the child with an abusive attachment figure, who may ask for 'permission' to do something that the rules do not allow the child to refuse, such as 'Shall we sit and watch *The Simpsons* together?' when what may well occur is sexual fondling on the sofa, or worse. The parent does not need permission to sit and watch the TV, but the request, not refused, sets up a situation in which the child has apparently been given a choice and is therefore implicated in what follows. No matter how perverse the encounter becomes, the child has apparently consented, he or she is falsely ascribed responsibility. Something of a similar kind seems to have been happening with Frank here - no matter how infantile, disabled or sexual the 'play' might become, my permission to begin had been sought, I had not said 'No' and so I could hardly complain. Perhaps there is also a therapeutic necessity here, is Frank semi-consciously asking whether I am up for involving myself, 'to become a part of the mess in a way I could experience internally' as Bromberg advocates we must in order to help dissociative patients (Chefetz and Bromberg, 2012 p. 157)? Would a comment such as 'You want to be quite sure I'm ok to see whatever might happen in the sandpit' have better hit the mark?

6.7 Connectedness

D: Connectedness - *a notable moment of meaningful association between ideas or agents (therapist and child or two characters in a play scenario etc.) or the significant absence of such meaningful association where it would be expected'*

6.7.1 A Counter-intuitive result.

The D - 'connectedness' theme posed some problems when it came to analysis of the collated data set. Whilst it seems entirely intuitive that in a study of work with participants selected for their propensity to disconnect this might be a regular feature of interest, having begun with three dissociative participants, phenomena concerning connectedness and disconnectedness would be of interest, the collecting of all items at either end of a perceived continuum 'notably disconnected - notably connected' yielded

what were essentially two sets of data. The code group included both all data items that showed 'meaningful connection' and all those that showed 'an absence of meaningful connection' but made no distinction between the two.

My anecdotal re-reading of the complete group suggested that Frank's material yielded the most moments of connection, yet he was by far the most fragmented of the three participants. Conversely Kayleigh's sessions appeared full of moments of disconnection yet I would have said she worked extremely well in psychotherapy with myself, was consistently thoughtful and engaged, and ultimately made a good recovery from her early abuse. Keen to understand what might be going on here I systematically re-scrutinised each item within its context in the session, and then re-allocated each one, now making an additional judgment as to whether it illustrated disconnectedness or connectedness. Occasionally a coded item illustrated both in which I case I then coded it twice and registered it in each collection[21]. The full frequency table can be found as Appendix 6.7, the final results can be viewed in the table below:

	Connected	**Disconnected**
Frank	62%	38%
Kayleigh	7%	93%
Robbie	54%	46%

Table 6.7 Frequency of connected and disconnected themes within D coded extracts

The figures confirmed my counter-intuitive first impression. Whilst connectedness and disconnectedness appeared in roughly equal measure in Robbie's sessions, for Frank and Kayleigh it seemed that personality coherence (strong for Kayleigh, fragmented for Frank) correlated inversely with moments of connectedness. What could be happening here?

[21] This necessarily made the total number of items coded slightly larger since some, initially just coded once, became coded for each.

I would hypothesise that observer bias is playing a significant part, with a clue staring at us within my original definition. The description of the code is of 'a *notable* moment'. Is it possible that what is being coded for is not simply all items in which a theme of connectedness or disconnectedness could be discerned, but only those which the observing therapist-researcher found 'notable'? Whether an item is notable is entirely dependent on the context in which it is viewed: a sea shell is not as notable on the beach, where we might expect it, as it would be on the forest floor. Even though I was only just starting out in therapy with all three participants, I already had a sense of the general state of connectedness both intra- and inter-psychically for each. As a psychotherapist I am primed to observe, articulate and explore not only the pathological landscape as it unfolds in the patient's interactions with me, but also to notice the often all-to-brief moments where something more positive occurs, to wonder about these and to build on them. So in my encounters with Frank in the consulting room, it is likely that I would pay especial attention to where the business-as-usual of his chopped up and fragmented presentation gave way to something sensible or cooperative.

With Kayleigh the process was the same, but the emphasis inverted by her presentation: she is cooperative, motivated and engaged in the room with me, yet the moments of disconnect, where affect does not match narrative, where she finds herself confused by a straightforward idea and so on are often the most informative. So in my encounters with Kayleigh, it is likely I would pay especial attention to identifying and noticing where coherence gave way to incoherence or something that jarred. Borrowing the language of the Structural Dissociation model (Steele et al, 2009 after Myers, 1940), Kayleigh attended her sessions as her ANP so my job necessarily veered towards watching out for and then bringing into sharp focus the indicators of dissociative states that were causing her such trouble. With Frank the direction of travel was in the opposite direction, he spent his time with me (and pretty much everyone else) in a travelling circus of EP players and an ANP that only occasionally made a relieving appearance. No wonder this is what I noted both first time around and when I then trawled my process recordings for sightings of 'notable' connection or disconnection.

6.7.2 Moments of Re-connection

Taking a brief closer look at the **D** extracts from Frank's sessions, the moments of connection are often occasions of *reconnection* when a switch back to sanity has

occurred, or when a lost capacity or an amnesia are restored. Again this is hardly surprising given that these symptoms are indicative of dissociative moments of disconnection. For instance having argued with me over his belief that he has been at his present children's home for four years, as he gets ready to leave Frank then has an entirely sensible 'connected' conversation relaying an accurate expectation of the altered arrangements concerning when we would next be meeting for therapy (F 2:1. 2:17). In addition there are several extracts that illustrate how Frank was very able to 'scrub up good' and step into sensible connected communication when he needed to organise something practical, for instance making the case for me to get a toy phone for the therapy room (F 4:12). However neither of these sub-groups appear to have anything extra to offer to a broader understanding. Perhaps more pertinent are **D** extracts where some intersubjective meaning is the prompt for the coding. The sustained play Frank developed with me in which a pet is being taken to the vet and we take turns to be owned or veterinary furnished many such moments of connection; the following extended extract shows coherent symbolic play:

Frank brings a dog that is not doing what it's told. I ask if this is a problem with the dog's hearing or is the dog being disobedient? Frank says both. I ask if the dog can hear other things, birds etc. Frank says it can and also that it hears the microwave door ring when its food is ready and it comes running (I wonder to myself what noises signified food coming for Frank when he was small?). I say that then I think it must be a problem with their relationship, has anything happened recently? Frank says that he shouted at the dog because the dog would not do what he wanted it to, he told the dog to come in and it wouldn't. I (as vet) say that I am going to send them to dog training classes together. Frank asks haven't I got any tablets that would help? I say that I do not think this is a problem tablets can solve, I think it is a relationship problem….(There follows a conversation about his taking tablets, how he understands the staff use these, some slavish compliance with medication versus a sceptical view about whether it solves any problems)…

Frank 7:10

Within the play Frank connects with me in a way that makes sense, explores ideas and builds further meaning together. He demonstrates a shared understanding of cause and effect and the narrative between us is not disrupted by elements too bizarre to be incorporated, effective curiosity can be expressed and with it the opportunity to

formulate experience together and make new meaning, precisely the opposite of dissociation (Stern, 2009 p.660).

6.7.3 Dissociated disconnection

On reading the **D** extracts collected from Kayleigh's sessions there are some striking examples of where her account of events leaves out a glaringly obvious link to a conflictual emotion or thought, yet her narrative is fluent and emotionally congruent.

Kayleigh launches off into a gleeful narrative about Mr. E. (her teacher). She tells me excitedly that two friends have separately noticed that he pays her special attention, for example showing her the page number in her book when he is not doing this for any other of the students, and various other small attentions. Mostly these sound like the kind of things a concerned teacher might do for a needy student, but there is also, Kayleigh reports, some bantering and a mutual sense of humour. I am aware of the risks that there may be here, of Kayleigh somehow inadvertently declaring her love, or Priti *taking over to do so….Later on she adds that she has told Mr. E about her 'problems', including the existence of* Priti. *It is unclear whether this makes it safer in her mind. I try to steer her towards awareness of her desires, asking something about whether she finds she sometimes daydreams about what a future with Mr. E. might be like? Kayleigh is not at all offended but protests assertively that whilst she thinks he is 'fit', she does not fantasise about him because 'there's no point in thinking about anything that can't happen'. She repeats this several times and though clearly authentic I am put in mind of 'The lady doth protest too much, methinks!'* [22] *I wonder if, quite unconsciously, Kayleigh is very good at not thinking about things that might cause her conflict/pain eg. 'Actually I feel completely in love with Mr. E. and want to be with him but know it's never going to happen.'*

Kayleigh 2:6

There is something distinctly dissociative about her lack of awareness, it is as though her romantic love is 'hidden in plain sight' from herself, but staring me full in the face! Her logic of *'there's no point thinking about something that can't happen'* suggests a strong capacity for successfully banishing thoughts and feelings that are incompatible. Kayleigh is easily able to 'supplant… an intolerable reality with a more tolerable one'

[22]Shakespeare, 2006, 3.2:239.

(Kluft, 2000) As her therapist, I am left worrying that her desire will break out of this exile in the person of *Priti* to cause a troublesome drama, hence trying to *'steer her towards awareness'*. Her response of credible ignorance does nothing to allay my fears and confirms how very disconnected - dissociated - she is from this powerful thread within her.

6.8 Parental Landscape

Pa: Parental landscape - *the child's material, both content of discourse, play, etc. and the process of transference communicate about their internal working models of adults in positions of caring for them.* The sub-set of data items coded for 'Parental Landscape' was both plentiful in number, the most frequently occurring code, and rich in content. For a child psychotherapist session material portraying what the child internally assumes they should expect of adults and how to behave towards their carers is viewed as highly significant and informative whether communicated in the transference or directly in play and conversation. Nearly all the aetiological models of dissociation offer a central role to early infant-parent interactions as these are determinate of whether the child can learn to modulate discrete behavioural states (Putnam, 1988), regulate fearful arousal (Schore, 2003), and develop a competent capacity to mentalise (Fonagy, 2002) or instead fail to integrate contradictory IWMs and instead develop a stable dissociative internal world:

> The study of attachment, in summary, suggests that dissociation during personality development concerns primarily a failure in the integration, into a unitary meaning structure, of memories concerning attachment interactions with a particular caregiver.
>
> (Liotti, 2009 p.59)

The items in the Parental landscape sub-set gathered around several themes. In addition the set had collected items relating to the participants' interest in myself as an adult in a quasi-parental role and what could be assumed about me or, more hopefully, could be explored in my person.

6.8.1 Confusing / Neglectful Parenting

Frank in particular could pull us both into a confusing exchange from which I found it hard to navigate my way back to a sensible thought or even a clear narration of the confusion. For instance he might bring an important toy to the session but then make efforts to keep it from view (F 5:2, F 5:3), or whisper to himself about an intended insult

'No, I'd better not say that!' (F 3:3) so that I was left 'un-insulted' yet knowing there was an insulting thought. At other points Frank showed honest attempts to engage tenderly that got compromised by ill-attunement, for instance trying to place cards on the *back* of my hand rather than into my receptive palm (F 6:14) or plastering a lovingly made 'bracelet' flat to my upper arm adhesively (F 6:17), suggesting that on these occasions he could not make the mental leap to imagine 'you-in-your-body' and anticipate how to match his intentions to my physical form. Frank loved to play vets, and a great deal could be understood from how pets and their owners got treated. There was some successful healing but there was also incomprehensible behaviour such as a dog being repeatedly called in to the consulting room by the vet only to be sent away again without explanation or treatment (F 7:15). To my enquiry Frank described the attitude of the vet as 'tricky'[23], an apt word to describe exchanges that were inadvertently disconsonant whilst not deliberately so. The parental landscape portrayed by these sorts of items is neglectful, unresponsive or unreliable rather than actively aggressive or abusive; however for the child this is still 'tricky', and for the infant may not offer 'good enough' (Winnicott, 1953) contingent responsiveness for building a secure attachment and an organised sense of self.

> The frightening aspect of this (complex intersubjective) experience, moreover, is not always due to overt maltreatment or aggression: it can be the consequence of the infant's need for protection being met by a frightened or dissociated response from the caregiver who is not otherwise maltreating.
>
> Liotti, 2009 p.59

This parental landscape is 'tricky' for the child because they cannot get it right, caught in an attachment dilemma of approach-avoidance which cannot be resolved. Robbie regularly put me in this position:

Robbie then begins on a new picture, painting an orange circle. He asks me to guess what this is but when I guess 'Pumpkin?' moans 'Why do you have to guess pumpkin? Why do you have to go and spoil it?' I am a little surprised by this and I wonder aloud about it saying that I thought he wanted me to guess but it seems that he did not. He repeats the question with what is obviously a bat and is again cross with me when I 'get

[23] I am grateful to Frank for introducing me to this word which has been so useful with other children who have experienced inadequate care. An abused / neglected child can agree to having had a 'tricky' start in life without immediate exposure to feelings of shame and the non-judgemental tone is less likely to prompt a reaction of defensive loyalty which can shut down the conversation.

it right'. I say that he seems to want me to 'get it wrong' when he asks me this question. At the next bat picture I guess all sorts of things that rhyme with 'bat' hoping to show that I know but am getting it wrong on purpose. Robbie is not taken one way or the other with this but it does not antagonise him like the correct guessing.

Robbie 5:13

It was my job to try to attune (guess what was in his mind) but to always get it wrong, and I was roundly castigated as deliberately depriving (R 1:10, R 6:3), always losing things (R 7:7), a hopeless servant (R 6:12, R 7:8) and internally just a '*big fat pooey mess*' (R 4:6). In particular I was punished for not knowing 'almost telepathically' what was in his mind, as though he had a preconception of perfect attentive parental attunement, something that he felt should happen, but little experience of this developing through an incremental to-and-fro. Instead Robbie seemed to imagine an adhesive mentalisation, as though understanding another's mind is achieved by a stuck flat equivalence rather than a dynamic exchange, which he writ large on how he related to me.

Kayleigh also struggled to understand how her parents' and her peers' minds might work, protesting her mother's refusal to discuss her anxieties with her and mystified by some of her mother's emotional responses:

Kayleigh adds that school have made an appointment for her at the health clinic and friend B is going to go with her tomorrow. She exclaims at once 'I know Mum will be really cross about it!', looking unhappy. I ask her if she has any idea why Mum will be cross. Kayleigh looks genuinely puzzled almost bewildered and then replies that she really does not know, but she does know that Mum will be cross. 'She's cross about anything I do….well not really normal things like going out with friends, like if I meet friends in town that's ok, but anything else she gets really cross straight away.' Later I suggest that maybe Mum is thinking it's about attention-seeking rather than real upset / concern - I expect Kayleigh to agree with this, but actually it does not really find a mark in her.

Kayleigh 6:8

Kayleigh's father equally offers no helpful point of reference for her, unreliably willing to engage when he is called upon though giving utterly unhelpful advice after the

assault by David (K 1:15) but unable to keep any boundaries for either of them so that he shares joints with her (K 6:16, 16:20). So much for Kayleigh's report of her real-life parental landscape, but it is the internal parental landscape full of consequent attachment confusions that shows itself when she is trying to judge the character of young men she might consider as boyfriends. Kayleigh's spends a lot of mental energy debating whether she should consider or stay with certain young men, yet she is entirely unable to use the evidence in front of her to assess whether they are likely to be safe and caring or not. One candidate is a young man who was present when others filmed her being beaten up, but as he brought her back her shoes afterwards she cannot tell whether he is a heroic saviour rather than a cowardly bystander (K 11:10); later a different boyfriend is charged with having seriously injured another young person and Kayleigh hesitantly tries to work out whether she ought to forgive him because, after all, he was just trying to defend himself (K 14:11).

6.8.2 Perverse / Abusive Parenting

It is counter-intuitive that items gathered from Frank's **Pa** codes as 'perverse' or 'abusive' did not induce confusion in me so much as disgust and a desire to robustly assert sanity. A dominant theme was of 'nasty-is-nice' as the following disturbing excerpt illustrates well enough:

Today Frank plays only with the girl baby and his feeding and attention are interspersed with his own greedy sucking on the bottle. He cuddles and strokes and kisses the baby in an overly sensuous way which feels a little sickly. He fills the bottle from a tub of water and then sucks on it himself. I say that this water is for playing, not really for drinking. Frank fills it up and as he replaces the lid hands me the bottle and says in the Mean Old Granny's *nice-but-nasty voice 'There you are, dear' I say that this granny calls me dear but she does not like me. Frank replies at once, genuinely surprised 'Yes she does!' I say that I don't think she does, she often gives me bits of rubbish, or a present that is nothing nice or useful saying 'Happy Christmas' or 'Happy Birthday' so I guess from that that she does not like me. This is repeated at some later point, the* Mean Old Granny *calling me 'Dear' in an inauthentic patronising way.*

Frank 5:16

Robbie treated me abusively much of the time, ordering me about in a preemptory fashion and relentlessly threatening me with sadistic punishment such as cutting off my

fingers (R 4:10) or stabbing my knee with a sharpened pencil (R 8:7) and delighting in making a mess that he would leave for me to clear up (R 7:10, 11:17). His play at the dolls house showed a mother figure as perpetrator of this kind of abusive behaviour:

(Robbie is playing that a doll representing himself and my doll, a young neighbour girl called Sophie, are jumping on the beds.) Robbie gets another female doll, and says this is the Mum. She comes in and shouts in a deep aggressive voice at the boy telling him not to do it and not to do it again. When she is gone, I voice Sophie to say that she was a scary Mum with her shout voice. Robbie's self-doll at once begins jumping on the beds again. As Sophie I keep off, saying in a small voice 'But what if she comes back?' Sure enough the Mum doll does come back and Robbie shows her punishing the boy with extreme violence, beating him hard over and over again by whacking his head on the floor. She shouts about how if he ever does it again she will kill him. As Sophie I run to get my Mum and say that we will call the police. The Mum then takes all the boy's clothes off so that he is left trying to cover his private parts when the three policemen turn up saying that they will take the Mum to prison. She says that she will not go and sets about beating one of them up.

Robbie 2:14-16

Whilst the content is disturbing, Robbie's ability and sporadic willingness to show his parental landscape in a symbolic way was hopeful. It would have been an interesting exercise to compare a narrative story stem analysis (Bretherton et al, 1990) at the start and close of his treatment to illuminate whether this sort of internal story had shifted at all.

6.8.3 Caring Parenting

There were very few examples of positive caring parenting in Frank's material despite the many minutes he spent in baby play. Only three of the 41 items coded for **P** within Frank's session notes show any ordinary good parenting, though it seems probable, as above (section 6.7.1), that my psychotherapist bias of being especially alive to the abnormal may have skewed this. There were some rather lovely transitions, for instance a shift from the exasperated aggression of shouting *'You're a complete terror!*' in the baby's face to the much more loving *'No you're not, you're just a cheeky monkey!'* (F 1:16), but these brief moments of relief were set in a shifting parental landscape in which the dominant feature was that no parental response was reliable.

Robbie and Kayleigh's material was similarly devoid of **P** items with a caring element, just 3/31 and 4/22 instances respectively. Kayleigh went to great lengths of loyalty to reframe her father's boundary-free parenting as positive, justifying his liberality - *'he lets me have drink and drugs because he's not a hypocrite'* (K 6:16) and comforting herself rather concretely that if he does buy her a promised phone *'it will show that he cares'* (K 6:19). Only when relaying a lovely day she had spent helping her uncle in his garden to earn some pocket money did she convey any sense of being with a sensible reliable adult from whom she might learn how to manage herself (K 9:8). Robbie reported one similar rare moment of bliss in the orbit of an attentive adult:

Robbie rallies quickly to announce 'I'm happy today'. I ask him if he knows what has made him happy. Robbie says that he had a happy weekend because a neighbour of his made cupcakes with him. As he paints I ask a few small questions. Robbie replies with uncharacteristic calm and coherence and I gather that this was a man called Timothy, and that his mother was playing a computer game of some kind whilst he did it and that the man also made cakes with his sisters later.

Robbie 5:7

Buoyed up internally by the legacy of this positive interaction Robbie can relate to me in an engaged and productive way, and he is pleased to share an uncomplicated comprehensible story. Robbie also managed to explore some elements of care through his use of the shop-bought teddy and our creation together of two further teddies which he used in a way not dissimilar to Frank's dissociative identity *Ben+Ben* as a concrete antidote to loneliness:

Robbie talks to the Teddy telling it not to worry and that he will be its Dad and look after it. He tells me that it does not have a family. At one point he turns this into trying to get me to say that he can take it home, saying it is lonely and it will be lonely because it has no family unless I let him take it home. I try to say, somewhat inelegantly, that perhaps it also helps him *not to feel lonely this idea of taking away something from the sessions with me.*

Robbie 6:5

More usually though these exchanges were infused with the familiar aspersions of inadequacy and bossy demands described above.

6.8.4 What can I make of my therapist's parenting?

Frank was very curious about me, continually impelled to intrude both psychologically and physically, asking me why my breath smelt of coffee (F 2:4, F 7:6) and attempting to rifle through my bag (F 1:3, F 5:19) and so on. Occasionally this felt innocent and truly toddler-like, a fascination with 'Mummy's things' such as his appropriation of my affectionate terms e.g. 'Foxy-loxy' (F 1:6) or wonderment over my ring (F 4:3). Unfortunately Frank's sexual preoccupations were never far behind and quickly corrupted his gaze, turning observations into intrusions and intrusions into excitements:

Frank suddenly notices something about me. I comment on this, he was talking and suddenly seemed surprised by the look of me. Frank smiles his gleeful/sly smile. I continue that I really do not know what it is that has suddenly caught his attention. I think to myself that it will be something about how I am dressed and something to do with me being a woman. Frank reaches out and pokes me just below the knee saying 'You've got fat socks on' I am today wearing a long dress with socks to my knees, I feel appropriately covered. Frank smiles an excited, triumphant smile. I say that he's reached into my space, and I gesture, to poke me and getting too close to me has excited him. 'Get a husband!' Frank says. I connect this up as I have done before saying that Frank has a sexual thought, he touches me in a way that is not ordinary and then another part of him worries and wants to remind us both that my adult relationship should be happening with another adult.

Frank 9:8

This last order to 'Get a husband!' or sometimes to 'Get a wife!' was a recurring parting shot hurled back over his shoulder after we had said goodbye at the end of many sessions (F 5:21, F 6:20, F 7:18, F 9:19). It appeared that Frank felt that each encounter with me had a sexual meaning which he tried to divest himself of at each departure by telling me, in effect to 'Go do it with someone your own age!'. On other occasions Frank seemed to 'disable himself' by slipping into being *Vanessa* when a sexual thought might usually have occurred, dissociation helping him to keep the present free of sexual content but at the heavy price of limited intelligence and distorted speech (F 12:9).

Robbie was so caught up in projecting the tricky and abusive IWMs of parents onto myself that there was no time or space for anything more positive or compensatory, but from my perspective Kayleigh actively used her relationship with me to feel thought about and cared for and to fill in some of the gaps in her early experience, and this went above and beyond the realm of our shared delight in her discovering of herself discussed above in section 6.5.2. It was clear to me that Kayleigh's avid incorporation of the therapist-mother-me as a new object occurred both in her conscious cognitive approach to me of trying to find answers for her confusions about relationships and how she felt about either parent, and also in the reliable process of sitting down with me weekly to talk and think about her life. However the data do not capture this. Neither the process recordings nor the coded items evidence this part of our experience together, though the items coded for Ps 'psychoeducation' may reveal an allied dynamic (7.4 below). This is explored further in the evaluation of the investigation (8.2 below).

6.8.5 Summary

The collection of extracts coded for parental landscape create a picture of three young minds struggling to navigate relationships against IWMs of confusing, capricious, abusive and sexualising parents. Themes of uncomplicated caring are thin on the ground and states of easy reverie are rare. Kayleigh is perhaps the best put together of the three in this regard, and we might speculate that the traumas which precipitated an escalation of her dissociation occurred well after her underlying attachment style was established.

6.9 Summary of Patient Themes

Taking an overview, the most obvious finding across the sub-set of patient themes is that those which are most closely connected with the dissociative disorders are less frequent when compared with those that might more broadly occur for all children and young people that have experienced early trauma and disrupted attachments. Whilst **V –** 'varying capacities' can be apparent in children and young people who are not overtly dissociative, we would still assume the variance to be associated with diverse states of mind, anxious versus relaxed, energised versus depressed and so on. **S –** 'switching' and **AR** - 'alternative identity relations' are, by definition, dissociative phenomena, whilst

Am – 'amnesia' is also a key element of the diagnostic profile for the dissociative disorders. These are all present to a significant degree and some useful patterns can be discerned from the detailed analysis of the collated extracts - the several ways in which the **Am** - 'Amnesia' group illustrate the use and misuse of forgetting / forgetfulness (Section 6.3) emerges as especially rich. However the remaining more frequent patient themes are, arguably, *less* exclusively dissociative. Issues of **Id –** 'identity' are likely to arise for all children with disrupted attachments, separated parents or differences that accrue discrimination such as minority ethnicity or learning disability. Similarly issues of **R – '**responsibility' may preoccupy many children and young people who have experienced or witnessed abuse at the hands of those they trust, not only those that become dissociative as a consequence. The two most frequently charted patient themes are both, by definition, universal, *all* children and young people will have a parental landscape (**Pa**) and *all* can be observed to be either connected or disconnected in relationship to their therapist (**D**). This is an important finding, and somewhat counter-intuitive. The very features which are diagnostic of dissociative disorders are not actually as present in the psychotherapy experience of the participants as the researching therapist would have predicted. Other features which are not definitively dissociative were far more prevalent. Perhaps I was caught out as Kluft describes by my own interest in fascinating dissociative eccentricities:

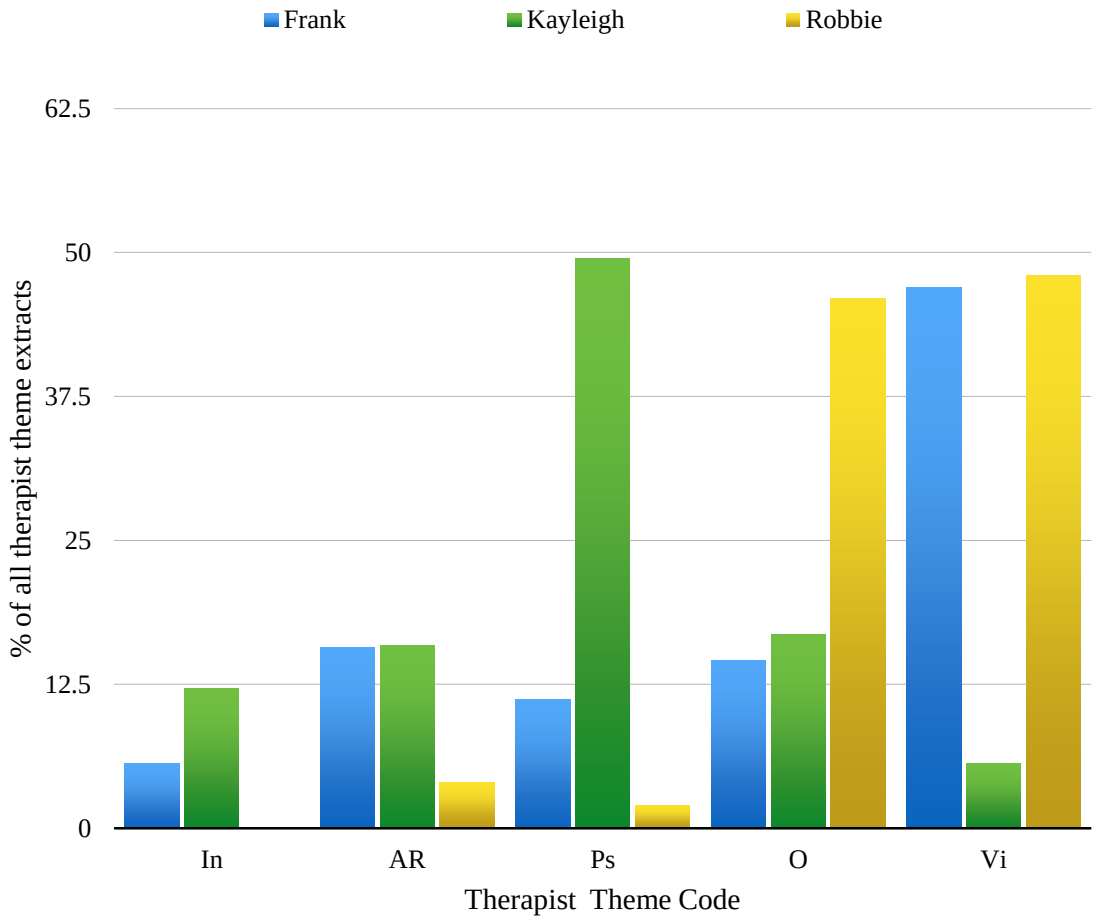
> Initially, my concerns were focused upon those aspects of MPD and its treatment that were relatively unique, strange and unfamiliar….I rapidly came to see that my original concentration, however comprehensible, was misdirected. My unwitting focus on the MPD phenomena and their resolution had, in effect, given precedence to the disorder rather than the patient who suffered it. Such a treatment approach was in danger of actualizing the old medical jest, 'the operation was successful but the patient died.'
>
> Kluft, 1993 p.145

In the next chapter the collated extracts coded for each therapist theme are analysed. If dissociative symptomatology was less dominant than predicted, is the picture for therapist activity similar, when and how often were additional interventions used?

Chapter 7 : REVIEWING THERAPIST-THEMES (Phase 5 part 2)

Whereas the patient themes were spread relatively evenly across the three participants, this was not the case for the therapist themes which evidence diversity in my activity with each. The combined frequencies and pie chart (Chart 5.4b) cannot illustrate this disparity which is better visually represented in the bar chart below:

Chart 7.0 Bar chart showing therapist theme frequencies for each participant



Key: In 'attitude to integration', **AR** 'attitude to alters', **Ps** 'psychoeducation', **O** 'organising', **Vi** 'resisting abuse'

The chart shows clearly that my recorded activity has a distinct character for each participant. With Kayleigh almost half the activity I record involves **Ps** 'psychoeducation', whereas with Frank this is exchanged nearly exactly for interventions related to **Vi** 'resisting abuse'. With Robbie the therapist themes are even

more narrowly delineated, dividing my responses equally between **O** 'organising' and **Vi** 'resisting abuse' pretty much exclusively.

7.1 Attitude to Alternative Identities

Al: Attitude to alternative identities - *Therapist shows acceptance / encouragement of alternative identities, the therapist conveys that alternative identities can be useful as informants or as parts of the child's self, conversely the therapist encourages the child to 'act their age' or 'be sensible'.* How the therapist approaches and responds to the voices, imaginary friends or personified indetities of a dissociative child is a controversial topic. Against a backdrop of denial about the reality of DID and in the face of repeated now debunked assertions that the condition is iatrogenic, how do we best engage with dissociative children in ways that avoid encouraging or colluding with distorted versions of reality? In my own experience both in-patient and community CAMHS teams can take a decidedly behavioural line, insisting that they will not address the young person except by their given name for fear of reifying alters or colluding with a deceit. Yet leading DID specialists are clear that whilst we must not give up our willingness to challenge misrepresentations of reality we ignore dissociative identities at our patients' peril: writing about therapeutic work with dissociative children and adolescents Kluft asserts:

> …the alternates are not after-thoughts that can be discounted with impunity. They are integral aspects of the patient's overall adaptation. Consequently therapies that attempt to avoid dealing with them are unlikely to succeed… Much as a physicist must deal with light both as a wave and as a particle, the therapist of the patient with DID must deal with the person both as a single person and as an aggregation of alternate states.
>
> Kluft 1996, p. 479

This is all the more imperative if internal voices are urging self-harm, or dissociative identities are violent. Kluft terms this 'invitational inclusionism' (Kluft, 2000; 2009 p.608) and espouses an active approach to support the psychoanalysis, going as far as using hypnosis to seek the cooperation and perspective of violent or mother-betrayer identities, and regularly 'checking in' to make sure all feel heard and included. He finds that 'far from reifying the alters (dissociative identities), it usually erodes their separateness quite aggressively' (Kluft, 2000). Working specifically with dissociative children, whilst Marks does not advocate explcitly calling on dissociative personalities to participate in the therapy, she, Silberg and Struik all actively seek to engage with the

purposive felt reality of dissociative 'friends', voices and identities, whilst equally actively re-iterating that the child is now safe and so no longer needs such clever but desperate measures (Marks, 2014; Silberg 2013; Struik 2014). Managing this dual perspective is something child psychotherapists are very familiar with: how to explore and attend to the meaning of very disturbed behaviour or symbolic material without this being mistaken by the child as confirmation of a distorted reality.

Frank's presentation made the dilemma of whether to engage directly with his alternative indentities even more complex because, usually, being willing to join him 'in the mess' (Bromberg 2012 p.157) was understood by him to mean a collusive enjoyment or excitement over the inevitably perverse interactions which ensued, and frequently ended up in a frenzy of mindless chopping or shredding of art materials (F 2:3, F 5:7). When we started work together I approached his disabled and infantile states as though these were deliberate, conscious deficits which he could and should 'snap out of'. This struggle is well illustrated in an excerpt from an early session:

Frank mutters 'You big doo doo!' under his breath. I say he's cross with me for not joining in pretending I think he has been here 4 years, and he's insulting me with a child's insult. Frank dives into infantile babbling: 'I ot u oo i uh oh-eh!' ('It's what you do in the toilet!") Frank looks at me expectantly. If I guess correctly what this means, I feel I am compromised in translation, agreeing to engage with a deliberately disabled version of himself. I say that he's talking in a baby voice, I cannot understand him. (Of course this is not in fact true, would it be better to say that although I can guess what he means, I will only respond if he speaks properly as 'Frank-with-a-brain' - this risks outlawing the material I need to get to grips with but avoids the collusion I hate?) Frank goes on to imitate the sound of someone urinating, then pulls a grotesque smile.

Frank 2:16

On occasion this approach was superficially 'successful'; one extract records how after I refuse *Little Frankie's* demands to hand over the prized pair of 'Barbar the Elephant' cards which I have won, telling him that he is not in fact a little child, he then plays the entire game as Frank himself, employing impressive concentration and memory skills (F 7:7). However my attitude was perilously close to that of his children's home

effectively telling him to 'Just grow up!' as though these other parts of himself had nothing to tell us about his story, let alone an important job to do.

He speaks in Little Frankie's *voice saying he cannot open it (the lid to the sand tray). I find myself annoyed. I tell him to use his grown up brain and just lift it and open it. I find myself thinking almost at once that this may be a bit unfair - it is hard to open even for me.*

Frank 14:2

I missed a trick myself here, missed attending to a counter-transference of wanting to outlaw or ignore the 'misfit' alternative identities, an urge not to appreciate or have to deal with the more disturbing parts, indeed to dissociate them. No wonder Frank regularly admonished me 'You don't know nothing!' (F 3:10). With hindsight I wish I could have found my way to a gently humorous comment such as 'Ah here comes *Little Frankie* to see if he can get me to do it for him. How useful to have this little version of you to get me involved when you want some help, or maybe just when you want me to do the work!' This sort of comment would have tried to convey acceptance without collusion, it could let Frank know: 'I see what it happening here, but I am curious and accepting (rather than irritated and judgemental).'

Certainly Frank used his alternative identities to smooth his passage, as discussed above (6.4); Frank regualrly *'made himself disabled'* (F 9:7), to avoid the difficult and to maximise the pleasurable, but surely this is no more or less than we all do all the time, just under the sway of different, hopefully healthier, IWMs? It took me several years and many more mistakes to realise that even when dissociative children are consciously switching in to other states of mind, we help most if we can get to grips with why this is necessary. We need to ask the question: what is the internal landscape of relational trauma that prompts the child to judge that an infantile, aggressive or disabled response is the best (safest) course of action?

Fortunately the data set also contains examples of where I retreat to observation (F2:9) or make an open enquiry about *why* Frank might be behaving as *Vanessa* or *Little Frankie*, and these interventions are more hopeful:

Frank speaks in a baby voice and I notice this to him. He gets clay balls out of the jar and fiddles with them, says that he will make something and then play a game, all in the baby voice. I note the baby voice again and he says ''At's because I want to be a 'aby,' I agree, we know that he does often wish he were a baby and I find myself wondering why, what's good about being a baby, has he any ideas? 'Don't know.' Frank says at once in his own voice. I ask more directly, has he got any ideas about why he would so much like to be a baby? When Frank says nothing again, I say, with a small smile, that I'm remembering that sometimes it has felt like it's the feeding he likes and wants. Frank continues to fiddle but then mutters something about 'Breast cancer' under his breath. Again I note this out loud to him, I've talked about a baby feeding and he is muttering something about breast cancer. 'You got breast cancer.' Frank announces in a sly tone. I say that thoughts about a baby feeding make him think of something wrong with breasts[24].

* * *

I ask again about the desire to be a baby, what is it that is satisfying. F relies emphatically 'I don't want to be a baby, you're a baby!' and tries to get me to talk about the rim of the boats. To my surprise he then declares, just as clearly, 'I do want to be a baby.' I say that he has both thoughts. Frank at once starts singing the Star Wars marching theme loudly and insistently, keeping this up throughout my following comment that part of him is very interested in baby things and wants to be a baby, another part of him seems to be very worried about the whole matter.

Frank 4:5 and 4:14

There were only two extracts from Robbie's material coded for **Al** one of which records myself putting a limit on the deliberate mess he is making with the paints (R 4:8) and the other a comment on back-classing him with younger children is helpful or not (R 13:1). Why was this so different with Frank, why did I not ever encourage Robbie to 'act his age' or to come back to being 'Robbie-with-a-brain' as I did Frank (F 2:3, F 11:8)? Perhaps part of the answer is that Frank usually had some limited control over how he presented himself, he appeared to have got used to pro-actively managing his world with a familiar group of alternative identities for whom he had some co-consciousness and a little observing interest. By contrast Robbie flew from one mood state to the next and

[24] The symbol of a cancerous breast painfully illustrates the attachment dilemma in primal terms – a choice to feed and risk poison/infection or to refuse and be hungry.

back momentarily, with no discernible observing 'I' and even less interest in my view. The potential significance of their living situations may be pertinent here: to my knowledge Frank was no longer being neglected or abused, but Robbie may well have been living in pretty much the same external landscape that had generated his dissociative style. Robbie had very little of the 'clear sighted and calm observer sat… in a corner of (his) brain… looking on at all the mad business' (Breuer, 1895) that perhaps can only come to the fore once the child is convinced they are in a safe situation.

By the time it comes to working with Kayleigh, over two years' later, my thinking about the genesis and function of alters is quite transformed and so the attitude I have towards her alternative identity *Priti* is fundamentally different. Kayleigh, for her part, was also a much easier young person to work with in psychotherapy than either Frank or Robbie, she was motivated to 'get better', and although I did often feel it would have helped to be able to actually meet *Priti* (K 1:6, K 8:12), in fact Kayleigh made her way towards reintegration without *Priti* ever putting in an appearance in the sessions themselves. During her assessment for psychotherapy we had already arrived at a shared perspective that whilst *Priti* was real she did not have her own body, unwittingly echoing Michael Sinason's description of 'a cohabitation of two minds in one body' (M. Sinason, 1993), and this allowed me to include our knowledge of her from the start in an organic way. The coded excerpts show that I freely refer to both how useful (K 1:16) and how unhelpful (K 1:9) *Priti* can be, that I actively enquire about the view of this alternative identity (K 3:17), that I offer her creative ways to express herself when she is struggling to communicate about *Priti* (K 3:16) and that I draw our attention back when Kayleigh tries to avoid talking about *Priti's* role (K 8:10).

This approach, of an acceptance of where she is at coupled with an agreement that we are trying to help her get to somewhere better, gradually allows Kayleigh to think for herself about how her mind has taken a dissociative turn:

I speak about how I know from her description that Priti *can be feisty, can argue and defend and protect both of them on occasion, but Kayleigh seems not to have that part of herself around. Where has her feisty, argumentative part gone? Kayleigh considers this with a sombre expression and becomes visibly vulnerable, saying with quiet distress*

that it's because she thinks it is her fault, and that she's always thought that - 'Well since Anthony anyway.' She elaborates a little about this.

Kayleigh 11:17

Psychoanalysis has at its core the notion of working to allow what is unconscious to be seen and understood with the consequence that the therapist may often work actively with the patient to unlock the puzzle of how present thought processes and behaviours relate to unresolved emotional conflict. Indeed what is an interpretation if not the offering of an idea about what material expressed in the consulting room may tell both patient and analyst about how their mind seems to be working? So far so much in line with a Kleinian child psychotherapy approach. However with highly dissociative children there may be an additional requirement for active elucidation of meaning on the part of the therapist precisely because the stable dissociative system has been set up to hide one part form the other and to 'not know' about the emotional burden carried by other alters. This may build on psychoeducational foundations and feels different in energy levels from Keats' 'negative capability' (Keats, 1817 p.277) or Freud's 'free-floating association' (Freud 1913 p.135); meaning is being proposed, connections are not so much being discovered as constructed:

(Kayleigh has been telling me about how she always has an outfit on under her school uniform so she can alter her appearance rapidly so as not to be recognised by other young people in the community.) I find I suddenly have a 'connecting' thought which I share with Kayleigh with some enthusiasm, giving this very much as my own idea, something that occurred to me, something for her to consider. I talk about how we know that it is when she, Kayleigh may be in danger or distress that her dissociative identity Priti, *initially helpfully, makes an appearance and 'takes over', and that this quick changing of hers is not dissimilar in some important ways - it is a way of disguising herself so as to be able to avoid or to deal will certain social threats. Kayleigh listens attentively but does not elaborate.*

Kayleigh 14:6

My intervention is not quite full blown 're-framing' but I am proposing a positive function for her now troublesome alternative identity, and this is built far more on my perspective than on hers. My notes go on to record disquiet about the risk of auto-

suggestion and the difficulty of co-constructing meaning when parts of the self are so separated that there is limited metacognition and the ordinary resonance cannot be heard. This theme is reiterated in the analysis of the collection of extracts relating to the therapist's attitude to the integration of dissocaitive identities which follows below (7.2).

7.2 Attitude to Integration

In: Attitude to Integration - *therapist or child refer to what 'getting better' or recovery might mean, therapist or child speak about integrating or fusing dissociative identities, therapist or child speak in other ways about the future of these identities.*

> The patient is not slow to sense that the therapeutic endeavour threatens to reproduce the situation against which his defences are mobilised;
>
> Fairbairn 1951 p.166

Whether we take the view that imaginary friends and dissociative identities are created as a protective strategy (Silberg 2013 pp.14-27, Chefetz and Bromberg 2012, p.165) or are symptomatic of a damaged dissociative internal landscape (Steele et al, 2009 p.240; Liotti, 2009 p.59; Schore 2009 p.115; Fonagy 2002), either way they become a stable and familiar way of managing and are not going to be easily given up. This could be said of course of all patients with deep lying internal world disturbances that are referred for psychotherapy; certainly most CAMHS clinics only offer weekly relational work to children and young people whose symptoms have already proved not amenable to less intensive treatments. Within psychoanalysis this may be conceptualised as 'resistance' which becomes in its turn the major focus of analytic interpretation. (Freud, 1895, 1904).

However, if we understand dissociative children as affect-phobic (Silber, 2013 p.17) and neurologically committed to perceiving all social intimacy as dangerous (Schore, 2003) we can see that there may be an additional problem here. 'Dissociative processes in children and adolescents organise the brain in such a way as to inhibit the healing effects of corrective experiences, even attempts to soothe can trigger avoidance programs' (Silberg, 2013 p.21). The invitation of the psychotherapy opportunity to talk and think together is not welcome and indeed quite foreign to a dissociative mind with an ill-developed capacity for metacognition; these are children with a 'stay away, don't

connect' communication style (Schore 2009, p.114) for whom such a strategy served to diminish overwhelming negative emotional experiences.

On approaching the samples of process recordings I was aware that different schools of thought exist in the field about whether integration into a unitary self should necessarily be the goal of treatment. Whilst a diagnosis of DID or ODSS might only be removed if significant fusion and reintegration has occurred, some sufferers are content to arrive at managing life as a group productively and pleasurably, accepting a life-long status quo of negotiating turn-taking between alters as a context demands (see Alderman and Marshall, 1998, for a persuasive view). Some clinicians are especially cautious of integration-directed work with children; Kluft expresses the view that 'it is important not to lead the child to think that the therapist is eager to achieve integration,' for fear that the child may prematurely drop defences out of 'masochistic compliance', yet he too argues that it should be an essential goal of treatment (Kluft, 1996 p.474). It would be hard to argue that Frank, Kayleigh and Robbie's varied states, causing them significant impairment in both cognitive and relational areas, needed no adjustment, so I was interested in quite what 'standing on the side of sanity' (Rhode, 2002) might mean in practice for a child psychotherapist working with such children.

Bromberg, writing specifically about engaging dissociative clients quotes Friedman eloquently on just this point:

> Hope can only be a present hope in the shape given it by the patient's present psychological configuration…In other words, the analyst must accept the patient on his own terms, and at the same time not settle for them. If he does not accept the patient on his own terms, it is as though he is asking him to be someone else, the patient will not have cause for hope, and he will not recognise the analyst's vision. If the analyst settles for the patient's terms, he is … betraying the patient's wish for greater fulfilment.
>
> Friedman, 1988 p.34 cited by Bromberg 1991, p.21

Nearly all of the extracts coded for **In** occur in Kayleigh's psychotherapy, indeed the feature was the least frequently occurring of all the five technique-related codes and only just made it past the exclusion criteria - nevertheless does an analysis of these suggest any answers?

Kayleigh consistently expressed resistance to the notion of integration in a variety of ways. To her enquiry during the assessment about how psychotherapy might 'work'

and how other people resolved their DID, I had briefly spoken of various possible outcomes, including fusion, integration and group-living. In our very first weekly session we again discuss what 'getting better' might look like and my notes record Kayleigh expressing the desire to put some distance between herself and *Priti* but at once explicitly emphasising: *'I'm not talking about that thing you said that some people do though, of saying 'goodbye' to their other personality!'* (K 1:10). Despite, indeed perhaps *because of* her knowledge that her family and her teachers were wanting this outcome, Kayleigh needed me to be quite clear that this is not on her map and should not be on mine. It has been suggested to me that what may have been occurring here was a projection from Kayleigh into myself of the desire to 'eliminate' a dissociative identity which is in fact an unwanted part of Kayleigh's self created by a powerful schizoid mechanism as Klein describes (Klein, 1946 p.19-20). Certainly Kayleigh would on occasion express her own thoughts about how to *'get rid of' Priti,* albeit in a fair-minded and compassionate way by '*putting her into another body'* (K 8:11), so at some times elimination was, despite protestations, indeed on her map.

Kayleigh also regularly reported on *Priti's* views about our conversations regarding her recovery and these clearly caused some internal trouble between them. After a session in which Kayleigh fluently expressed some anxieties about what adult life with DID might be like (K 8:13), how she would manage a job, whether any children she had might be frightened by a mother with multiplicity and so on, she experienced something of a reprisal:

Kayleigh's face clouds over and her expression becomes anxious as she says that it has not been a good week, Priti *did not like the way we spoke last time, is very unhappy about the kind of things Kayleigh has been thinking and has shut her up a lot this week. There is some verbal stumbling here and Kayleigh cannot get her words out clearly, illustrating the very problem she has had.*

Kayleigh 9:4

It seems that sharing ideas about *Priti* was *per se* threatening, so that her resistant responses were not limited to protesting an obvious drive towards integration; Kayleigh

began session 11 by announcing with a smile *'Priti did not like that idea of yours!'* following a shared discussion about how useful it might be for me to meet *Priti.* I might have anticipated that *Priti* would receive news of my interest and acceptance as proof of my good intent, but the opposite occurred. Had I not appreciated that whilst Kayleigh had a very positive transference towards me, *Priti* was fiercely independent and a champion of the 'stay away, don't connect' approach to adults? For *Priti* the talking and thinking of psychotherapy were necessarily anti-dissociative and so therefore 'anti-her'. In this dynamic it is undeniable that *Priti* exerts influence like a pathological organization in the way Rosenfeld describes: 'committed to narcissistic self-sufficiency and … strictly directed against object-relatedness' (Rosenfeld, 1971).

However my approach had more in common with M. Sinason's encouragement to show understanding towards the destructive cohabitee (M. Sinason, 1993), and in the extract below we can see that I try to do something of this kind: Kayleigh had previously let me know that *Priti* was suspicious that I secretly wanted to *'harvest'* her *(Priti)* (K 8:14) so that in the exchange that follows I use the very familiar psychoanalytic technique of trying to pick up and articulate *Priti's* negative transference towards me:

Kayleigh elaborates that Priti *does not want to show herself even though I have said that I would be very happy to meet her. 'She's scared of you!' Kayleigh says with some enjoyment. I say that I wonder what it is that scares her? Kayleigh shakes her head, shrugs a little, her gestures suggest that she, Kayleigh, could not be expected to have a view 'She doesn't even like me saying that…that's what she's saying now.' I think a little aloud and say that I wonder if* Priti *sees me as 'not on her side' as someone who is a threat, thinking perhaps that really I would like to do away with her rather than to find a way for her and Kayleigh to live more happily together in a way that doesn't get them into so much trouble from time to time. Kayleigh indicates that she thinks this might be the case.*

Kayleigh 11:2

However I also step beyond just highlighting the negative transference in some implied reframing when I explicitly propose an alternative therapy agenda *'for her and Kayleigh to live more happily together'.*

Most successful were the interventions where I spoke to both the positive and the negative aspects of dissociative life. There is an overlap here with the growing understanding of the most helpful stance both parents and professionals should take when working with young people presenting with Gender Identity Disorder (GID). Specialists advocate an attitude of 'open minded curiosity' that pays close attention to the lived experiences of the young person whilst also not fore-closing on any particular outcome (Carmichael, 2013).

Kayleigh describes her alter Priti's *controlling behaviour further and I reflect, deliberately trying to show some respect to* Priti *in the way I speak about her, that I remember from what she has told me that when she, Kayleigh, was eight and trying to manage so much stress around having been sexually abused, she asked* Priti *to take over and help, and* Priti *was a real saviour for her, but now that she's growing up and becoming stronger as Kayleigh herself, now* Priti *is also a hindrance. As though having a revelation, Kayleigh asks with obvious anxiety and a little bewilderment 'Will I be able to get a job if I still have* Priti*? Will a boss understand? I have to make myself stop and think rather than wander off into the nuts and bolts of employment law, to reply that I guess we don't know how it will affect things but that Kayleigh is clearly worrying that having an alternative identity around in* Priti *may disrupt her working life as well as her home life.*

Kayleigh 9:14

After listening to myself describing what we understand together both about why her alternative identity of *Priti* became so necessary and also about how things have now become problematic, Kayleigh is able to spontaneously think about a future and the implications of *not* finding some resolution. Bromberg puts this attempt succinctly:

> The heart of the process depends on the ability of the analyst to avoid imposing meaning, so that the patient can feel free to enact new ways of being without fear of traumatically losing the continuity of 'who he is.'
>
> Bromberg, 1993 p.171

Perhaps something of this kind occurred when Kayleigh phoned me as we prepared to pick up her psychotherapy after a summer break some 8 months after the end of the

research sessions to tell me with huge excitement that she had 'great news'. She went on to say that she had 'dismantled the control panel' so that her *Priti* was no longer able to take over uninvited, though she was still around for advice and encouragement if needed. Despite internal protest, and apparent resistance, Kayleigh had indeed found her own 'new way of being' to shift internal dynamics towards greater integration.

7.3 Psychoeducation

The items collected under this code were originally collected with extra identifiers to include the subject matter, PsD for education on dissociation, PsS for sexual matters including 'protective behaviours' information, and PsO for other educative interventions.

7.3.1 Is psychoeducation psychoanalytic?

Traditional psychoanalysis abjures educative processes primarily because its focus is an exploration and re-working of unconscious emotions and phantasies. Freud himself did, notably, take some trouble to advocate for the sexual enlightenment of children, concluding in his open letter to Dr. Furst on the matter:

> What is really important is that children should never get the idea that one wants to make more of a secret of the facts of sexual life than of any other matter which is not yet accessible to their understanding; and to ensure this it is necessary that from the very first what has to do with sexuality should be treated like anything else that is worth knowing about.'
>
> Freud, 1907 p. 138

We might expect this to be even more necessary for children who have been subjected to unwanted premature sexual experiences as Frank and Kayleigh had, and who both showed a need for their therapist to help them unravel confusions and furnish them with the same straightforward information as their parents, carers and teachers.

Controversially Anna Freud went even further than her father on this point, initially advocating not only a 'preparatory period' of building motivation and what we might now call a positive therapeutic alliance, but also giving educative intervention a central role alongside analysis, asserting that the child therapist should endeavour to do both: 'to analyse and to educate, that is to say in the same breath he must allow and forbid, loosen and bind again.' (Anna Freud, 1927 p.65). The young children with whom she was working afforded Anna Freud examples of where perversity or hostility seem to be exacerbated rather than quieted by the freedom of the therapy setting and the

understanding of their therapist. This was always a very present danger for Frank, who could easily take my willingness to allow and engage with his sexual or infantile preoccupations as licence to dive into perversity. However Klein took the opposing view to Anna Freud and was adamant that in treating children 'not only was it unnecessary for the analyst to endeavour to exert an educative influence but that the two things were incompatible' (Klein, 1927, p.340). The debate that ensued at the Symposium on Child Analysis concerned the use of an educative role that was much more than just the provision of factual information akin to Freud's notion of 'enlightenment', there is clearly a moral or pedagogic element being variously advised or abjured. Klein was quick to counter Anna Freud's position with criticisms which included the charge that because of this emphasis on the educative she had 'confined her investigations to superficial conscious or pre-conscious strata' (ibid. p. 364).

Anna Freud asserted that both the ego and the super-ego of a young child were insufficiently mature to manage the return of 'repressed passions' and that therefore the therapist must give equal attention to the child's external world. Whether we agree with this or not in relation to *all* children, dissociative children are by definition likely to have segregated diluted self states that are incompletely developed and which do not have full psychological resources available to them, that is to say they will have the weak immature versions of ego and superego on which Anna Freud's position on the impossibility of transference and the necessity of educative intervention rests. In addition dissociative children are forged in the crucible of relational trauma such that their eternal world circumstances, the impact of negative abusive events and their attachment disruptions, are all facts of life that drive pathology in tandem with the internal landscape of inconsistent unreliable unintegrated objects constructed by these experiences. 'The very presence of alters (dissociative identities) precludes the possibility of an ongoing unified and available observing ego and disrupts autonomous ego activities such as memory and skills' (Kluft, 1993 p.146). Might this be why clinicians working with dissociative children from Kluft forward to the ISSTD guidelines for treatment of dissociative children (ISSD, 2004) state a perspective not dissimilar to Anna Freud's and stipulate the imperative for educative elements?

The trauma specialists working with dissociative children concur. Indeed Silberg has named her treatment program the 'EDUCATE' model (Silberg, 2013), and this starts

with age appropriate teaching about dissociation and about how trauma can cause a child's mind to respond in this way, continuing with interventions to actively build the child's awareness of their continued reliance on dissociative ways of coping together with the explicit visualisation of a more hopeful future (Silberg 2013, p.59-75) - 'demoralised children need to 'borrow' a sense of hope form the therapist' (ibid. p. 53). Similarly Marks advocates a therapy approach that captures the child's interest in how their mind is put together and explains simply to children how dissociation has 'worked' to help them cope with unthinkable dangerous situations but is now causing them problems; she is straightforward in addressing the need for children to work to 'make the brain strong' in order to be able to manage thinking and talking about themselves without re-traumatisation (Marks, 2014). How like Anna Freud's conclusion that the immature ego may need preparatory support and confidence in their therapist to be ready for the strong medicine of psychoanalytic treatment.

7.3.2 Psychoeducation about sexual matters

In her parental landscape Kayleigh found herself between a rock and a hard place. Her mother appears to have responded to her daughter's abuse and subsequent excited preoccupation with sexual matters by shutting down all conversation on the topic, something she herself found bewildering but *Priti* blatantly flouted. Her father and his partner, on the other hand, responded to her confusion and distress with unboundaried information confirming that, even as a child, she should expect to be a sexual player and that her role was to learn to manage others' sexual needs better. If I had been working with Kayleigh in a secure environment or even if she were being cared for in a robustly supervised foster home, then it might have been possible to focus more exclusively on her internal world within our therapy and leave the educative and protective work to others. As it was she was very much 'out and about' in a community of sexually active young adults, without a moral compass and within which parallel segregated aspects of herself could put her at risk. Despite a very keen intelligence and easy access to public information Kayleigh had something of a 'blank' when it came to ordinary sexual politics, there were great gaps in her knowledge and little sense of her 'self' within in all. The risks to her personal safety and the possibility of further trauma were too great to proceed in the hope that a psychoanalytic approach would make good the amnesias and deficits quickly enough, so that psychoeducation alongside therapy was essential.

The PsS (psychoeducation about sexual matters) extracts show the range across which I recorded giving Kayleigh 'real-world' information. A few relate to her own experience of sexual abuse directly, how usual or unusual this might be (K 1:7), or whether an eight year should know what sex is or not (K 2:8, K 8:6). However the vast majority involve myself responding to Kayleigh's active attempts to learn 'what is normal' - what she should expect and how she should behave - much of which she is naively surprised by. We talk about the nature of teenage girls having 'safe' crushes on celebrities or teachers, people that are actually out of reach (K 1:4), what is age appropriate and legal (K 6:10, K 9:11), and what it might be 'ordinary' to do or not do on a first date (K 11:12). With a less dissociative un-abused young woman this last conversation about what is 'ordinary' might centre on her own internal needs, desires, fears and prohibitions, how to understand, listen to and balance these, but in Kayleigh these aspects were segregated. Dissociative personality *Priti* had charge of the needs and desires and was unafraid to metaphorically 'take the bull by the horns' to get what she wanted, but this left Kayleigh naive and with no awareness of her libido, despite craving intimate male relationship. In psychoanalytic terms, we might take the view that Kayleigh's dissociation cut off her id impulses, projecting these into the vehicle of *Priti,* leaving her to manage a critical superego with a weakened (split) ego. In the context of her telling about consensual sexual activity I ask Kayleigh directly if her body enjoys the contact (K 2:9), I challenge her telling of a clearly flirtatious encounter as though she has no active desire, asserting the normality of this (K 8:6) following which she admits to some limited enjoyment (K 8:7), and in the face of her disquiet that she finds some acts with some boys 'disgusting' I assert the normality of being repulsed by sexual intimacy with people she is not actually attracted to (K 11:24). This work went hand in hand with the more usual analytic fare of exploring her present day passions and anxieties in relation to her history, particularly her delight in the attention of older men in the light of how little she had received from her father, but the deficit in her understanding was never far away:

Following some extended bewilderment about her enjoyment of her male teacher's affectionate interest in her, I talk about how very little girls can often be seen flirting with their Daddies. Kayleigh is initially very surprised, almost shocked by this, and I have to emphasise that I'm not talking about sex but I am talking about playfulness, and enjoyment. I use expressions like 'the apple of his eye' and 'Daddy's little princess'

and also emphasise that this is a safe playfulness because it is, all things being as they should be, never going to go anywhere. Nevertheless, I continue, there is a learning going on here about 'What kind of man do I love?'. We acknowledge together that Kayleigh has very little of this in her life, and I wonder as I have done before whether this makes her enjoyment of her relationship with Mr. E. even stronger.

Kayleigh 1:19

In addition the PsS extracts illustrated interventions aimed to promote self-protective behaviour usually prompted by concern for how the desperately needy part of her threatened to put her at risk; these extracts include myself stating that 'Mr E. is a teacher and it would be quite wrong for him to go out with you' (K 1:18), warning Kayleigh that it would not be good idea for her to declare her affection to him (K 1:21), suggesting that it would be quite inappropriate for her to go to the sexual health clinic with a married man she had met on the bus (K 6:11) and enquiring explicitly about whether she has armed herself with contraception before a date (K 8:15). I also actively let her in on my thoughts about a potential new boyfriend, the positives of his being her own age, so possibly she will have more control, and the negatives that include him being a bystander to a physical attack on her on a previous occasion (K 11:11-14). Much of this might be necessary when working with any young person who has suffered sexual abuse, but a dissociative mind adds an extra difficulty. I regularly tried to make connections with *Priti's* approach, indeed evidence of *Priti's* adaptive value might be that I felt a great deal less concerned for Kayleigh's decision making and personal safety when she was 'at the control panel'. In contrast to Kayleigh's low self esteem and naive compliance, *Priti* did not suffer fools gladly, she was hypervigilant to any signs of being disrespected, set ground rules for dates and was unafraid to 'dump' anyone who did not treat her properly. The whole picture - Kayleigh's caution balanced by *Priti's* confidence would surely have served her better still.

7.3.3 Psychoeducation about dissociation

The dissociative child is, by construction, disorganised in attachment style, compromised in understanding their own mind, unable to fulfil their cognitive potential, prone to sudden changes of state in response to mistaken perceptions of danger. If there is sufficient residual metacognitive capacity (Fonagy 2002, p.80) then there may be the possibility of Anna O.'s 'clear-sighted and calm observer sat…in a corner of her brain

(looking) on at all the mad business' (Breuer and Freud 1893 p.101), and something of this kind was possible for Kayleigh who was keen to understand her diagnosis (K 2:12, 2:14) and to be able to explain it to her teachers (K 3:20) or have it explained to her mother (K 8:6). Most pertinent for Kayleigh was my transparent sharing with her from the start of the conviction that 'Though this be madness, yet there is method in 't.' (Shakespeare, 2006 2:2 195) and that we would be trying to puzzle it out together, such as discovering what important functions *Priti* may fulfil for Kayleigh in their hours of need (K 6:7).

However, many other dissociative children are presented for treatment convinced they are simply mad, bad or both. If I were beginning with Frank or Robbie today, I might make a very different start, emphasising a view that all states, no matter how hard to be with, are valuable and are trying to make a contribution to keeping the self safe and functional.

7.4 Organising

O: Organising - *therapist records the desire to organise or the action of verbally /physically organising the child, conversely where chaos is noted but allowed as an important communication.* Dissociative children are consummate experts at dividing themselves and segregating their experiences, so it is hardly surprising that a therapist working with such patients should observe in herself a desire to organise the ensuing chaos in the consulting room. Extracts coded for **O** appeared robustly in all three participants' therapy sessions (Frank 15%, Kayleigh 17% and a huge 46% for Robbie), 22% of the total five 'therapist' codes overall.

7.4.1 The Kleinian perspective

Klein's is clear about the traditional psychoanalytic stance:

> …the analyst should not show disapproval of the child having broken a toy; he should not however encourage the child to express his aggressiveness, or suggest to him that the toy could be mended. In other words, he should enable the child to experience his emotions and phantasies as they come up. It has always been part of my technique not to use educative or moral influence, but to keep to the psycho-analytic procedure only, which, to put it in a nutshell, consists in understanding the patient's mind and conveying it to him.
>
> Klein, 1955 p.129

She advocates an unstructured approach which privileges the emergence of the child's internal world and brooks no imposition of structure or active 'organising' by the therapist. This is not to say that a successful psychoanalysis was devoid of processes intended to re-organise a conflicted psyche, indeed Freud's metaphor of the archaeological dig rests on the notion of bringing deep-lying mental items to light so as to restore order to the mind (Breuer and Freud. 1895, p.139). There is just one example of this kind from the collection of **O** items:

After early chaos and a foray to retrieve some paint brushes Robbie takes the teddy with him to the painting area and announces: 'I'll be here and you can be over there sewing - are you lonely? I say that he's wondering what this is like, being lonely. Robbie repeats, 'No, but <u>are</u> you feeling lonely?' I say that perhaps this is what he thinks I should be feeling with him and teddy in one place and me left over here. He again repeats the question, it is genuine rather than irritating or forceful. I say that he really wants to know that I get this feeling that I am <u>actually</u> feeling lonely and he can know that I am feeling it.

Robbie 6:13

Robbie deliberately organises our positions and then uses the experience to try to get information about what is going on inside me, to organise his thinking about 'how loneliness works' and perhaps to answer an unspoken question about what I do with this, whether I too am someone who dissociates from painful states of mind? I am there to help him organise this by reflecting and interpreting the need for him to know that his enacted projection has found a mark. There is nothing new here, but how do the remainder of the collection shed light on the quality of the organising activities within the sessions and how do such interventions fit within a traditional psychoanalytic approach?

7.4.2 Organising resistance to anarchy

With all three participants I experienced a recurring impulse to calm things down, structure activity or verbally organise expressed confusions, and with all three I regularly acted to do so. Repeated observation of the chaos / confusion and attempts to interpret this as a communication of an internal state did nothing to alleviate and usually (most especially with Frank and Robbie) only served to exacerbate their arousal and

dysregulation. My notes record making both Robbie and Frank tidy up (F 5:17, R 13:25), forcefully taking Robbie's paint brush from him (R 4:8) and only agreeing to take my turns at Frank's beloved 'pairs' every time I had got him to listen to me first (F 6:7), an essentially *behavioural* intervention. I also entered into a great deal of normalising or explanatory 'real-world' conversation with Kayleigh (K 3:3, K 6:18) much of which falls under the **Ps** 'psychoeducation' code discussed above (section 7.3). That I felt the organising urge was unusual in my practice is also apparent, especially so with Frank; a counter-transference note gathers this up as my feelings of *'Responsibility, clarity, respect for Frank, boldness like a surgeon, this thing needs to be brought to light'* (F 6:1), a later one states my desire to *'marshal his sane capacities'* (F 11:1), and when I re-read the entire collection I am struck by how very determined I am not to allow both boys to dive into a mindless dissociative mess.

Much of this organising help is practical, physically so with Robbie and Frank, and is not simply prohibitive - 'stop that!' but often collaborative or scaffolding 'let's do it this way', much like a mother might help her toddler to hold his cup without dribbling or help the four-year-old get his coat on. When Robbie is caught up with a creative project I move to catch the brush laden with paint that would fall to spoil his picture (R 1:5), I warn him about using too much tape (R 4:13), and I physically mop up behind him as a watery mess threatens to overflow (R 11:8, 11:16). I do not let the brush fall and observe the 'fall out', I do not let the tape run out without warning or allow a flood and then talk about the experience; instead I act to sustain the positive exploration and to ensure some measure of success. All this is not very psychoanalytic; my usual practice would be only to step in where danger or irretrievable damage were imminent so why the different approach with these dissociative children?

Experience of *not* acting to limit Robbie's haphazard painting of the furniture or Frank's repetitive crushing of his clay models taught me that, for these two, prolonged self expression led only to a frenzy of mess and destruction that left the room and both of us in pieces. One of the consequences of having to try to learn to regulate fearful arousal in relation to unreliable or capricious parental figures is a poor sense of judging threats to the self and maladaptive behavioural responses. Disorganised children have at least one hyper vigilant self state continually on alert for dangers but those that are also dissociative have the additional difficulty that they cannot bring the information held in

the segregated parts of the self together in order to assess the situation and make a good decision about how to respond. They are stuck in the past without easy access to mediating reparative experiences. I am reminded again of Anna Freud's experience with the 'devil girl' for whom the liberty of the analytic setting was a '…mistake …crediting the child's superego with an independent inhibitory strength which it did not yet possess' (Anna Freud, 1927 p.63). Sullivan's notion of actively keeping the 'anxiety gradient' low when treating traumatised patients in order to avoid re-triggering dissociative responses (Sullivan 1954), is worked over by Bromberg into a therapeutic goal of 'safe surprises' (Chefetz and Bromberg, 2012 p.167). Similarly I was aware of trying to establish a 'work-face' with all three that was sufficiently unfettered for the chaos and mess to find expression whilst being sufficiently contained for us both to be able to have a chance of thinking together. By acting to prevent chaos, and explicitly encourage organised and organising activity, I was refusing a slide into mindless fragmentation which Fonagy describes so keenly in a paper where he proposes that dissociation is the converse of mentalisation:

> The abused child, evading the mental world, rarely acquires adequate mental control over the representational world of internal working models… Caught on a vicious cycle of paranoid anxiety and exaggerated defensive manoeuvres, the individual becomes inextricably entangled into an internal world dominated by multiple and often dangerous, evil and above all *mindless* working models of relationships. He has abnegated the very process which could extract him from his predicament, the capacity to reflect on mental states.
>
> Fonagy 2002 p.82 (italics mine)

When Robbie and Frank's impulse towards 'mental evasion' threatened to drive the sessions into anarchy (F 12:6, R 7:10, 11:17), and with little capacity to reflect, I acted to 'organise'. I would argue that this kind of organising has much in common with the emotional-physical regulation of infant states of arousal by an attuned care-giver, maintaining the child's psychobiological equilibrium which may over time become an internalised capacity for self-regulation.

Perry (2009) emphasises the need for patterned repetitive organising and regulating therapeutic input for traumatised children to diminish their anxiety and impulsivity (Perry, 2009 p.243), and advises that therapy must target the lower areas of the brain in traumatised children since it is experience at this level that 'literally provides the (brain) organising framework for an infant and child' (ibid. p.245). Something of this kind may

have been occurring when Robbie developed a rhythmical running in front of me to our room (R 5:3), or when he got me to methodically name and date his pictures whilst he, again rhythmically, piled them up (R 2:9), Frank's love of the predictable turn-taking in our games of matching 'pairs' (F 5:5) may well have been unconsciously prompted by the comfort and calm of such a reliable interaction. Whilst Perry argues that therapeutic input must therefore be strictly sequential along a developmental pathway, Bromberg would counter that therapist and patient cannot avoid all levels of interaction occurring simultaneously and that the goal must be to arrive at sufficient affective 'safety' at a sub symbolic level for the reactivation of painful dissociated experiences to be bearable and available to for processing at a verbal level (Chefetz and Bromberg, 2012 p.167-8). Put simply, if I did not keep things safe enough for Robbie and Frank, including the organising interventions of the **O** group extracts, then degeneration into dissociative chaos was the unhelpful outcome.

7.4.3 Finding order - what are the 'rules' ?

Some of Robbie's self-organising activities had a relieving latency stamp to them, a symbolic and actual 'getting things in order', none more so than his 'brain-wave' of cutting up pictures we had made together to create a puzzle we could then successfully piece back together (R 7:8). Kayleigh's **O** extracts too have a latency flavour in their illustration of her desire for 'rules' which she would verbally chew over at length in front of me, such as which kind of communication to use for friends, school or family (text, email, skype, social media) *'in order to reassure / orientate herself'* (K 9:7), or very fine detail about how to make sure her clothes matched up (K 14:7). Similarly whilst Kayleigh's attraction to the traveller community was overdetermined, one strong thread was the clarity of the rules about romantic and sexual conduct, organising her behaviour in an area in which she otherwise felt quite at sea (K 16:11).

For the sexually abused child who has had to incorporate incomprehensible painful and confusing sexual experiences at the hands of powerful carers who both love and terrify them, finding their way to a 'normal' orientation towards their own and others' sexual excitement is a challenge indeed. Both Frank and Kayleigh were motivated to 'try and sort out the sex business' in their minds, to discover the 'rules', though for Frank this was especially hard as the window within which he could begin to consider sexual matters without getting aroused himself and assuming myself to be the same was very

narrow (F 9:10). I describe Kayleigh, by contrast, as almost *'drinking in good sensible sanity'* (K 11:24) with a palpable sense of gratitude (K 11:26) that I will talk to her about what may or may not be normal in romantic sexual relationships. Kayleigh actively used our sessions to get me to help her organise her understanding of sexual matters, to re-construct what was good sex against a back-drop of premature bad sex (K 2:9, K 2:11, K 11:24) (see section 7.3.2 above for a fuller discussion).

A final note of caution might be that all the interventions so far, the acceptance of alternative identities, the psychoeducation and the organising activity are in the service of the psychoanalytic endeavour, not a substitute for it.

7.5 Resisting Abuse - Vi

Vi: Resisting Abuse - *therapist resists, refuses or limits involvement in an activity/exchange initiated by the child with elements of collusion or abuse, conversely the therapist is willing/content to be involved as a victim.* Unexpectedly this is the most plentiful therapist item from the children's therapy sessions, comprising 45% of the incidence for all 5 therapist coded extracts from Frank's material and 48% of Robbie's, though featuring much less for Kayleigh at just 11%. In other words nearly half of the interventions I recorded myself making with the two boys contained this element of whether, as their therapist I should resist being involved as the recipient of abuse, a technical dilemma common to work with children who have themselves been chronically abused. A central 'added value' of psychoanalytic psychotherapy is the active use and examination of the transference relationship with the therapist rather than symbolisation explored through say sand tray scenes, small world play or creative artwork, and we are often referred children and young people for treatment precisely because their hostile chaotic and indeed dissociative un-symbolised presentation limits their capacity to access other treatment modalities.

7.5.1 The value of saying 'No!'

There is undoubtedly a great deal to be said for saying 'No' and sticking to it. Children who have been abused need their therapists to keep robust boundaries if they are to have a chance of internalising a new experience of being with a safe reliable adult. Some **Vi** extracts are of this kind, detailing behavioural interventions in which I refuse to let Frank capriciously leave the therapy room (F 4:18), will not let him leave his mess and

insist on his helping to tidy up (5:17, 5:18), refuse to open a locked cupboard (6:16) and will not accept cheating (F 9:6, F 9:7). The extracts also illustrate a very active modelling of firmly protesting physical attack, such as Frank throwing pieces of clay at me (F 5:15) and record the only occasion on which I actually lost my temper with him:

However he finally snatches my spectacle case, opens it and puts a handful of disintegrating clay pieces into the case with my glasses and shakes it. I 'crack' and shout 'No!' three times, pointing my finger at him. Frank is clearly shocked.

Frank 14:10

The extracts show that I was also concerned not to be 'taken for a fool', in terms of being a sensible grown up who would not repeatedly put themselves in the way of disparagement or danger, someone who would not be so stupid as to trust a person who had already proved untrustworthy, otherwise *'he's got me looking like an over-eager fool, trying to cooperate with someone who is just toying with me for their own amusement'* (R 13:7). When Robbie took to running on and shutting me out of the room, I tried to talk to him about the meaning of getting inside my room without me, but I also took to locking the therapy room door so that he had to wait for me to open it (R 8:4), and when he deliberately wrecked or threw sand all around the room I made a rule that these things would go away for a week and then we would try again (R 13:5). Just as for Frank, reflecting on the meaning seemed to bring little change:

I do say that Robbie is so cross today that it's hard for me to get anything right, everything I do is wrong. 'Shut up' and then 'Shut up or I'll punch you'. I say that he's trying to bully me into being quiet 'Yes, shut up.'

Robbie 7:8

- so that although I continued to try to put words around his abusive attitude towards me, describing his treatment of me as being like that of *'a very bad servant'* (R 5:10), and recording counter-transference of *'I am holding out against becoming a slave'* (R 7:12) I also instituted the rather behavioural rule that I would only pass him things if he said 'please'!

7.5.2 Resisting collusion, diminishing perverse excitement

Frank was highly motivated to embroil me in activities that were dodgy, sexualised and perverse. Most usually, but not always, I was cast in the victim role being persuaded, coerced or cajoled into activities that 'felt wrong'. Sometimes his invitations were glaringly obvious, begging me to break a clay sculpture (F 2:3), or to excite him by saying the word 'vagina' (F 9:11) and describing sexual activity (F 11:6), or to get into a physical scuffle over something he is attempting to steal from the therapy room (F 5:20), but equally often I found myself refusing on a hunch so that '*I wonder to myself why I am resisting such a thing (his request to bury a shovel) but still feel that I should'* (F 1:8) or refusing on the basis of previous experience for example to mirror a face he has made (F 2:14) or replay his dramatization of a cartoon character (F 5:9, 5:10). These are not activities that I would routinely refuse with most children, indeed the to-and-fro of mirrored expressions might be the beginning of engagement with even the most deprived young people, re-laying a foundation of contingent responsiveness (Tronick, 2004) against a back-drop of very poor early regulation in the way described for some of the **O** 'organising' extracts, and my refusals could leave Frank begging (F 9:9) and myself feeling mean (F 1:2). Even naming a state of mind, that most basic of psychotherapeutic interventions, could provoke rather than reduce arousal:

I reflect that these (clay faces) are things I made with him to show different emotions but he's showing me that he has no time for this sort of serious thinking at the moment. He's in the 'fatty boom boom' state of mind. Frank is excited by even the mention of it.

Frank 5:8

7.5.3 Understanding and using the transference: does this help?

This robust refusal to be continually dismissed or to be inveigled into a perverse interaction is essential if the therapy is not to degenerate into simply an abusive reenactment in which the therapist, rather than the child, is the victim. Identification with the aggressor may be one way to survive but it is hardly a route to recovery. Whilst dissociative children clearly need a therapist that can defend herself against attack and survive intact, by and large they will be children who have had the opposite experience, of *not* being able to defend themselves and of *not* surviving intact, but instead failing to cohere into an organised sense of self. Their traumatic reality must find expression in the consulting room and into the mind of the therapist if they are to feel themselves to be understood let alone come to understand themselves.

In the end, the most useful understanding of the therapist's felt quandary is of a powerful communication of the child's own attachment dilemma writ large on the screen of the transference relationship. I was repeatedly put in a position by both Frank and Robbie of being 'damned if I did (engage) and damned if I didn't', which is precisely the position of a young child who must try to maintain physical and emotional proximity to an abusive caregiver, the imperative to stay connected is simultaneous with the imperative to stay away. This is certainly the way I might now tackle the issue, saying something like 'Ah, now I think I'm really beginning to get this feeling of what it's like to be in an impossible situation, where whatever I try to do it's not right.' Unfortunately it is not possible to illustrate this from the three participants' therapy, as I did not have this understanding when working with Frank and Robbie and Kayleigh's transference communications did not put me in quite the same position.

7.6 Summary of Therapist Themes

There is an overall pattern in the relationship between the frequency of each therapist activity which broadly mirrors the trend of the patient themes. That is to say the therapist activities which might be considered most particular to working with dissociation turned out to be the least frequent. **In** – 'attitude to integration' and **Al** – 'attitude to alternative identities', both activities that would only ever be in evidence when working with dissociative patients, were discovered to be activities I found myself doing not so very often. By contrast with Kayleigh, who presented most clearly with DID, I found myself regularly needing to use a **Ps -** psychoeducative approach. Actively organising interventions (**O**) were necessary to maintain any reasonable thinking space in Robbie's psychotherapy, but this was not so much a function of distinctively dissociative behaviours but of a purposive anarchy that might emerge in the psychotherapy of any child with extreme anxiety or ADHD. Similarly, the need to manage a dual agenda in both receiving and resisting the abusive dynamics, which in this study were evident in the psychotherapy of both Frank and Robbie (**Vi**), is a staple of a child psychotherapist working with any child that needs to express the emotional legacy of abuse they have suffered by re-enacting it in the transference. That is to say, despite a directed interest in what I had to do differently, the single most frequent intervention was that of managing perverse or hostile transference with a view to elucidating its meaning, which is rather the ordinary fare of child psychotherapy with

abused children. The additional techniques of active educating and organising, not traditional in a Kleinian approach, were also routinely useful in particular instances, but was this in response to specifically dissociative features rather than features that may be common to all abused and neglected children?

In the following chapter the patient and therapist themes are brought together into a thematic map to suggest how the evidence in this study offers an answer this question. Potential relationships between the two sets of themes are proposed and some suggestion are made about what child psychotherapists may wish to include in their 'toolkit' when approaching work with dissociative children and young people.

Chapter 8: CONCLUSIONS

8.1 Evaluation

In what ways did the methods of this study produce meaningful information about dissociative children and their presentation in psychotherapy? How possible was it to find evidenced patterns between the themes that emerged?

8.1.1 Shortcomings

Applying thematic analysis to process recording notes totalling over 60,000 words produced a huge tranche of over 750 coded extracts. Even though these cohered with reasonable integrity into the 13 patient and therapist themes that were then discussed in detail, the investigation was not large enough to do full justice to the findings; the method simply produced too much data for the scale of the project. Each discussion had to be pared down to the most salient or prevalent features with the result that more minor sub-themes, or those only prevalent for one of the three, were noted but not explored. For example within the extracts coded for **O** - 'organising' for Kayleigh there was a small sub-group of items where she spoke about herself helping or organising others, showing an internalised capacity to actively manage confusion or distress by thinking even though she often could not do this for herself, but there was simply not space to describe or analyse this interesting feature in any depth. There were at least eight such instances as well as the jettisoned 'additional other', **C** - 'credibility' and **F** - 'fabrication versus reality' codes.

In addition it was apparent that certain aspects of the patient-therapist experience do not turn up in process recording notes, which by its nature is skewed towards the 'micro' dynamics, the here-and-now blow-by-blow rather than the 'macro' or underlying currents. The result was that some over-arching themes were not captured. For instance Kayleigh's use of myself as a positive compensatory parental figure did not feature in the **Pa** - 'parental landscape' collection, though it was clear from 'macro' evidence and corroborated in supervision that she engaged with me along a teacher-

aunt-therapist axis of transference and sought to fill in gaps in her early experience. Elements of this dynamic do turn up in other themes, notably **Ps** - 'psychoeducation' and **O** - 'organising', but the lesson here is that a researcher using process recording notes should be aware that there is necessarily a gauge to her attention which may filter in and filter out certain types of phenomena. If the therapist making the record is aware at the time of atmospheric or overarching dynamics then these may well make their way into the analysis, but this may depend very much on how busy she is with other matters in the room. In this respect process-recording may only be as good as the therapist's negative capability can engender, and may only be assumed to capture dynamics and features relevant to the therapeutic endeavour. It is, after all, for this purpose that the notes are made. This could possibly be addressed by 'directed' or 'prompted' process recording in which additional elements were explicitly required.

Finally, in a small-scale investigation carried out by a lone clinician-researcher such as this one, there is an inherent limit to the scope of both the analysis and findings. There was insufficient space to consider the possible relationships between variations in findings and the differences in the genders and ages of the participants in any depth, and the generalizability of any apparent correlations would in any case inevitably be limited by the very small sample size of just three participants. Moreover, whilst a key clinical question in the mind of the treating child psychotherapist would necessarily be one of how the children's dissociative presentations are linked to painful or conflicted internal states, this is not an enquiry which could be asked of or answered by this project. The data collected and the analysis then applied did not chart incidence of 'painful or conflicted internal states', and so could not offer any meaningful calibration of how extracts coded thematically for each patient feature might link with these. Whilst it was possible on occasion to notice a correlation, such as that discussed regarding Frank's admonishment to 'get a husband!' (section 6.8), this was not systematically produced by the thematic analysis itself, which did not seek to measure the proximity or relationship of items to either to each other or to additional elements such as internal states. However the question remains an important one for child psychotherapists, whose central purpose is to help children manage and work through the painful internal conflicts that are impairing their emotional growth and development.

8.1.2 Advantages

The systematised gathering of every noted example of a particular feature or theme was most helpful in illustrating the subsequent discussions. The collections of each set of extracts offer a comprehensive body of material on each theme that allow a substantial appreciation of the quality and weight of how that feature appears in the material across a number of axes.

A comprehensive collection allows a useful comparison between the therapist's impression or preoccupation with a particular feature and the reality in the consulting room, and hence both illuminates and mitigates against the effects of observer-bias. For instance, if asked before the study for my sense of what preoccupied me most in work with dissociative children, my answer would have included both the struggle to manage fantasy versus reality whilst retaining the symbolic, and disquiet about my actively organising interventions. The collections allowed both the quantitative discovery that in fact I did not spend much time managing fantastical material (**F**) but did regularly act to organise (**O**), but also a fine tuned scrutiny of the quality of that organising.

This method of identifying and gathering all instances of a feature also allows an analysis of how much similarity or difference there may be between them. Placing all similarly coded items alongside each other in visual proximity makes it possible to view convergence and divergence much more easily than relying on memory or notability in the researcher-therapist's fallible mind. For example it became clear, during the reviewing phase (Phase 5) that Frank's instruction to me of 'Get a husband!' (coded for **Pa** - 'parental landscape) occurred very reliably either as a parting shot or following sexual material, there was high internal coherence and discernible precipitating dynamics. Equally it became clear that my observation of **D** - 'connectedness / disconnectedness' items was a very mixed bag, and indeed not, ultimately, a very useful category being rather too subjective and rather too 'catch-all'.

Furthermore this method offers opportunity to view the development of a theme across the time frame of the investigation, which in a subsequent study could be extended across the entirely of treatment. For instance within Kayleigh's sessions, of 13 extracts sub-coded **PsD** - 'psychoeducation about dissociation', 12 occur within the first half of the treatment period examined. We might hypothesise that once a child or young person has heard and understood how dissociation works, the need for this sort of activity declines; this would fit with the EDUCATE (Silberg, 2013), 'Don't let sleeping dogs lie' (Struik, 2014), and indeed Kluft's phased treatment models (Kluft 1993, 1996) of

therapeutic intervention which include psychoeducation as part of the initial phase of the work. Using the coding method, charting the occurrence of a patient or therapist feature over time can be easily achieved by use of graph software and results from a group of participants plotted on the same visual field to assess whether a trend is confirmed or should be dismissed.

There are advantages also to garnering a systematised complete set of extracts coded for each theme, as this allows the selection of the very best or the most typical for exemplifying that feature, and also facilitates relatively easy comprehensive referencing of the consequent discussion. This should not be underestimated as an extremely helpful practical tool in the arena of single case studies. Whilst the traditional case study paper which child psychotherapists present to receive professional qualification does not require a systemised approach, most incorporate the identification and analysis of a particular emergent theme or themes under a psychoanalytic lens. From my own experience of such a study, involving trawling the notes of at least 90+ sessions, applying a system of coding would have been a great improvement, diminishing a somewhat haphazard recapturing of events. As explicated in section 4.6, thematic analysis allows a directed scrutiny of the notes and so fits the brief of analysing rich data for a declared purpose such as a substantial single case study.

Finally only comprehensive collection justifies the thematic connections and thematic map that can then be made under the recursive analysis of the researching therapist (Phase 6 - 'producing the report', Braun and Clarke, 2006, p. 93). Deducing inter-theme relationships is of course the intended rationale for the collection though in this study such analysis proved less immediately productive, with relationships between the themes less clearly emergent than intra-theme trends. Nevertheless some tentative correlations could be proposed and it is to these we turn next.

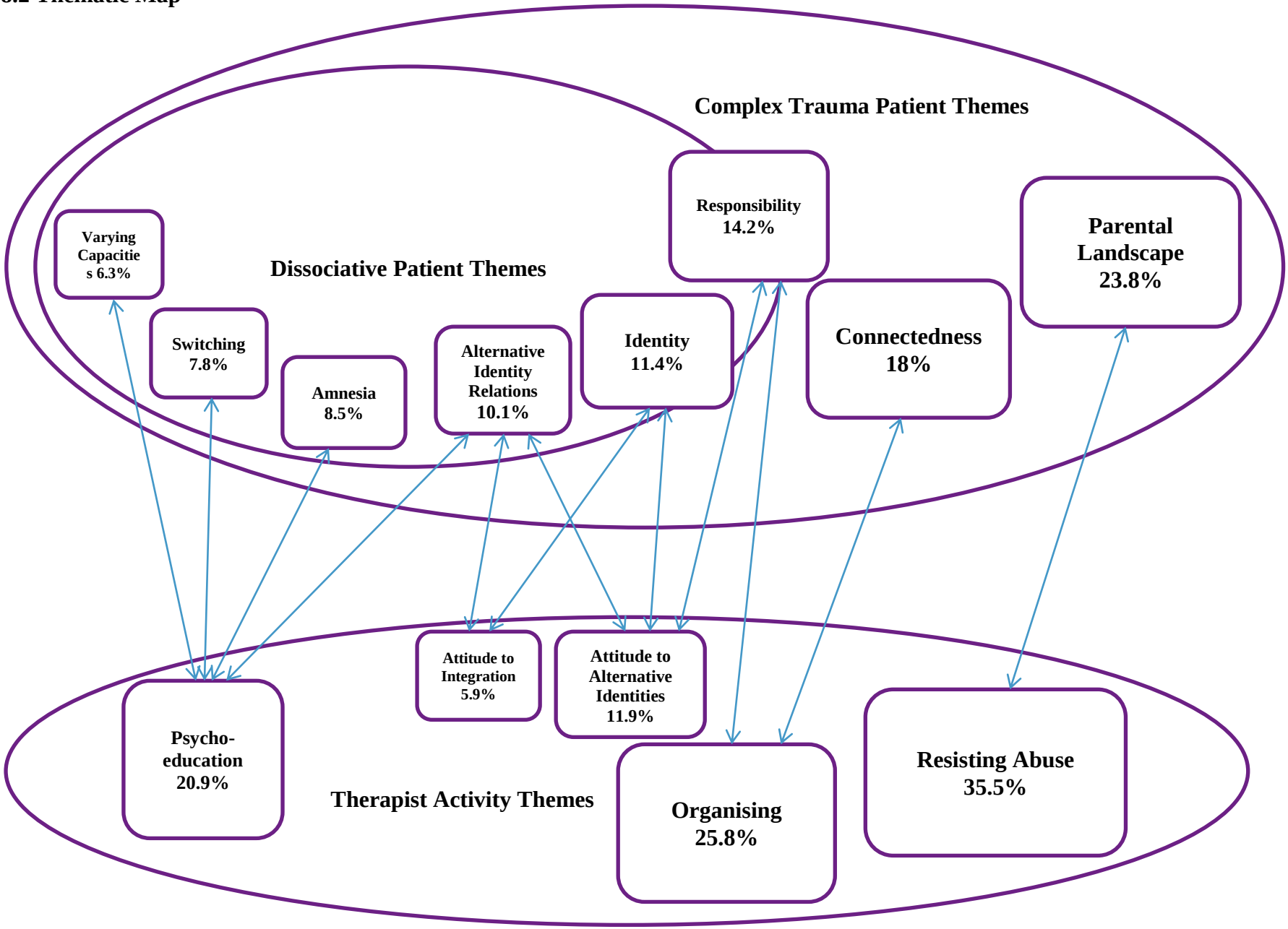
8.2 A Tentative Thematic Map

Within the two subsets some broad interrelationships can be hypothesised as briefly described in chapter summaries section 6.9 for patient themes and section 7.6 for therapist themes above. However in addition it is possible to propose some putative correlations between the range of patient features and the range of therapist activities. There are some natural matches here. In unstructured psychotherapy work, a therapist intervention involving her attitude to alternative indetities and the integration of those

identities is only likely to be present where a patient demonstrates or speaks about such things. Similarly she is only likely to engage in psychoeducation about dissociation where this is in evidence or is being reported or to actively organise the session when things are becoming significantly disconnected, confused or anarchic. A finer mathematical analysis, for instance of how proximal instances of patient **AR –** 'alternative identity relations' and instances of therapist **In –** 'attitude to integration' and **Al –** 'attitude to alternative identities' are in relation to each other within a session might allow a statistically evidenced view on the strength of such association. For now, this view remains emergent from the researcher's recursive and intimate familiarity with both the qualitative and quantitative sweep of data, and is visually depicted in the thematic map that follows.

In this map the area of box named for a coded theme is drawn to represent, by area, the relative frequency with which it occurred within the entire sub-set. This gives a visual impression of how much weight can be afforded to that particular feature / activity. The patient themes are arranged in order of frequency from left to right, sitting within a dissociative feature sub-group (**Va, S, Am, AR**) or within the entire complex trauma field (**D, Pa**) or on the border (**Id, R**). Ranged below are the therapist activity themes, again in boxes whose area reflects the frequency of each theme, positioned to allow ease of mapping onto the patient features.

8.2 Thematic Map



8.3 Conclusions

This investigation sought to explore two broad questions.

In answer to the question of how dissociative children present in psychotherapy: Whilst there are some very particular symptomatic features particular to dissociative children, the most frequently occurring are those common to traumatised children in general - difficulties in a sense of agency and identity (**R** and **Id**), distractibility and lack of continuity in engagement with their therapist (**D**), and mixed IWMs as revealed in their parental landscape (**Pa**). The specifically dissociative symptoms (**Va, S, Am and AR**), though remarkable, were not as prevalent for these participants as the more generally post traumatic symptoms.

In answer to what implications there may be for altered technique: when working with dissociative children, child psychotherapists may find actively educative (**Ps**) and reframing (**O**) interventions helpful, may need to consider the 'anxiety gradient' of their patient by acting to calm fearful arousal, and should take an accepting invitational attitude to alternative identities or imaginary friends (**Al** and **In**). However the core skills of the child psychotherapist in withstanding and understanding powerful hostile and perverse transference communications, and in easy facility with accepting the important emotional meaning of sub-symbolic communication (**Vi**), are vital to helping dissociative children recover in therapy. These skills are exactly those necessary for work with all abused and attachment disordered child patients, regardless of whether they are actively dissociative or not.

Combining the two findings the suggestion would be that child psychotherapists take care not to get too caught up in the sometimes bizarre differences of their dissociative patients. The controversy about dissociative symptoms, a degree of misplaced psychiatric 'glamour' about the condition or anxiety about our capacity to help such children can lead to giving more attention to these differences than is warranted as Kluft describes: 'My unwitting focus on the MPD phenomena and their resolution had, in effect, given precedence to the disorder rather than to the patient who suffered it' (Kluft, 1993 p.145). However this investigation suggests that in the consulting room non-dissociative complex trauma features may be more prevalent, and require more therapist attention and management, than dissociative symptoms, even with clearly dissociative children.

8.4 Implications for future research

Given the paucity of research on dissociative disorders in childhood it is unsurprising that this investigation serves as a scoping exercise that offers up many further potential avenues of enquiry. Any one of the themes could be selected and investigated more thoroughly. For instance the Am - 'amnesia' code threw up at least four related sub-themes of traumatic forgetting, pervasive forgetting, secondary forgetting and therapist forgetfulness which could be identified and tracked across the entire trajectory of a child's psychotherapy and triangulated with standardised memory testing across the period. In terms of projection and counter-transference dynamics it could be illuminating to test the therapist's memory function before and after sessions, and to extend this to a comparison with non-dissociative children. Further more sophisticated research questions and hypotheses might then be generated, for instance 'how does traumatic amnesia correlate with the amount of time since the trauma occurred' or 'secondary forgetfulness is employed more often by older dissociative children'.

Another line of extended enquiry could be assessment of the validity of the themes for presence / frequency by using process-recording or audio transcripts from the work of other psychotherapists with dissociative children to discover whether the findings of this study are reliable and can be generalised. In terms of the 'mapping the new planet' analogy, this would be akin to repeated 'forays' at different locations with a ready made 'list of landscape features to check out'. Identifying features could be manualised and the same material rated by several researching 'coders', including non-psychotherapists, in order to determine and finesse inter-rater reliability. We could reasonably expect this to mitigate against the distortions that might arise through a therapist's natural focus on what is 'notable' in terms of the therapeutic endeavour, an issue which arose in collecting the **D** - connectedness/disconnectedness extracts (see section 6.7 above). Over time we would expect that a more accurate 'map' of how dissociative children present, and the kind of activities their therapists utilise, could be drawn.

8.5 Final Thoughts

The study was an excellent scoping exercise which produced a robust illumination of how some dissociative symptoms may present in therapeutic work with dissociative children, and provides a useful springboard for discussing helpful changes to technique. It makes a good beginning in a largely under-researched field pointing out a potential direction of travel for both clinical work and further research. The investigation is

notably rare in taking work with children as the starting point as almost all research into the dynamics and treatment of dissociative disorders has postulated backwards from data collected about adults with DID or OSDD. In this sense the thesis makes a unique contribution to the field.

To some extent the whole endeavour has been to determine how best to set a work face where some useful therapy can actually get done; to arrive at a relational setting where the rich potential of psychoanalysis may be accessed by dissociative children to move them on to healing and health. The thesis goes some way to explore and suggest that a balance between the behavioural, the cognitive and the psychoanalytic may be necessary. If we accept the theoretical perspectives that dissociation is feeling-avoidant (Silberg, 2013) and thinking-avoidant (Fonagy, 2002) it follows that a treatment modality aimed at thinking about feelings is going to struggle to make an impact without some alterations or additions.

The investigation necessitated re-familiarising myself with the process notes I had gathered for Frank and Robbie some years previously, and provided an unexpected rapprochement. The work with both had been curtailed somewhat precipitously when each moved on from the schools where I met with them, and I had carried a sense of regret that I had not helped either more in ways that might endure. It is certainly true, and the re-reading of all three sets of notes consecutively bore this out, that by the time I came to engage Kayleigh I was a good deal more aware of the history and theoretical aetiology of DID and also more confident about deviating from what I understood to be an orthodox psychoanalytic approach in the service of the recovery needs of this particular group of patients. However, having taken a close look once more at the entire set of sessions across a term's work with both Frank and Robbie in the course of the thematic analysis, I was relieved to find that I had by no means been entirely off course. I had endeavoured with each to receive, withstand and understand confusing and hostile communications and there were, perhaps especially with Frank, significant moments of shared exploration and connectedness.

Perhaps my own professional development here mirrors what I would like to recommend for the profession as a whole. The nature of the child population referred for treatment to specialist mental health services will necessarily include significant numbers of children who have experienced severe neglect and abuse from a primary care-giver,

since these children are emotionally impaired in enduring ways. Many of these children will have developed dissociative manoeuvres, so we may reasonably assume that, whether we have recognised it or not, child psychotherapists will have been working with dissociative children since the profession began. Psychoanalytic skills are invaluable to the part of the work which necessitates a capacity to receive, endure and find meaning in extremely complex or opaque communications from our patients. This much child psychotherapists will have been offering dissociative children to some good effect just as this much I was able to offer Frank and Robbie despite my lack of specialist knowledge and skill with dissociative children at the time.

It is my conclusion from this study that such skills remain vital to the work with dissociative children, but I suggest that the 'take up' of learning and re-learning about the self and other in psychotherapy, the very processes which promotes recovery from relational trauma, will be significantly enhanced if we can openly accept the reality of dissociative disorders and if we are willing to use additional interventions to support our psychoanalytic work. These interventions include transparently building a safe trusting relational context for the therapy, actively attending to keeping our dissociative patients' anxiety levels low when confusion or anarchy threaten, and being prepared to educate as well as interpret in terms of sharing understanding about how young minds may respond to trauma. In addition I would recommend that the aetiology and symptomatology of dissociation be included as an essential part of the curriculum in child psychotherapy training and that supervision of clinical work with traumatised children pay explicit attention to potentially dissociative activity in the consulting room.

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APPENDICES

Appendix 4.2a Patient Information Sheet for Children

We at *(insert name of relevant institution)* want to ask you to agree to join in our research project.

Here are some important questions other children have asked:

What is Research?
Research means finding out new things to help other children in the future

If I agree will what I do at *(insert name of relevant institution)* change?
No, you will still come and see *(insert name of therapist)* for sessions just as you do now.

If I agree will anybody else find out private stuff about me?
No. There are strict rules about making sure private stuff is kept private, and we will be sticking to all these rules.

Can I take my agreement back if I don't like it?
Yes. You can take your agreement back and you will still get to come to all your sessions just the same.

What about my *(insert name of parent/carer)*?
We will also ask *(insert name of parent/carer)* if they agree to make sure everyone understands what is going on and is happy with it.

What if I have more questions?
You can ask *(insert name of therapist)* or tell *(insert name of parent/carer)* any more questions you have and we will do our best to answer them.

EXAMPLE
As the sample size is small this sheet can be tailored to individual children:

If I agree will what I do at Oaklands change?
No, you will still come and see Jo Russell for sessions just as you do now.

If I agree will anybody else find out private stuff about me?
No. There are strict rules about making sure private stuff is kept private, and we will be sticking to all these rules.

Can I take my agreement back if I don't like it?
Yes. You can take your agreement back and you will still get to come to all your sessions just the same.

What about my Dad and Shelley?
We will also ask Dad and Shelley if they agree to make sure everyone understands what is going on and is happy with it.

What if I have more questions?
You can ask Jo Russell or tell Dad or Shelley any more questions you have and we will do our best to answer them.

Appendix 4.2b Patient Information Sheet for Teenagers

Participant Information Sheet – Teenagers and Parents

This sheet tries to answer some of the questions young people often ask about why we at (*insert name of institution*) are asking for their consent to use anything we learn from our work with them in some research we are doing.

Why are you doing research anyway?

The aims of the research are to help us get a better understanding of:

- how children and young people come to experience or present themselves as more than one identity
- how this connects or does not connect with things that have happened to that child or young person as they were growing up
- how best to do therapy to help these children and young people grow up to be happy, settled adults

What do I have to do?

We will not be asking you to do anything extra for our research. All you have to do is attend your sessions in the usual way.

What if I change my mind?

If you decide at any point that you do not want our work together to be part of the research then you can tell your therapist, or another adult you trust (a parent, a carer or a teacher) and we will not use any details from the work with you. Saying you no longer wish your therapy to be part of the work will not affect the treatment we are offering you, you will still have the same amount of time with the same therapist and you will continue to be offered psychotherapy sessions for just as long as if you were still involved in the research.

How will my personal details be kept private?

Any detailed notes about your sessions which are made and kept by your therapist do not have your name or other 'identifying features' like your date of birth or your address on them. If they are written copies they are kept in a locked filing cabinet which only your therapist can open and if they are on a computer they are protected by a password

known only to your therapist. Any written notes about your more general care can only be seen by other professional people if they are directly involved in looking after you. When the research is written into a paper care will be taken to make sure no one reading it could guess it was about you apart from yourself. In the UK there are laws about how personal information can be kept and who can see it and we will be sticking to these rules throughout the research.

Will my parents or carers know?

If you are an older teenager then you can give your consent for yourself and this is enough. If you are a younger teenager or you are very confused at the moment then we will also ask for your parent or carer's consent. If you are in care this could be your social worker or guardian.

Is anybody else involved?

The research will be overseen by the University of East London and the ideas about how to involve children and young people in therapy have been looked at by an expert group of adults called the University Research and Ethics Committee to make sure it is fair to all the children and young people who are participating.

What if I don't really understand all this?

You should only agree to give your consent to being included in our research if you feel you understand enough about what it will mean for you it to say 'Yes' and sign your name. If you are unsure you can ask your therapist to explain it a bit further and if you are still unsure then you should not give your consent.

Appendix 4.2c Consent Form for Children

Research Project: **FINDING OUT MORE ABOUT DISSOCIATION**

Older children and Teenagers

By signing this form you are agreeing that what we learn from our work with you may be used in a research project to find out more about dissociation, and that you have read and understood the 'Participant Information Sheet'.

You are free to take back your consent at any point during your treatment and this will not affect who you see for sessions, what kind of help you are offered or how long you will carry on meeting with your therapist for.

There is nothing extra you have to do except turn up for your psychotherapy sessions as usual.

The only time we would involve other people is if, during the course of your therapy, your therapist learnt that something that could harm you might be happening to you or another child – this is the same for all children and young people in psychotherapy whether they are part of research or not.

At the end of the research, what we have learnt will be written up in a paper, and we can also write a summary in everyday language if you want to see this. Anything we do use will be fully disguised so that your privacy is kept safe.

Signed…….

Name……..Date……..

Appendix 4.2d Consent Form for Parents

Research Project: **FINDING OUT MORE ABOUT DISSOCIATION**

Parents or Carers with Parental Responsibility

By signing this form you are agreeing that what we learn from our work with your child …….*(insert name of child)* may be used in a research project to find out more about dissociation, and that you and/or your child have read and understood the 'Participant Information Sheet'.

You are free to withdraw your consent at any point during your child's treatment and this will not affect the kind or length of the treatment they receive.

There is nothing extra you or your child have to do, they just need to attend their psychotherapy sessions at *(insert name of relevant institution)* as usual.

The only time we would involve outside agencies is if, during the course of your child's therapy, their therapist learnt that something that could harm your child or another child might be happening – this is the same for all children and young people at *(insert name of relevant institution)* whether they are part of research or not.

At the end of the research, what we have learnt will be written up in an academic paper, and we can also write a summary in everyday language if you would be interested to see this. Anything we do use will be fully disguised so that your family's privacy is kept safe.

Signed…….Date……

Name……..

Relationship to Child…….

Appendix 4.2e Ethical Clearance

GRADUATE SCHOOL
Director: Alan White, BA(Hons) PhD
uel.ac.uk/gradschool

Ms Jo Russell

12 Cleremont Terrace
Brighton
East Sussex
BN1 6SH

29th August 2014

Dear Ms Russell,

University of East London/The Tavistock and Portman NHS Foundation Trust: research ethics

Study Title: "Dissociative identities in Childhood: An exploration of the relationship between adopting these identities and painful states of mind in three young people. Are there implications for psychoanalytic technique?"

I am writing to inform you that the University Research Ethics Committee (UREC) has received and reviewed all the documentation related to you applications made in 2009 and also that made in 2012, on which a decision was delayed due to issues regarding whether there was a need for NHS Ethics approval.

These matters having being resolved to the satisfaction of the Committee, it is now in a position to state that ethical approval had been granted.

For the avoidance of any doubt, or misunderstanding, please note that the content of this letter extends only to those matters relating to the granting of ethical clearance. If there are any other outstanding procedural matters, which need to be attended to, they will be dealt with entirely separately, as they fall entirely outside the remit of our University Research Ethics Committee.

If you are in any doubt about whether, or not, there are any other outstanding matters you should contact Mr William Bannister at the Tavistock and Portman NHS Foundation Trust (e-mail WBannister@tavi-port.nhs.uk).

Yours sincerely,

Professor Neville Punchard
Chair of the University Research Ethics Committee (UREC)
Tel.: 020 8223 6683 (direct line)
E-mail: c.fieulleteau@uel.ac.uk

c.c.
Barbara Harrison, Director of Studies
Valerie Sinason, 2nd Supervisor
Mr Malcolm Allen, Dean of Postgraduate Studies, Tavistock and Portman NHS Foundation Trust
Mr Will Bannister, Associate Director, Education and Training, Tavistock and Portman NHS Foundation Trust
Professor John J Joughin, Vice-Chancellor, University of East London

Docklands Campus, University Way, London E16 2RD
Tel: +44 (0)20 8223 2674/7097 Fax: +44 (0)20 8223 2826 MINICOM 020 8223 2853

Appendix 5.1 Repeated Topics from Initial Read

Robbie (10 sessions across 14 weeks):

- Responsibility – R not believing he has done something / R authentically mis-ascribing responsibility to me / R deliberately falsely ascribing responsibility to me
- Varying capacities – especially drawing, mixing paints, executing tasks
- Amnesia – remembering, forgetting, confusion around not knowing
- Connectedness as productive but maddening, desire for organising versus terror of organising, depressive position
- Chaos + Mess
- The nature of transformation, painting self, jettisoning objects, adding concrete portions
- Technique – therapist resisting /experiencing nature of abuse

Frank (11 sessions across 14 weeks):

- Therapist technique - involvement/collusion v resistance to abuse
- Connectedness / not, cognitive capacities / varying capabilities
- Amnesia
- Therapist management of reality v fabrication
- Parental mindset / landscape as revealed in process + content
- Therapist acceptance or not of dissociative identities, attitude to dissociative identities
- Responsibility + agency
- Therapist desire / action to organise
- Patient dilemma – dissociation as stabilising, disclosure as risky
- Switch points

Kayleigh (10 sessions across 16 weeks):

- Inauthenticity v credibility, self-belief, fragility of identity
- Psychoeducation – DID, protective behaviours, sexual relations
- Varying cognitive capacities, clever v stupid
- Patient resistance to integration – notions of recovery
- Parental mindset / landscape
- Therapist desire / action to organise
- Joy at discovering identity / function of clothing
- Therapist dilemma, understanding v condoning,

- Relations between dissociative identities
- Lack of selected facts – stream of consciousness
- Therapist acceptance or not of dissociative identities, attitude to dissociative identities
- Responsibility + agency
- Seeking consent - ethical considerations
- What is internalised from the therapeutic work + how

Appendix 5.3 Comparison of Unweighted (UW) and Weighted (W) Frequencies

Coding	Actual Number			Total	UW %	UW % Rounded Up	% within participant data			W %	W % Rounded Up
	R	F	K				R	F	K		
Patient											
Am Amnesia	16	8	11	35	4.63	**5**	7.33	3.19	3.83	4.8	**5**
Va Varying Capacities	9	10	6	25	3.31	**3**	4.12	3.98	2.09	3.4	**3**
D Connectedness	39	20	15	74	9.77	**10**	17.89	7.97	5.23	10.4	**10**
I Identity	12	2	34	48	6.35	**6**	5.50	0.80	11.85	6.1	**6**
P Parental Landscape	31	41	22	94	12.43	**12**	14.22	16.33	7.67	12.7	**13**
R Responsibility	23	10	26	59	7.80	**8**	10.55	3.98	9.06	7.9	**8**
C Credibility	1	3	27	31	4.10	**4**	0.46	1.20	9.41	3.7	**4**
AR Alter'ye Identity Relations	8	9	24	41	5.42	**5**	3.67	3.59	8.36	5.2	**5**
S Switching	11	17	2	30	3.97	**4**	5.05	6.77	0.70	4.2	**4**
Therapist											
F Reality v. fabrication	1	16	3	20	2.65	**3**	0.46	6.37	1.05	2.6	**3**
Al Attitude to Alter'ye Identities	2	14	17	33	4.37	**4**	0.92	5.58	5.92	4.1	**4**
In Attitude to Integration	0	5	13	18	2.38	**2**	0	1.99	4.53	2.2	**2**
O Organising	23	13	18	54	7.14	**7**	10.55	5.18	6.27	7.3	**7**
PsD P.E. DID	0	0	13	13	1.72	**2**	0	0.00	4.53	1.5	**1**
PsS P.E. Sexuality	0	5	33	38	5.03	**5**	0	1.99	11.50	4.5	**4**
PsO P.E. Other	1	5	7	13	1.72	**2**	0.46	1.99	2.44	1.6	**2**
Vi Resisting Abuse	24	47	6	77	10.19	**10**	11.01	18.73	2.09	10.6	**11**
Other											
e Ethical/Consent	0	0	3	3	0.40	**0**	0.00	0.00	1.05	0.3	**0**
i Internalisation	3	2	4	9	1.19	**1**	1.38	0.80	1.39	1.2	**1**
r risk of disclosure	3	18	0	21	2.78	**3**	1.38	7.17	0.00	2.9	**3**
m method in mad	6	2	0	8	1.06	**1**	2.75	0.80	0.00	1.2	**1**
X additional interest	5	4	3	12	1.59	**2**	2.29	1.59	1.05	1.6	**2**
Total	218	251	287	756		**99**					**99**

Appendix 6.7 Reorganising 'Disconnectedness' to 'Disconnectedness' and 'Connectedness'

		1	2	3	4	5	6	7	8	9	10	Total	%
Frank	Disconnected	F 1:15 **1**	F 2:12 **1**	F 4:9 **1**			F 7:17 **1**	F 8:1 F 8:11 **2**		F 12:14 F 12:15 **2**		**8**	**38%**
	Connected	F 1:1 F 1:4 **2**	F 2:1 F 2:2 F 2;17 **3**	F 4:8 F 4:12 **2**	F 5:1 **1**	F 6:6 **1**	F 7:2 F 7:10 **2**	F 8:11 F 8:17 **2**				**13**	**62%**
Kayleigh	Disconnected	K 1:14 K 1:22 **2**	K 2:6 **1**		K 6:5 **1**	K 8:2 K 8:4 K 8:8 **3**	K 9:9 K 9:18 **2**	K 11:21 K 11:9 **2**			K 16:1 K 16:14 K 16:18 **3**	**14**	**93%**
	Connected									K 14:3 **1**		**1**	**7%**
Robbie	Disconnected			R 4:5 R 4:9 R 4:10 **3**		R6:1 R6:4 R6:8 R6:9 R6:15 **5**			R 9:1 R 9:11 **2**	R 11:12 R 11:17 x2 **3**	R13:3 R13:6 R 13:22 R 13:24 **4**	**17**	**44%**
	Connected	R 1:13 **1**	R 2:5 **1**	R 4:6 **1**	R5:1 R5:2 R5:6 R5:7 R5:12 R5:16 R5:19 R5:20 **8**	R 6:6 **1**	R 7:9 **1**	R 8:3 R 8:10 R 8:15 **3**	R9:4 R9:5 R 9:7 R 9:10 **4**		R 13:10 R13:17 **2**	**22**	**56%**