1. Review of ISSTD Guidelines for treating DID in adults
2. Discuss the history of the understanding of dissociation and its antecedents

Chu:

1. Current understanding of trauma and its impact has mostly been realized in the past 30 years (PTSD in DSM III, 1980)
2. Judith Hermann 1992
3. Underpinnings include research from Janet and Freud from the turn of the 20th century
4. Major themes in therapy, even until the ‘80s Psychoanalysis (fantasies of sexual abuse derived from Oedipal wishes) 🡪 Psychodynamic (conflict of sexual drive, instincts, and fantasies considered more important than the reality of the abuse)
5. Important information and research is “disremembered/denied” i.e. the *Rape in America: A Report to the Nation.*  The need to look the other way also discussed in Herman’s book.It is difficult for society to accept and difficult for victims to recover without societal report, which has a component of political movement. Vietnam War and Women’s Movement – two major political movements having impact.
6. Civil war (soldier’s heart) 🡪 WWI (shell shock) 🡪 WWII (physioneurosis, combat fatigue) 🡪 Vietnam War (rap groups) /Women’s Movement (rape centers) 🡪 DSM III PTSD
7. Shame and secrecy are pillars of childhood sexual abuse and children feel responsible for their victimization. To help with safety the child must view the abusing parent as good – part of the foundation for disorganized attachment (double bind)
8. Children fear family disruption by telling and have been told not to tell – which often comes out as psychiatric symptoms and unhealthy functioning
9. 1974, Congress – Child Abuse Prevention and Treatment Act (mandated reporters)
10. 1988 CAPTA amended – over 3.3 million reports, 772,000 substantiated, highest rates of maltreatment – ages 0-3
    1. 549,000 neglect
    2. 124,000 physical abuse
    3. 70,000 sexual abuse (30% under age 8)
    4. 56,000 psychological mistreatment
11. 1980s – ISSTD and ISSTS (International Society for Traumatic Stress Studies)
12. Treatment model
    1. First generation (up to 1980s) – psychoanalytic in nature, abreactive (was beneficial to some
    2. Second generation”Growth” (late 1980s-early 1990s)
       1. specialty programs available, more clinicians trained to help with PTSD/dissociation
       2. Focused on phase-oriented approach and became standard of care by late 1990s
    3. Third generation “Conflict and Maturation” (mid 1990s to Present)
       1. False Memory Syndrome Foundation (1992) – challenged childhood amnesia, dissociative disorders, and practices of clinicians treating victims of abuse
       2. ISSTS and ISSTD with others conducted several studies to show correlation with childhood abuse, trauma, amnesia, and dissociation
       3. Clinicians trained to realize dissociative clients highly suggestible and need to use restraint (neutrality) and direct inquiry
13. Explore the interplay of dissociation, trauma and multiplicity within the dynamic unconscious

Chu:

1. Psychiatric patients (study 1990)

-77% report intrafamilial sexual abuse/psychological harm

-intrafamilial, chronic sexual abuse highly correlates with dissociation

1. 1980s research supported – people who suffered extended traumatization in childhood not only developed posttraumatic and dissociative disorders, but had major deficits in ego functioning
2. severe and long-standing trauma leaves victims feeling assaulted by unwanted, thoughts, feelings, reminders, chronic anxiety, disturbed sleep and irritability
3. the dissociative barriers (amnesia/alters) act as protection – the same barriers can cause altered perceptions, cognitive functioning, and interferes with a sense of continuity
4. Explore the interplay of dissociation, trauma and multiplicity within the dynamic unconscious

Howell:

Relational Theory: humans wired for attachment and relationality, but along with attachment comes the capacity for shame. Too much shame can be traumatic leading to dissociation. Failed relationships become continuous problems in dissociation. Traumatized folks defensively respond to anxiety and shame and address conflict between differing and opposing relational aspects and configurations of the self ie) shamed-self versus other parts of the self that may operate more adaptively and with less conscious pain.

Multiplicity- multilevel structure in which there are internal and external relationships that mirror and repeat in important ways the problems in early relationships. Look for repetitions of dominant/submissive, annihilating/annihilated and sadistic/masochistic patterns of the early environment.

Unconscious

Repressed unconscious is considered a unity, contents were formed by the agency or will, albeit unconscious, of the person.

Dissociated unconscious consists of many autonomous subcenters of consciousness that are not necessarily a product of a person’s agency. They are most likely result of person being psychologically overwhelmed.

Dissociative multiplicity includes a tightly woven system of interrelated dissociated self-states

DID= making the unconscious conscious=intercommunication of dissociated identity states and the integration of their memories and affects

Repression: willful exclusion of information from the consciousness. Usually refers to info that was accessible at one time, but not at another. Horizontal splitting

Dissociation: is both automatic, psychologically passive and an active motivated defense. It can arise in trauma and nondefensively in hypnosis. States and systems of states can exist side by side. ie) My father is a wonderful man, while other state remembers abuse. Vertical splitting

Janet put together dissociation, trauma and hysteria

Carl Jung’s concept of “complex” similar to Janet’s “fixed ideas”. Complex: affectively-charged clusters ideas accompanied by somatic interventions

Freud Dissociation 1: splitting of consciousness, phenomenon is one of doubling or multiplication

Freud Dissociation 2: people can make some matters conscious dividing the mind into conscious and unconscious parts.

Freud Dissociation 3: split between ego and superego

Freud Dissociation 4: Splitting of the ego in the process of defense, 2 different contradictory views of reality can exist in the mind simultaneously without experience of conflict or resolution.

DID has been considered rare because of our need to believe that child abuse is rare. Just as Freud may have understandably feared professional shame for his beliefs and observations, current clinicians face the same dilemma.

1. Explain the role of attachment in the development of dissociative disorders

Chu:

* 1. attachment theory examines the way children relate to parents/caregivers based on how the adults respond to them
  2. 4 styles of attachment
     1. Secure – caregivers are attentive to infant’s needs and respond appropriately
     2. Avoidant insecure – child is highly stressed/inconsolable when caregiver leaves, may want contact but avoids it when caregiver returns
     3. Resistant insecure – child highly stressed/inconsolable when caregiver leaves, not easily consoled when caregiver returns
     4. Disorganized – child finds caregiver frightening or alarming, child is in double bind – both afraid of the caregiver and dependent on the caregiver for comfort and survival
  3. When the child is abused and has been emotionally abandoned therefore has not external support – she relies on dissociation/fragmentation which allows separating the images of good parent and abusive/neglectful parent and the amnesia shields the child from the memories of abuse

1. “the sequence, in the child’s mind, of multiple representations in which both self and the other person shift among the three incompatible roles of persecutor, rescuer, and victim should be understood as a metaphorical rendition of the construction of contradictory emotion schemata that arose during the interactions that led to the disorganized attachment” pg 68
2. Borderline Personality Disorder
   1. consider trauma history and personal response to the client’s presentation
   2. intrafamilial abuse and neglect lead to disruption in attachment that are not subtle, but gross lapses in care and attend that occur over multiple periods of the child’s development
   3. also consider the mismatch that may be present between temperaments and personality characteristics – even a well-meaning, non-abusive family can leave a child “unseen”
3. Reframing BPD
   1. 3 “buckets” to summarize BPD symptoms
      1. Recurring relational disturbances
      2. Lack of affect tolerance and impulse control
      3. Negative and empty views of self
   2. The intense idealization then devaluation of relationships may be better understood as recapitulation and reenactment of early abusive relationships
   3. Since the abuser (caretaker) used narcissism, manipulation, exploitation, and control it is not surprising traumatized clients engage others in this way (including the therapist)
   4. Consider reframing the behavior as deficits in learning and deprivation concerning interpersonal relationships rather than malicious or deliberate
   5. Since BPD have a disability with utilizing supportive relationships, it creates intolerable rage that is often manifested as angry outbursts, self-destruction, suicidal ideation
4. Treatment implications
   1. Relational issues must have a central role in psychotherapy of these disorders
   2. Only processing the trauma is not enough – a collaboration (especially in the therapeutic alliance) and correcting maladaptive negative beliefs about self reduce symptomatology and enhance interpersonal ties
   3. Therapist can ally with clients’ sense of having been victimized and help clients begin to understand their own feelings and behaviors
   4. Continue to pair angry motives and feelings by empathizing and validating the experience then connect that although understandable, the angry feelings must be identified and expressed in a manageable fashion
   5. The therapeutic alliance is critical and remains so throughout treatment
   6. Over time, interpretations and confrontation can be addressed in treatment

Liotti

Infant attachment disorganization is, in itself, a dissociative process, and predisposes the individual to respond with pathological dissociation to later traumas and life stressors

Fright without Solution (an early relational trauma): caregivers communicating fear and aggression in non-dangerous situations; caregiver becomes both the source and solution of the infant’s alarm.

Drama Triangle: reciprocal interactions of the powerful benevolent rescuer, equally powerful but malevolent persecutor and the helpless victim.

* Disorganized child construes attachment interactions as shifting representations of both the attachment figure and the self as each other’s persecutor, rescuer, and victim
* The child represents the attachment figure negative as the cause of the child’s ever growing fear, and positively as a rescuer.
* The caregiver, notwithstanding the frightening attitude caused by unresolved traumatic memories, is usually willing to offer comfort to the child; thus the child may feel comfort in conjunction with the fear.
* The child may comfort the caregiver which may convey the self as the powerful rescuer of a fragile adult.
* Multiple transferences of the underlying state: a frightened, desperate, often unconscious longing for help.
* These defenses produce a relational dilemma that hinders the therapeutic process: seems impossible to the patient to achieve both self-protection and protective closeness. The patient might oscillate between dependence on the therapist as rescuer, and avoidance of therapist as persecutor (phobia of attachment)
* Dissociative mind emerges at the beginning of life together with operations of the attachment systems
* Care-seeking interactions between disorganized infants and their parents are heavily influenced by dissociative process and are linked to the caregivers’ unresolved traumas and losses.
* Caregivers’ dissociation interacts is a self-perpetuating loop with the ongoing dissociative processes in the infant’s mind.
* Attachment-based model of dissociation supports Janet’s view on the unity of the self: Unity of self-representation is achieved through integrative processes. Defenses do not play a primary role in fragmentation of the self throughout childhood. Dissociation may be secondarily used as a defense against mental pain in later developmental stages.
* Dissociative symptoms emerge not only as a reaction to traumatic experiences, but also through the mediation of a disorganized IWM (Internal Working Model) that becomes active whenever mental pain activates the attachment motivational system.