MULTIPLE PERSONALITY DISORDER AS AN ATTACHMENT DISORDER

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ABSTRACT

Multiple Personality Disorder (MPD) can be viewed as a disorder of attachment. Bowlby (1969, 1973, 1980, 1988) described how the emotionally neglected (passively abused) child detaches from internal and external signals that would normally lead him to search for a parent; the MPD literature uses the label "dissociation" for the same state which Bowlby called "detachment." Upon the detached state are superimposed the sequelae of active abuse. From this perspective, many of the problematic transference phenomena in the treatment of MPD result from reactivation in the transference of ethologically adaptive attachment behavior. The patient's difficulties in maintaining boundaries, periods of sudden withdrawal, and eventual movement through a period of anxious attachment, represent steps towards internalization of a secure base of attachment.

INTRODUCTION

One may view Multiple Personality Disorder (MPD) as an attachment disorder complicated by the sequelae of active abuse (specific acts which cause physical or sexual harm). When the mother (or other primary caretaker) is dissociative and detached, the child is likely to use dissociation as the primary defense against the overwhelming trauma of active abuse. The therapist can note evidence for an attachment disorder in nearly every aspect of the psychotherapy of MPD. From this perspective the resolution of the attachment disorder, rather than the resolution of the effects of sexual and physical trauma, causes the extended and turbulent nature of the psychotherapy of more complex cases of MPD.

VARIETIES OF TRAUMA

Renewed clinical interest in MPD probably could not have occurred until clinicians accepted that reports of abuse presented by adult clients were not necessarily fantasies of the Oedipal or any other variety. As Kluft (1990) succinctly stated, "The importance of real trauma to the development of psychopathology is increasingly recognized" (p. 1). Numerous studies of MPD patients, both empirical (e.g., Coons & Milstein, 1984; Kluft, 1984b; Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, Norton, & Wozney, 1989), and anecdotal (e.g., Bliss & Bliss, 1985; Schreiber, 1973), have found a highly significant relationship between this diagnosis and patient reports of child abuse. Prospective studies have noted the development of dissociative symptoms and MPD in children who were being abused (e.g., Fagan & McMahon, 1984; Riley & Mead, 1988). Descriptive theories of MPD also have emphasized trauma as an etiological factor (Braun, 1984; Braun & Sachs, 1985; Kluft, 1984b; Ross, 1989; Spiegel, 1986). Going beyond etiology, scientific writing about MPD treatment has tended to focus on the direct and indirect (i.e., reenacted) effects of childhood trauma on the patient's transferences (Barach, November, 1987; Loewenstein, in press), cognitions (Fine, 1988), and complexity of pathology (Kluft, 1988).

In addition to the sadistic, invasive, ritualistic, and humiliating traumatic experiences reported by MPD patients, clinical material suggests that another kind of childhood trauma may be ubiquitous. Within the total traumatic environment (Giovacchini, 1986), another type of trauma, which I am calling "the parents' failure to respond," profoundly influences the development of dissociative psychopathology. Under this rubric I am including (1) the parents' failure to protect the child from abuse, and (2) the parents' tendency to dissociate or otherwise detach from emotional involvement with the child. Though physical neglect can follow (Wilbur, 1985), the mother's chronic failure to respond to indications of distress or emotional need in the child is by itself traumatic, eventually causing a corresponding detachment in the child. The child's reactive detachment sets the stage for reliance on dissociation as a response to "active abuse."

BOWLBY'S THEORY OF ATTACHMENT

Bowlby's theory of attachment (1969, 1973; 1980; 1988) is a useful framework with which to understand the effects of parents' failure to respond. He described the survival value to the species of certain behavioral systems which increase proximity to the mother as a predictable outcome, thereby protecting the infant from predators. These systems develop gradually over the first two years of life as a result of the infant's "interaction with his environment of evolutionary adaptedness" (Bowlby, 1969, pp. 179-180). Attachment behaviors, such as sucking, clinging, crying, following, and smiling elicit caretaking behaviors from the mother figure.

Caretaking behavior aids the survival of the species in tandem with attachment behavior. By picking up, feeding, smiling back and so forth, the mother brings the child closer.

Attachment behavior begins at birth (Klaus & Kennell, 1982) and persists through life. Once a secure attachment bond forms, the toddler uses the mother as a secure base for exploration (Bowlby, 1988), returning to her when frightened. The older infant and toddler can draw upon the memory of a caretaker, and the knowledge that she always returns, as the basis for a feeling of security. By age five, the child normally has concluded the process of internalizing and symbolizing his secure base, and is able to redirect attachment behavior onto others, and onto groups (Bowlby, 1973; 1979). Adult attachment relationships realistically mirror the situation which prevailed during childhood; obviously, such relationships would be reflected in both the transference relationship and the therapeutic alliance (Bowlby, 1988).

Bowlby (1973) identified three phases of the normal response to separation. The child first *protests* the loss and uses attachment behaviors to try and bring back his mother. When Mother does not return, the child seems to *despair*, but still awaits her return. Eventually he seems to *detach* and appears to lose interest. However, attachment behaviors will return upon reunion if the separation has not been too extended. Following reunion, the child whose parent has been appropriately responsive to his attachment behaviors will often cling to the parent, demonstrating anxiety at any hint of separation.

Bowlby's theory provides a new perspective on clinging behavior, or *separation anxiety*. In contrast to traditional psychoanalytic models which viewed separation anxiety as a displacement of some other fear (Bowlby, 1988), Bowlby saw anxious attachment as the result of real or threatened separations or temporary abandonments by caretaking figures during childhood (Bowlby, 1973). When a child knows that an attachment figure will be available whenever he needs a secure base, he will develop a lifelong ability to tolerate separations well, and will handle new situations confidently. Lacking such knowledge, he will demonstrate anxious attachment and general apprehensiveness at new ventures.

The availability of an attachment figure during childhood also influences the person's response to losses. When a frightened child needs his mother but ultimately finds that he is abandoned and alone, he protects himself from further suffering by detaching himself from any awareness of his feelings and needs. Summarizing studies of children who underwent prolonged separations, Bowlby (1980) noted detachment as the final stage of dealing with a separation. During detachment, the child stops emitting attachment behavior and even turns away from attachment figures when they return (as Robertson's [1952] film of a two-year-old's week long hospitalization and separation from his parents poignantly demonstrates). Bowlby saw detachment as the result of a deactivation of the system of attachment behavior. By defensively excluding from awareness "...the signals, arising from both inside and outside the person, that would activate their attachment behavior and that would enable them both to love and to experience being loved" (Bowlby, 1988, pp. 34-25), children experiencing prolonged separations can block attachment behaviors and their associated affects. Once established as a defensive process, detachment then becomes the child's characteristic coping style.

RELATIONSHIP BETWEEN DETACHMENT AND DISSOCIATION

My reading of Bowlby's work is that the detachment he describes is actually a type of dissociation. Although Bowlby uses the term *detachment* in describing how children respond to abandonment, he is really describing a dissociative process. In its usual definition, dissociation refers to a disjunction of the association between related mental contents (Braun, 1986; Putnam, 1989; Ross, 1989). It is "[a] psychophysiological process whereby information—incoming, stored, or outgoing—is actively deflected from integration with its usual or expected associations" (West, 1967, quoted in Putnam, 1989, p. 6). Detachment is the same process, applied to a specific category of sequestered information: stimuli for attachment behavior.

Detachment protects the abused child from crying out for help and finding out that he is alone. In traumatic situations such as "active abuse," a child feels pain, terror, and other overwhelming feelings. Such feelings obviously make the child want his mother. But whether he fantasizes floating away and watching the abuse from somewhere else, or develops alters in order to "imagine...that the abuse is happening to someone else" (Ross, 1989, p. 55), the child detaches from the affect. As I will show later, an abused child has learned to expect no help from mother because she already had emotionally abandoned the child on a regular basis.

A case study demonstrates how detachment is a part of dissociation. Riley and Mead (1988) describe how MPD developed between ages two and three in a girl who was being abused by her biological mother. At 14 months, before any abuse began, they noted "a strong psychological attachment...between the child and both guardian parents. She was also able to let her parents leave the room without exhibiting anxiety" (pp. 41-42). After visitation with the biological mother (and abuse) began, she started to cling to the guardian mother, would awaken during the night to be sure she was there, and was frightened when left alone with the examiner. In Bowlby's framework, she showed indications of an insecure attachment, which is certainly understandable in light of having been abused when the attachment figure (the guardian mother) could not protect or comfort her.

Eventually the child moved from anxious attachment to defensive detachment. She developed an alter, Lila, who dealt with visits to the biological family. Although she appeared happy and contented when observed with her biological parents, she acted as if she did not know her guardian mother (i.e., detachment) when the latter made an unexpected visit. Lila's fascination with peek-a-boo, a game wherein children "play" at separation, further suggests that attachment issues were salient.

EVIDENCE OF NONRESPONSIVITY IN THE PARENTS OF ABUSED CHILDREN

Several sources of data, reviewed below, suggest that the parents of neglected and actively abused children fail to be emotionally available to their children. In some of the sources, the relationship between the parents' failure to respond and the child's detachment is also clear.

Injured Children

When a child is injured, varying degrees of parental negligence can exist, ranging from complete innocence to calculated sabotage. The dissociative or preoccupied parent is more likely to have a child wander away into a dangerous situation while her attention is "otherwise engaged."

A study cited by Bowlby (1973) of children injured in traffic accidents in one section of London is a case in point. Almost two-thirds of the children had been alone; among younger children, more than half had been alone. Bowlby also summarized two studies of the family backgrounds of children injured in traffic accidents, and one study of the families of children who had been burned. Compared to a control group, the injured children in all three studies were more likely to be unwanted or unloved, or to have a mother absorbed with other family problems. In such families, it would be easy for a forgotten child to wander out the door and into the street, or to get near a hot stove.

Emotionally Detached Parents

Furman and Furman (1984) described parents who "intermittently decathect" their children. These parents periodically seemed to withdraw from their emotional investment in their children, either out of depression or as an expression of conscious or unconscious anger. The writers often found this kind of dysfunction in the parents of preschoolers who had been molested or raped. Seeming to refer to extrafamilial molestation, they commented, "Children this young are rarely left in situations that will eventuate in a sexual molestation if their parents have an unremitting investment in them" (p. 427). They also found intermittent decathexis to be common in parents whose children tended to "get lost."

Furman and Furman noted that the parental dysfunction was reflected in the child's own tendencies to withdraw attention from others and to be on "cloud nine," which are dissociative behaviors. In analysis, the children of intermittently decathecting parents were extremely sensitive to the analyst's withdrawal due to internal preoccupations; in my clinical experience, MPD patients demonstrate the same kind of sensitivity.

Clinicians observed a similar pattern of parental detachment in the mothers of some developmentally delayed infants. Fraiberg, Adelson, and Shapiro (1974/1987) provide a painfully vivid description of a dissociative mother and her child's detachment. The mother had been grudgingly parented by relatives after her mother's postpartum suicide attempt, and had been sexually abused by her father and a cousin. During a testing session, her baby begins to cry. It is a hoarse, eerie cry in a baby.... On tape, we see the baby in her mother's arms screaming hopelessly; *she does not turn to her mother for comfort.* The mother looks distant, self-absorbed. She makes an absent gesture to comfort the baby, then gives up. She looks away. The screaming continues for five dreadful minutes on tape. In the background we hear Mrs. Adelson's voice, gently encouraging the mother. "What do you do to comfort Mary when she cries like this?" [The mother] murmurs something inaudible.... As we watched this tape later..., we said to each other incredulously, "It's as if this mother doesn't *hear* her baby's cries!" (pp. 104-105; the emphasis is mine).

Psychoanalytic Case Study of Adults Who Were Raped As Children

Katan (1973) discussed six adult analysands who reported having been raped as children. In one case, the patient's mother, disappointed in her marriage, had turned to social activities. Bridge was so important to her that she had little time for her children.... A succession of nursemaids took complete care of the little girl and also shared a room with her.... The mother['s] interest in the child concentrated on toilet training.... The nursemaids... did not pay sufficient attention to the child to protect her against overwhelming sexual assaults [e.g., oral rape by the nursemaid's boyfriend].... Mother frequently excited the child by inviting her into the bathroom while taking a bath. These were the only times the patient remembered getting her mother's attention (pp. 216-217).

In a second case, the patient's parents worked all day, and the mother "returned in the late afternoon, worn out and irritable, to do household chores which she despised. Her patience with her children was very limited. Yelling and spanking were her only means of upbringing" (p. 210). When the father fondled the child and also bit her, the mother expected the child to protect herself. When the patient was five, she was orally raped at school. She recalled her mother saying, "She is damaged for life... nobody will ever want her" (p. 212). Katan commented, "Some of my patients... had the tendency to expose their own children to the same experience, mostly by not protecting them when they should have been protected" (p. 220).

In treating mothers who have come for supportive therapy when their children have been sexually abused, my colleagues and I have found dissociative behaviors and even MPD in a notably high proportion of the cases.

MPD Patients As Parents

MPD patients are by definition dissociative. If it can be shown that their symptomatology causes them to be intermittently unavailable to their children, they present the researcher with an opportunity to study the effects of disengaged parenting on children. Kluft (1987) reported on the parental fitness of a group of seventy-five females with MPD, based on the patients' descriptions of their own behavior. In this study, Kluft did not report on the functioning of the children. Among the pathological parenting behaviors found in the entire sample were "impairment due to amne-

sia" (20%), "abdication of parenting by alters" (17.3%), and "affective absence" (5.3%). Due to amnesia and the wish to please the interviewer, these percentages may be too low. Sixteen percent of the mothers admitted to having physically or sexually abused their child, or failed to protect the child from physical injury. Kluft classified over 45% of the mothers as "compromised/impaired"; although they were not abusive, their symptoms interfered with their functioning as mothers, or they failed to act in the best interests of the children.

Kluft (1984a) discussed one child with MPD whose father was dissociative and whose mother had MPD. Although there was no evidence of abuse by either parent, the child presented a classic MPD picture (with amnesia); the precipitating event was a near-death by drowning. Kluft did not discuss the specific parenting style to which the boy had been exposed.

Coons (1985) found a significantly greater percentage of emotional disturbance in the children of MPD patients as compared to the children of a matched sample of non-dissociative psychiatric patients. Although the study did not specifically explore the parenting styles of the MPD patients, "eight of the nine emotionally disturbed children had mothers who continued to dissociate and/or were poorly motivated for therapy" (p. 160).

Though the available data is sparse, the existing studies suggest that parental dissociation is associated with childhood psychopathology.

MPD Patients' Description of Parental Failure to Respond

Wilbur's (1985) description of non-nurturing abuse summarizes the emotional and physical neglect that many MPD patients describe. Putnam et al. (1986) found that over 60% of their case series of 100 MPD patients reported extreme neglect in childhood.

Any therapist working with MPD patients hears daily examples of parental non-responsiveness. Whether these memories reflect literal events or merely symbolize the patient's emotional experience, they show the prevalence of neglect as a theme in the emotional life of MPD patients. Many patients report that their mother was periodically depressed to the point of being bed-ridden, was hospitalized for depression, and/or received ECT. One patient's mother "always burned all the food," having been so dissociative that she lost time whenever she tried to cook. Some parents rarely attended school functions, showing little interest in academic progress. Commonly, patients report that their mothers pushed them away or punished them when they cried, told them that their problems were insignificant, or locked them in their rooms or a closet until they stopped crying. One patient reported that her mother sat and watched television while her father raped another child in the next room.

Summary of the Evidence

Several converging data sources (in addition to what patients have remembered) indicate that abused children commonly receive preoccupied, dissociative parenting. When children have been injured in accidents, or victimized by extrafamilial incest, their parents tend to have been "intermittently decathecting" (detached), unloving, or entirely rejecting. When parents have been detached from their children (or unavailable to protect them from injury, as in the case of Lila [Riley & Mead, 1988]), the children demonstrate the pattern Bowlby called detachment: an active turning away from the abandoning parent, and a withdrawal to a dissociated state. As parents, they often reenact the parenting they received: they are unable to protect their own children from abuse, and they dissociate when their children need them.

TRANSFERENCE PHENOMENA REFLECTING THE PARENTS' FAILURE TO RESPOND

Given the presence of detachment as a dynamic in MPD patients and their parents, one would expect to find many representations and reenactments of attachment-related issues in the treatment of MPD. The attachment issues are more prominent in relatively complex patients with many alters (Kluft, July, 1991, personal communication). An awareness of attachment issues can drastically shift one's perspective on what clinicians usually call "dependency." Thus, Putnam's (April, 1990) description of intrusive abuse, leading to a lack of boundaries, as "the core problem" in MPD, changes to an awareness that the *alternation* between intrusion/assault and abandonment is the core problem.

Attachment issues sometimes become evident through the use of detachment in early sessions. Because MPD patients often enter therapy feeling that no human can be trusted, they use various protective mechanisms to get the help they need without having to develop a sense of trust. Some patients will immediately produce child alters who seem to trust and cling to the therapist, but they are quickly replaced with distant or hostile alters who protect the personality system from the expected assault. Using attachment behavior as a framework, one can reconceptualize this sequence as representing the reactivation of attachment behavior in the transference.

Early in treatment, when the patient is often flooded by signals that suggest that internal and external danger is close at hand, the need for an attachment figure is strong. Bowlby would remind the therapist that attachment behavior is elicited by fear, and that the frightened person seeks proximity to an attachment figure. Thus, there are frequent emergencies, phone calls, requests for extra sessions, requests for hospitalizations or medication (symbolic feeding). Alternatively, patients run from their attachment wishes by self-destructive behaviors or by dropping out of treatment. When they later re-enter treatment, they commonly say that they felt they were "getting too close."

Caretaking behavior, as well as attachment behavior, is ethologically determined. Not unexpectedly then, the attachment behavior of child alters can readily elicit caretaking behavior from the therapist. The therapist new to MPD may be surprised by the intensity of his wish to respond to the attachment behaviors of the child alters. This behavior sequence has usually been discussed in the MPD literature

from the equally valid viewpoint of countertransference-based violations of the patient's boundaries (e.g., Barach & Comstock, November 1990; Chu, 1988; Greaves, 1988). Eventually, the therapist realizes that any caretaking behavior must be applicable to the needs of the system *as a whole.*

While the tendency of some MPD patients to violate the therapist's boundaries has usually been understood as the transference reenactment of abuse (Barach, November 1987; Loewenstein, in press), boundary violations also reflect the reactivation of attachment behavior within the transference. For example, some patients monopolize the therapist's answering machine, spend hours in the therapist's waiting room, leave notes on the therapist's car, drive by the therapist's house, etc.

There are positive and negative aspects to this kind of acting out. The positive aspect, as Winnicott (1965) pointed out, is the patient's hope that the original trauma can be corrected, that this time she will not be abandoned. The reactivation of attachment behavior also raises the possibility that the adult patient may eventually develop an internal sense of security in her attachment and will not need to detach (i.e., dissociate) in response to internal and external demands. As Greaves (1989) said, "the external reference point of the therapist becomes a place of focus for the patient's emotions in the external object world, hence a vehicle of eventually-integrated experience" (p. 225).

The negative aspect to the reactivation of attachment behavior is that the patient may see the therapist's empathic neutrality as an abandonment which is more real than transferential, thereby wrecking the therapeutic alliance. The patient often unconsciously perceives the therapist as unresponsive, as her mother was. To protect herself from anticipated future abandonments, the patient may then move into a state of detachment, often by calling upon an intellectualized or numb alter. The expression of dissociated anger which eventually follows, accompanied by further demands (Barach & Comstock, November, 1990), can push the therapist into detachment or retaliation. Anger at the departed attachment figure is a common response to separation, which may have the function of overcoming obstacles to reunion and making it less likely that the attachment figure will leave in the future. But repeated experiences of separation and loss are likely to elicit malicious, dysfunctional anger from the one who has been left, weakening the attachment bond instead of strengthening it (Bowlby, 1973). Indeed, the MPD patient who is furious at the therapist's unwillingness to fulfill every demand is often terminated, medicated, or hospitalized—in other words, "sent away" in one manner or another.

Early in treatment, MPD patients usually demonstrate either separation anxiety or detachment when a therapist leaves for vacation. I cannot recall any MPD patient who has ever been able to retain positive feelings over an extended absence without separation anxiety (the fear that the therapist will not return) or detachment. Many MPD patients find that they are unable to picture the therapist in their mind when he is out of town or out of the office. Some therapists have resorted to giving the patient a transitional object to remind her of the therapist during a vacation, but the ability of the object to evoke a sense of security tends to wane after a few days; in other words, detachment sets in.

If treatment progresses well, a few alters begin to develop a sense of security in their attachment, which may then spread throughout the system of alters as integration nears. At first, the attachment bond is concrete in nature and requires picturing the therapist, fantasizing about the therapist, having imaginary conversations with the therapist as issues come up, talking to other people about the therapist, etc. The traditional derogatory term used for this period of the therapeutic work is *dependent,* or *regressed.*

In the conceptual framework of attachment theory, such developments are an extremely positive sign, showing that the patient has entered a period of anxious attachment. As Bowlby (1969, 1973) noted, anxious attachment following detachment is a sign that defensive exclusion of the need for proximity to an attachment figure has been breached; anxious attachment thus indicates a departure from the use of dissociation as a defense mechanism. Gradually, but not always steadily, the patient begins to find the therapist to be a secure base to which she can return when frightened. The patient's nascent sense of security then makes the stress of abreactive work bearable. Often the patient begins to make major gains in self-confidence at this time. The therapist should not discourage attachment, but should maintain his attitude of empathic neutrality. He should encourage the patient to express wishes for dependence and attachment just as he encourages expression of all other feelings, but he should not endeavor to gratify those wishes other than by his steady, nonjudgmental, mirroring presence.

Not all MPD patients seem to be able to develop a secure base for attachment. Some seem to get stuck in the period of anxious attachment, while others, staying with the use of detachment, never invest in the therapeutic alliance. Many of these patients demonstrate the pattern which Kernberg (1984) called *malignant narcissism.*

However, as many MPD patients move toward integration, they gradually develop an internalized sense of security which is much less dependent on the actual or imagined presence of the therapist. The feeling of internal security is available to the personality system as a whole, and patients will often make forward strides in their lives which they previously feared to attempt.

CLINICAL EXAMPLE

Ann (a pseudonym) came into treatment complaining of chronic anxiety. She was having panic attacks in numerous situations in which she could find no objective external danger. With people she was either seductively compliant or sarcastic; she left the impression that she could "take or leave" the people in her life, including the therapist. She made little eye contact and did not seek comfort when distressed. In other words, the clinical picture showed detachment. As treatment progressed, Ann described dissociative symptoms. Gradually the diagnosis of MPD was made.

Ann was sure that the therapist would forget her in between

sessions and when he took a vacation. In other words, she expected that she would disappear from the therapist's mind as she had disappeared from her mother's. The first attempt to establish a continuity of attachment came from a child alter who asked the therapist to keep a small toy that was important to her. She could picture in her mind that the toy was still with the therapist, even though she could not yet imagine that her mental representation stayed with him. Ann was highly sensitive to the therapist's momentary wandering of attention. She tended to become more detached and numb when this would occur. Eventually, Ann's sudden detachment sometimes alerted the therapist to the fact that his thoughts had begun to wander, and was a helpful indicator that countertransference issues needed exploration.

After abreactive work began, Ann went through a period of making numerous calls to the therapist. These calls, at reasonable hours, were usually not crisis calls (suicide, intrusive flashbacks, self-mutilation, etc.). Rather, they reflected moments of separation anxiety, when the patient wanted to check if the therapist "was still there." Listening to the therapist's answering machine later sufficed. The patient also used imagined conversations and interventions from the therapist (pictured in great detail and involving age-appropriate comforting of the relevant alters) to cope with situational transitions and anxieties. At times, Ann had sudden upsurges of denial concerning parental abuse; these tended to occur when she strongly feared losing the attachment bond to her parents. Her internalized sense of self-confidence developed and she found friends, a career direction, and more willingness to try new ventures.

Ann did not work directly on material related to her mother's failure to respond until after the active abuse had been processed. She allowed herself to feel much younger than ever before in the treatment, accompanied by intense sadness and mourning. She used her internal "secure base" and the therapist as supports for her mourning, no longer needing the therapist to quell separation anxiety. Although she felt intense sadness, she did not dissociate from it or detach from those around her; she knew why she was sad, and accepted these feelings as her own.

SUMMARY

Though the effects of active abuse on the etiology of MPD are important, attachment issues are the central part of the disorder. Just as the mother's failure to respond to and protect her child affect every developmental task, so do attachment issues affect every aspect of the treatment. The achievement of an internalized secure base allows the MPD patient to abandon dissociation as a coping style, so that she can feel a part of her world. ■

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