Disorganized Attachment, Development of Dissociated Self States, and a Relational Approach to Treatment

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ABSTRACT. Disorganized (D) attachment, and the double-bind characteristics of the relationships that foster it, form a basis for theoretical approaches to understanding the development of alternating, dissociated self states with incompatible, idealizing/devaluing or victim/persecutor models of attachment, such as are observed in borderline personality and dissociative disorders. This model proposes that the double binds inherent in abuse by a primary caretaker are likely to generate two or more dissociated self states, with contradictory working models of attachment. In contrast, because dissociated states ensuing from extra-familial trauma can be expected to have been constructed primarily around fear, all parts of the self will operate according to the same attachment paradigm. Because relationships within the family of origin appear at least as important as trauma in the development of dissociated self states, this has important implications for treatment of child abuse survivors. D attachment may result from several parental behaviors: abuse, neglect, frightening, intrusive or insensitive manner; and disrupted affective communication. Longitudinal research demonstrates that D attachment in infancy predicts dissociation in childhood and early adulthood. Theoretical models describing the relationships among D attachment, the development of segregated internal working models of attachment, and the emergence of dissociated self states will be discussed. A relational approach to therapy calls for consideration of attachment issues in creating the frame for therapy and tailoring treatment to the individual trauma.
survivor. The therapist can serve as a relational bridge between dissociated self states, allowing the patient to internalize a working model of the therapeutic relationship. This interaction provides a vehicle for integrating dissociated self states and opportunity for development of more flexible, adaptive models of being with others.

KEYWORDS. Borderline personality, disorganized attachment, dissociation, dissociative disorders, self states, trauma

When salient experience must be unnoticed, disallowed, unacknowledged, or forgotten, the result is incoherence in the self structure. Interconnections among experiences cannot be made, and the resulting gaps in personal history compromise both the complexity and the integrity of the self. (Ogawa, Sroufe, Weinfeld, Carlson, & Egeland, 1997, pp. 871-872)

Disorganized, incoherent representations of attachment may prevent important aspects of the self and object from being integrated, thus predisposing the self structure to fragmentation and dissociation. Just as overwhelming trauma may cause dissociation of terrifying memories, so may incomprehensible, contradictory interactions in significant attachment relationships create double binds, leading to disorganized (D) attachment and development of dissociated self states. The attachment system is organized by complex mental representations of the self, the caretaker, and the quality of the relationship, and is therefore a major organizing principle in the development of the self. In the presence of any stressor, internal or external, the attachment behavioral system controls the child’s pursuit of safety by motivating the child to seek proximity to the caretaker. Disorganized attachment arises when a child is unable to form any coherent strategy for maintaining attachment to a parent or other significant caretaker, because the caretaker is unable to provide safety or threatens the child.

In treating survivors of abuse by a significant attachment figure, it is essential to understand the entire personality within its developmental context, rather than just treating trauma and dissociative symptoms (Barach & Comstock, 1996; Chu, 1998; Gold, 2000; Davies & Frawley,
Attachment theory plays a key role in understanding both the characterological outcome of survival of child maltreatment and the development of a dissociative psychic structure (Alexander, 1992; Alexander & Anderson, 1994; Barach, 1991; Barach & Comstock, 1996; Blizard, 1997, 2001; Howell, 2002a; Liotti, 1992, 1999a, 1999b; Lyons-Ruth, 1999, 2001a, 2001b). While trauma has long been accepted as one of the major causes of dissociation, it explains neither the variability of dissociation, nor the development of dissociated self states that incorporate contradictory models of attachment. Among the many factors contributing to dissociation, including trauma, biological processes, hypnotic states, and defensive processes; D attachment offers a means of conceptualizing how double-bind relationships in early childhood foster the development of segregated, conflicting working models of attachment, which may evolve into dissociated self states.

The role of the double-bind in the genesis of schizophrenia (as it was conceptualized in the 1950s) was articulated by Bateson (1972). Briefly, in a double-bind situation, the victim is repeatedly placed under a negative injunction, which is contradicted by a second injunction, both of which are enforced by punishment or signals that threaten survival. A third injunction prohibits the victim from escaping. A significant element in the theory is that one injunction may be articulated verbally, while a conflicting message is communicated via body language. Spiegel (1986) suggested that Bateson’s theory may have been prematurely discounted because it was applied inaccurately to patients with a biologically-determined schizophrenic disorder, who were often confused with persons with dissociative identity disorder (DID). He noted that extreme, double-bind communications are typical of parents of those who develop DID, who often rationalize their abuse by telling the child that it was deserved. Further, the child has no escape from dependency on the parent. While Spiegel’s linking of the double-bind to child abuse was essential to understanding the origins of DID, Bateson’s model appears now to be applicable to the development of D attachment, which may lead to dissociation.

The concepts of the double-bind and D attachment may help to alleviate some of the long-standing difficulty in articulating the relationship of the alternating ego states of personality disorders with the dissociated self states of post-traumatic disorders. To enable discussion of varying degrees of dissociation between states, as observed throughout the spectrum of dissociative disorders, “ego state,” “identity state,”
"alter personality" will be subsumed under the more inclusive term, "self state." There are a multitude of configurations of dissociated memories, affects, behaviors and self states observed in survivors of trauma. For example, in uncomplicated post-traumatic stress disorder (PTSD), resulting from devastating experiences in adulthood, memories for trauma may be dissociated from their traumatic affects and behavioral schemas. These elements of traumatic experience may intrude into normal consciousness individually, or as a relatively circumscribed self state, the “emotional personality” while the “apparently normal personality” (Nijenhuis, Van der Hart & Steele, in press) continues functioning at other times, albeit in a constricted manner. These self states will likely have similar attachment paradigms, because the traumatic experience occurred long after attachment developed in early childhood.

In other cases, the personality becomes fragmented into multiple self states. If there are partial amnestic barriers between them, they are diagnosed as dissociative disorder, not otherwise specified (DDNOS); while full amnesia between states for behavior, identity and history indicates dissociative identity disorder (DID; American Psychiatric Association (APA), 1994; Dell, 2001). Further study is needed to determine how these configurations correlate with the severity and chronicity of trauma, whether trauma is a result of natural disaster, neglect or malice, and with the closeness of relationship between perpetrator and victim (Freyd, 1996; Williams, 1994).

When the focus of clinical attention is on two or more self states with contradictory attachment patterns, the diagnosis of personality or dissociative disorder is determined by whether these states are partially or fully dissociated. The alternation between these states creates the identity disturbance, affective instability, and idealizing and devaluing in relationships that are characteristic of borderline personality disorder (BPD; APA, 1994; Kernberg, 1975, 1980). A number of theorists see these contradictory self states as ensuing from D attachment, and have conceptualized them as victim and persecutor/perpetrator (Hesse & Main, 1999; Howell, 2002a; Liotti, 1999a, 1999b), helpless/hostile (Lyons-Ruth, 1999, 2001a), dependency and counter-dependency (Steele, Nijenhuis & Van der Hart, 2001), and masochistic and sadistic (Blizard, 2001). Similarly, most cases of DID incorporate victim and perpetrator states. These cases usually originated in families with the severely neglectful or abusive caretaking relationships that lead to D attachment, which appears to contribute to the formation of dissociated self states (Blizard, 1997, 2001; Liotti, 1992, 1999a, 1999b). Intriguingly, Kluft
(2002) reported rapid treatment of two cases of DID resulting from severe trauma that did not involve problems with attachment. Identification of similar cases may shed more light on the interaction between trauma and D attachment in the etiology of dissociated self states.

The thesis to be developed here is that contradictory relationships are at least as important as trauma in determining how well-integrated the self structure will be. When a coherent attachment system cannot be formed, segregated models of attachment may develop. These models may evolve into dissociated self states, depending on the availability of other, benign attachment relationships and on the occurrence of trauma, especially within the primary relationships. Thus, attachment, trauma and dissociation are all related issues in the treatment of survivors of neglect, double-bind relationships, and abuse.

THE DEVELOPMENT OF DISORGANIZED ATTACHMENT AND ITS RELATIONSHIP TO DISSOCIATION

The concept of dissociation of the self structure is integral to attachment theory, beginning with Bowlby’s (1980) discussion of defensive exclusion and segregated systems, even though he did not use the language of dissociation, and D attachment had not yet been identified (Hesse & Main, 1999; Solomon & George, 1999). Dissociative processes are essential to disorganized attachment, which in turn predisposes to further dissociation throughout life. Dissociative processes observed in both children and adults with D attachment include trance-like states, disconnected behavioral responses (Main & Morgan, 1996; Main & Solomon, 1990), and lapses in discourse related to unresolved trauma or loss (Hesse & Main, 1999; Main & Hesse, 1990).

Secure, Insecure, and Disorganized Attachment

According to Bowlby (1982), when the child is faced with any stressor, internal or external, the attachment behavioral system controls the pursuit of safety by motivating the child to seek proximity to the caretaker. He proposed that the child constructs internal “working models,” which are complex mental representations of the self, the caretaker, and the quality of the relationship. These internal working models organize the child’s thoughts, feelings and appraisals regarding the self as worthy of care and protection, and of the attachment figure as willing, able and available to provide these. Three basic patterns of attach-
ment were characterized: secure, insecure avoidant, and insecure anxious/ambivalent (Ainsworth, Blehar, Waters, & Wall, 1978). When the caretaker is available, consistent, and sensitive to the child’s needs, the child feels lovable and protected and forms a secure attachment. In this case representations of self and attachment figure are coherent and reasonably well-aligned. When the caretaker is consistently insensitive or rejecting, the child perceives the self as unlovable and the object as uncaring, thus forming an avoidant attachment. In anxious/ambivalent attachment, the caretaker is unpredictably available or role-reversing. The child feels uncertain of her lovability, and is occasionally angrily rejecting, but more often heightens her expression of distress and becomes preoccupied with soothing the caretaker.

In insecure attachment, the child avoids emotional pain and negative appraisals of self and other by engaging in two processes of defensive exclusion: deactivation and disconnection. In deactivation, information and affective appraisals linked to activation of the attachment system are excluded from consciousness, either cognitively, by failing to recall them, or behaviorally, by looking or moving away from an activating stimulus. In disconnection, painful information about an individual is cognitively “disconnected” from awareness. The child is unaware of the reasons for her behavior or feelings, but when disconnection is partial, feelings associated with the activation of attachment gain limited access to consciousness (Solomon & George, 1999). Deactivation is typical of avoidant attachment, with the child focusing on the environment to the exclusion of the attachment figure. In ambivalent attachment, the child continues to pursue the caregiver, disconnecting painful experiences of inconsistency or insensitivity.

According to Bowlby (1980), if the child’s attachment system is chronically activated but not soothed, as when there is continued separation, rejection, or punishment for attachment-seeking, then defensive exclusion of attachment becomes more or less complete. To defend against cognitive, affective and behavioral breakdown, the child may construct segregated systems, which separate attachment information from consciousness in an extreme and potentially pathological form. As a result, the child may form multiple representations of self and other that are incompatible and difficult to integrate. Bowlby proposed that this would occur in children with insecure attachment. However, these multiple, segregated internal working models are more characteristic of what is now understood as D attachment (Main & Solomon, 1990). Although Bowlby (1980) referred to defensive exclusion as repression, in
its more severe forms, it might be better understood as dissociation (Solomon & George, 1999).

Disorganized attachment results when caregiver behavior frightens the infant. The simultaneous experiencing of fear of the caregiver, and activation of attachment behavior, which is designed to seek safety from the caregiver, places the child in an irresolvable paradox; wherein she can neither approach the caregiver, flee, nor shift attention to the environment. These intense, conflicting motivations may cause the child to freeze and become dazed or rapidly alternate between approach and avoidance of the caregiver. Disorganized attachment appears to develop in response to overt neglect and maltreatment, frightening or insensitive caregiving, and disrupted affective communication. There appears to be a complex interplay among relational patterns, D attachment, trauma, and dissociation, each in turn interacting with the others.

**Precursors to Disorganized Attachment**

Physical and sexual abuse, psychological unavailability, neglect, maternal risk for parenting difficulties, and intrusive/insensitive caregiving are correlated significantly with D attachment (Carlson, 1998; Carlson, Cicchetti, Barnett, & Braunwald, 1989), but there appears to be no relationship to constitutional factors (Carlson, 1998; van Ijzendoorn, Schuengel & Bakermans-Kranenburg, 1999). For the significant number of infants with D attachment for whom there is no evidence of abuse or neglect, it is likely to be the result of frightening (FR) parental behavior (Hesse & Main, 1999; Schuengel, Bakermans-Kranenburg, van Ijzendoorn, & Blom, 1999; van Ijzendoorn et al. 1999).

Main & Hesse (1990) hypothesized that, in mothers with unresolved loss or trauma, attachment-seeking by their infants might evoke painful, dissociated memories, precipitating FR behavior, such as:

- Trance-like states, or bizarre, altered vocalizations,
- Inexplicable threatening behavior or frightened expression such as stalking or alarmed retreat,
- Deferential role-inversion such as submission to infant aggression or seeking safety in the infant,
- Sexualized behavior toward the infant,
- Disorganized/disoriented behavior or collapse of caregiving strategy such as freezing while infant is crying.
Home-observation studies confirmed that insecure mothers with unresolved loss were far more likely to exhibit FR behavior, which in turn predicted D attachment in infants (Lyons-Ruth & Jacobvitz, 1999; Schuengel, Bakermans-Kranenburg, & van Ijzendoorn, 1999; Schuengel et al., 1999).

Lyons-Ruth and colleagues (Lyons-Ruth, Bronfman, & Atwood, 1999; Lyons-Ruth, Bronfman, & Parsons, 1999) found that, even in the absence of FR behavior, the following contradictory caregiving strategies and disrupted parental affective responses predict D attachment:

- **Conflicting cues or failure to respond to clear signals** from the infant,
- **Negative-intrusive behavior**: verbal teasing or physical insensitivity;
- **Withdrawal** such as holding infant away from body; failure to greet infant.

These findings suggest that Bateson’s (1972) double-bind theory is applicable to the parent/infant relationship.

Two types of infant disorganized behavior were distinguished. D-approach infants typically continue to express distress and approach the parent, and D-avoid resist infants avoid or angrily resist the caretaker, although both exhibit confused, contradictory or fearful behavior (Lyons-Ruth, 2001a). Mothers of D-approach infants tended to be helpless, with fearful, withdrawing behavior; while mothers of D-avoid resist infants were more likely to be hostile, displaying role confusion and negative-intrusive behavior. Intriguingly, hostile mothers tended to have suffered physical abuse in childhood, while helpless mothers more likely experienced sexual abuse without violence. In either case, the contradictory cues leave the infant without a clear attachment strategy, potentially causing dissociative trance or rapidly alternating approach and avoidance of the parent (Lyons-Ruth & Block, 1996).

**Theoretical Models of Disorganized Attachment and Dissociated Self States**

Main and Hesse (1990, 1992; Hesse & Main, 1999) proposed when the child’s attachment system is activated by fear of the caretaker, the child experiences cognitive and behavioral collapse, leading to dissociative, trance-like states or contradictory behavioral responses. The child’s rapid alternation between approach and avoidance strategies...
may develop into incompatible, segregated systems of attachment, which could become dissociated executors or self states, the basis of DID.

Barach (1991) proposed that the detachment of emotionally neglected children from signals that ordinarily stimulate attachment behavior is a form of dissociation. Children whose primary caretakers were detached or dissociated would then use dissociation to detach from the overwhelming, painful affect of abuse. Ogawa et al. (1997) later confirmed that avoidant attachment in infants predicts dissociation, although less strongly than D attachment. These parents might also fail to protect their children from abuse, leaving the frightened child unable to seek safety from the attachment figure, a paradox that we now understand leads to D attachment. Interestingly, Barach portrayed a mother who was completely unresponsive to her baby’s crying, displaying the disrupted affective communication shown to precipitate D attachment by Lyons-Ruth and Jacobvitz (1999).

Liotti (1992) suggested that a consistently detached caretaker would probably foster a coherent, avoidant attachment, which is not likely to result in dissociation. In contrast, when the caretaker’s attachment behavior is dissociative, inexplicable, or frightening, the child is likely to construct multiple, incoherent internal working models of the self, corresponding to D attachment. He proposed three likely pathways:

1. If there are other stabilizing relationships, and no abuse occurs, one of the various internal working models may predominate, and development may be relatively unimpaired.
2. If the child continues to be exposed primarily to disorganized, dissociative relationships, but there is no significant maltreatment, a mild dissociative disorder may develop. Interpersonal stressors may precipitate switches among models of the self, but not the development of fully dissociated self states.
3. If the child is the victim of serious abuse, D attachment may predispose to dissociation during episodes of abuse. During dissimilar patterns of traumatic experiences, different models of the self may be used to construct segregated self states with amnestic barriers between them, leading to DID.

In contrast to Barach’s thesis that detachment precipitates dissociation of abuse, I proposed that dissociation is actively used as a defense to preserve attachment to an abusing caretaker (Blizard, 1997; Blizard & Bluhm, 1994). Rather than becoming consistently detached from the
caretaker, the child dissociates conflicting self states in order to segregate experiences of caretaker nurturance from those of abuse. Building on Liotti’s (1992) suggestion that disorganized attachment may result in segregated systems of attachment with incompatible internal working models, I proposed that the child would be motivated to preserve a representation of the attachment figure as caring and the self as lovable, but dependent, by dissociating it from an internal working model representing the caretaker as unapproachable or dangerous, and the self as powerful, but detached (Blizard, 1997, 2001).

Liotti (1999a, 1999b) pointed out that, although the early interactions leading to D attachment are based on frightened or aggressive parental reactions, the approaching child will eventually be able to achieve proximity, otherwise she cannot survive. The parent likely experiences some comfort through contact with the child, and may momentarily be more. Accordingly, the child has memories of fear juxtaposed with memories of comfort on the part of both child and parent. This helps to explain the source of an internal working model of soothing, even with some of the most abusive caretakers. Liotti suggests the child may develop five meaning structures based on early experiences: (1) the self as victim or (2) persecutor of the frightening parent; (3) the self as able to comfort/rescue or (4) be comforted/rescued by the frightened parent; or (5) both self and parent as victims of some inexplicable, outside danger. These representations of self and caregiver resemble common types of self states in dissociative spectrum disorders: victim, persecutor, helpless child, helper, and inconsolable, terrified state.

Lyons-Ruth (1999, 2001a) proposed that dissociation may result from disconnections between procedural, enactive, “how-to” knowledge and narrative knowledge, as well as among various systems of enactive knowledge. When there are conditions in the family which prevent integration of narrative and enactive systems of knowledge of “ways of being with” others, then disorganized attachment or other forms of dissociation between affect, knowledge and behavior may occur (Lyons-Ruth, 1999). For example, enactive systems may be compartmentalized as, “how to behave in church,” versus “locker-room talk.” The dissociation of enactive versus narrative knowledge is exemplified in a child’s confusion about her brother’s intentions when he terrorizes her. Her mother’s demurral, “He wouldn’t hurt you, he’s just playing,” combined with his laughter, made her conclude he was just joking. This type of disjuncture is intrinsic to families with hostile/helpless relational patterns. When the child is distressed, her approach may be frightening, causing the helpless parent to retreat or freeze, while the
hostile parent rejects or attacks her. The child’s needs for soothing and safety are subjugated to the parent’s fear of attachment or need for control. Thus, internal working models tend to embody traumatic affects, and dissociation of the hostile or helpless component is more likely. The disorganized attachment pattern that results is the beginning of segregated systems of enactive, implicit knowledge about relationships which may develop into dissociated self states.

**Empirical Findings Relating Disorganized Attachment and Trauma to Dissociation**

A prospective, longitudinal study, following over 150 high-risk children from infancy to age 19, revealed that D attachment in infancy is significantly correlated with dissociative symptoms in children throughout childhood and adolescence (Carlson, 1998; Ogawa et al., 1997). Age of onset, severity, and chronicity of trauma also predicted level of dissociation, as did neglect. But, it was unclear whether these aspects of trauma are independent factors or simply have a cumulative effect in predisposing to dissociation. The combination of disorganization and trauma clearly predicted higher levels of dissociation. These findings lend preliminary support to Liotti’s (1992) hypotheses that D attachment would predispose to dissociation, and that severity of trauma would influence the degree of dissociation. Combined with the discovery that frightened, frightening, misattuned, or dissociative parental behavior may generate D attachment (Lyons-Ruth, Bronfman, & Parsons, 1999; Lyons-Ruth & Jacobvitz, 1999; Schuengel et al., 1999), the connection between D attachment and dissociation offers some confirmation of Liotti’s thesis that mild dissociative disorders may result when there is disorganized attachment but no abuse.

**TREATMENT OF PERSONS WITH DISSOCIATED SELF STATES**

**The Interaction of Trauma, Attachment and Dissociation in the Characterological Structure**

In order to treat persons for whom trauma was an integral part of primary relationships, it is important to understand the developmental context within which dissociated self states formed. The primary attachment paradigm, or the alternation between discrepant internal working mod-
els, will affect the patient’s defensive structure and transference. When trauma is experienced, the person with secure attachment has the ability to seek out close associates for both comfort and cognitive processing of the traumatic experience. Even when alone, the internalized representation of the attachment figure allows self-soothing. For the person with avoidant/dismissing attachment, deactivation leads to focusing on neutral events. This prevents the soothing of intense affects and impedes formation of narrative memory, leading to denial of the impact of the experience, isolation of affect, and in severe cases, dissociation of the memory. In ambivalent/preoccupied attachment, the focus is on comforting the attachment figure, disconnecting one’s own need for soothing, and deflecting opportunities for cognitive processing, which again may interfere with the ability to develop narrative memory for the traumatic event. Anxiety may be experienced without knowledge of its source. In D attachment, irreconcilable needs for attachment and self-protection cause alternation between dissociated internal working models, leading to dissociation of traumatic experiences. Thus, it is often difficult to disentangle attachment issues from the effects of trauma.

Dissociated self states may form in order to sequester traumatic memories and affect, to segregate contradictory internal working models of attachment, or some combination of these. If trauma overwhelms the integrity and continuity of the self, damaging internalized links between self and other (Bromberg, 1998), numerous small traumas can generate many areas of sequestered, dissociated experience (Frankel, 2002). The difficulty of integrating these self states is related to the severity of trauma and the extent to which they encompass incompatible internal working models. However, the greatest obstacle to integration, and the highest degree of amnesia, may occur when the child has had to resort to dissociation of self states to cope with the double-binds inherent in attachment to an abusive caretaker.

When evaluating adult patients for treatment, the categories of attachment defined in infant studies have some heuristic value, but may be limited in describing the complexity of internal representations of attachment developed over a lifetime. It may be more useful to Lyons-Ruth’s conceptualization of disconnections among enactive models to describe varying degrees of segregation among multiple internal working models. Attachment may be disorganized with one parent, but not the other (Carlson, 1998). There may be a persistent approach or avoidance of the caretaker, despite disorganization (Lyons-Ruth, 2001a). Attachment models continue to be modified in a reciprocal process in ongoing relationships (Alexander, 1992), so that intervening influ-
ences, such as loss of, or changes in, a caretaker, or care by relatives may contribute to the development of disparate internal working models. Conditions that may interfere with integration of internal working models include traumatic experiences, loss, contradictory or dominant/submissive relationships, and family norms preventing open discussion of interaction.

In all internal working models, there is a dyadic representation of the roles of self and object (Lyons-Ruth, 1999). Children with D attachment in chaotic, potentially violent families have a very different quality of attachment from those in relatively stable families (Lyons-Ruth, 1996). If there was severe intrafamilial abuse, then internal working models constructed around the traumatic relationship may take the form of victim/perpetrator dyads, paired with child/caregiver dyads that embrace only the benign aspects of the relationship and dissociate the abusive experiences (Blizard, 1997, 2001). Thus, it may be more helpful for treatment purposes to identify the internal working model of each self state, and try to discern what relationship it is based on, rather than to try to characterize the person as a whole as having a particular attachment paradigm.

**Enactive Learning in the Therapeutic Relationship**

In treatment of persons with dissociated self states, a relational approach allows trauma to be addressed within the context of significant attachments (Davies & Frawley, 1994; Schwartz, 2000). Because the therapist is someone from whom the patient seeks help, she will likely become a significant attachment figure. Lyons-Ruth (1999, 2001a, 2001b) characterizes therapy as a process of enactive learning about new ways of being in a relationship. The more disorganized the patient’s attachment, the fewer secure relationships may otherwise be available. The therapeutic relationship may offer the first opportunity to balance attachment and autonomy, and experience security without risking loss of self-other boundaries (Biringen, 1994). Through interacting with the therapist, the patient is helped to increase the permeability and complexity of internal working models, revise them cognitively and affectively, and move toward a more secure state of mind (Alexander & Anderson, 1994).

The therapist may function as a “secure base” (Bowlby, 1988) from which the patient can actively explore the trauma and losses of his past (West & Keller, 1994). The therapist should be consistent, with clear boundaries and predictable availability. It is important to balance needs
for contact and self-sufficiency, especially with disorganized patients who alternate between preoccupied and dismissing self states. The therapist should neither try to replace the parent, nor be too protective, as this would deprive the patient of the opportunity to explore painful material and mourn the parent’s failure to provide nurturance and security. The opportunity to explore past and present relationships, experience sadness, grief or anger, and turn to the therapist for help, understanding, and clarification, again and again, is the process of enactive learning that helps generate a more secure attachment.

The mere act of seeking help from a therapist may cause dissociated attachment needs to surface in the transference, bringing forth a helpless, insecure, childlike self state (Barach & Comstock, 1996). A history of caregiver unavailability may evoke fear of rejection, while past maltreatment may precipitate fear of betrayal by the therapist. Persons who were abused by a parent will likely perceive a double-bind when seeking treatment. The vulnerability experienced by activating attachment needs may precipitate a defensive shift to a dismissing internal working model, causing the patient to deny the need for help (Barach & Comstock, 1996) or denigrate the therapist (Blizard, 2001). Distancing from the therapist may arouse fear and reactivate the attachment system, evoking a needy state again. Alternation of these internal working models may make the patient appear irrational or manipulative. The patient may feel out of control or frightened, while the therapist feels disoriented, incompetent or exasperated. A common countertransference may be to disparage them as “borderline.” However, when dissociated self states are understood as arising from the dilemma of attachment to an abusive caretaker, then shifts between self states can be viewed as defensive tactics aimed at managing contradictory needs for attachment and safety (Blizard, 2001).

When treating persons with dissociated self states, the therapist can begin the process of integrating contradictory states by functioning as a relational bridge (Schwartz, 2000). Dissociated self states incorporate incompatible internal working models, which are based on desperate, opposing attempts to protect the self from attack or abandonment. Because of the intensity of the affects associated with them—terror, rage, despair—the patient cannot focus on the discrepancy between internal working models, and a cognitive interpretation will likely fall on deaf ears. Confrontation with the unacknowledged discrepancy, as often suggested by object-relations theorists (Kernberg, 1980; Masterson, 1976), places the patient in a double-bind, since the defensive purpose of maintaining dissociated self states is to preserve the attachment rela-
tionship with the caregiver, despite experiences of rejection or abuse. If such confrontation is done prematurely, before the patient has developed a healthier attachment to the therapist, it is likely to increase resistance by widening the dissociative split. By maintaining a consistent and even-handed approach to both hostile and helpless self states, the therapist can provide a single, enactive model of interaction. From this experience, the patient can develop an internal working model that encompasses the therapist’s relationship with both self states, creating a relational bridge between them. In the process of internalizing this relational bridge, the patient begins to be able to connect the segregated self states, hear the therapist’s reflections about their differences, and reflect cognitively on her own self states.

The Interactions of Type of Abuse, Predominant Attachment Style, Alternating Self States, and Therapeutic Relationship

The ability of the patient to assimilate a new internal working model of the therapeutic relationship will depend on the predominant attachment style, the degree of dissociation, and the frequency of alternation of self states. How fearful the patient is of the therapist will depend directly on the history of abuse, relationships to abusers, gender of perpetrators, and whether abuse was in the guise of being affectionate, violent, coercive, or sadistic. Three case examples will illustrate some of the possible configurations of predominant attachment model and alternating self states that may derive from the complex interactions of abuse and multiple attachment relationships. (All cases are composites of patients, with identifying details significantly altered.) All three patients were probably disorganized with at least one significant early attachment, and the predominant internal working model, or frequent alternation between internal working models, significantly affected the ability to engage in therapy and the quality of the therapeutic alliance.

Dana had the alternating, masochistic and sadistic, self states that typically develop when the primary caretakers are unpredictably nurturing and abusive (Blizard, 2001). Her mother was quite rejecting, critical, sexually abusive and unpredictable—probably dissociative herself. Dana’s father died when she was an infant. When hurt or rejected by her mother, Dana would turn to her older brother for companionship, but he unpredictably victimized her, reenacting his mother’s abuse of him. Dana had dissociated victim and perpetrator states modeled on the abusive relationships with mother and brother, as well as states incorporating her roles with their benign aspects.
Early in therapy, she was bombarded by mood changes of unknown origin, as she reacted to perceived threats by shifting between self states. As treatment progressed, it became clear that she was engaging in transference enactment of her various roles with her family. For example, she might come into a session complaining of severe anxiety and nightmares with no awareness of the precipitant. Then she would describe blithely that she was taking her mother shopping that day. When I reminded her that she had talked many times of how she could never please her mother, in a childlike voice she would recite the two, clear memories of her mother actually praising her. I might comment that, as a child, she had needed to hold onto whatever good she could get from her mother. Feeling helpless and deprived of love, she might switch to a rebellious, male, teenage, self state, clearly an introject of her brother, threatening to “cut her out” by cutting herself. By so doing, she could feel powerful by discharging anger and dismissing her need for attachment to an abusive mother. I would reframe this as her ability to be self-sufficient and protect herself. But then, faced with the aloneness of this position, a child state might emerge, terrified to leave the session, and wanting to cling to me. This could trigger her fear that I would abuse her sexually, as her mother had done. Again, the male self state might come forward, exhorting her to be self-sufficient to avoid betrayal. Responding to this internal imperative, Dana might start talking about not needing to continue in therapy, dismissing her attachment to me. Again, I would reframe this as her intent to protect herself from being vulnerable to exploitation, and encourage her to continue observing me closely for signs of treachery.

My role as a relational bridge began by responding positively to each self state, clarifying the internal working model and validating her needs for attachment or self-protection. Over time, it was possible to reflect to her the reasons for defensive shifts between preoccupied and dismissing states. As she was able to understand that these personifications were internalized representations of her mother and brother, rather than independent persons, the dissociative amnesia lessened, and she began to be able to conduct internal negotiations between self states. When describing a drawing she had made of this process, she identified a figure as a mediator, and stated that it was modeled on me. She had very concretely internalized my role in relating to all parts of her. Dana was more amenable to therapy than some patients with alternating victim and perpetrator states, who are often dismissed by therapists as “borderline.” Perhaps having had some positive, childhood relationships with elderly neighbors provided an alternative, favorable internal
working model on the basis of which she could risk a therapeutic alliance.

Jeremiah provides an example of the dissociated attachment paradigms that can result when the primary relationships are both detached and sadistically abusive, and there are no benign relationships available. He presented in a predominantly avoidant/dismissing mode. His attachment needs were enacted internally, largely in fantasy, by dissociated masochistic and sadistic self states. Both parents were cold and distancing. His father could be unpredictably angry, but far more frightening was the planned, sadistic abuse he organized. Jeremiah perceived his mother as putting on a charade of excessive maternal concern, while being largely absent and absorbed with her own needs. He probably experienced some comfort in serving as her narcissistic object, soothing her by listening attentively. However, her failure to protect him from his father made Jeremiah suspect that she gained some sadistic pleasure from watching helplessly. In addition, a cruel grandmother lived with them for several years, and apparently abused Jeremiah in bizarre ways.

The horror of his father’s deliberate, sadistic abuse, his grandmother’s cruelty, his mother’s failure to protect, and the absence of any other benign attachment made Jeremiah so afraid of everyone, that he retreated into a fantasy life. He allowed a shell of himself to behave with perfect comportment and excel in his work as a research physicist. He had two dissociated self states that operated mainly in fantasy. One was helpless, preoccupied with attachment, and despairing over his inability to have any relationship. He soothed this despair by fantasizing a perfect woman who was totally devoted to him, understanding his every feeling. A dismissing state disowned the vulnerability of his neediness by resorting to sadistic fantasies, imagining torturing her slowly and horribly for rejecting him.

Therapy with Jeremiah was intensive, but slow. For years, he required two to three sessions a week to assuage his need for attachment and keep him from the “abyss” of solitude he experienced the rest of the time. In session, he talked nonstop, feeling that the words were not coming from himself, and rarely expressed any emotion. He could not tolerate any comments from me, his therapist. When he was able to allude to his transference at all, his intolerance of intrusion seemed to be around fear that the therapist would experience sadistic pleasure at his suffering. Gradually, he became able to tolerate reflections of his feelings. My first efforts at acting as a relational bridge began with interpreting his dilemma: feeling safe in intolerable isolation versus fearing abuse in a relationship. It was several years before he dared to let his angry feel-
ings emerge. He could rarely discuss his sadistic fantasies directly. He found he could express his rage and despair by describing movies that portrayed these feelings graphically. It was only in this indirect format that he could express his fear of my betrayal and fantasies of sadistic revenge. By listening attentively, first reflecting the needs for attachment, revenge, and understanding portrayed by the actors, and later applying these to Jeremiah’s own experiences, I served as a relational bridge between his dissociated self states. Eventually, he was able to tolerate some empathic confrontation and began to engage in the give-and-take of normal conversation.

For many years, Jeremiah experienced what few, superficial relationships he had outside therapy as draining and intensely disappointing. Being around men induced intrusive images of sexual abuse, making male friendships intolerable. Although he longed desperately for a close relationship with a woman, he was terrified of both the possibility of rejection and his potential to harm her. Eventually, he was able to form some friendships, but not to become intimate.

In contrast to the first two cases, Amy had a preoccupied self state based on her relationship with her mother, and partially dissociated self states based on her relationships with her abusive father and uncle. Her mother was the victim of severe verbal abuse by Amy’s father, and had been sexually abused as a child. When not depressed, she was able to comfort Amy, but often she was role-reversing, using Amy as a confidante. She was never able to protect Amy from her father, who was alternately idealizing and abusive. However, Amy was able to assume a caretaker role with her father, maintaining her idealized position with him and avoiding much of his rage. Amy also had a significant attachment to a great-uncle with whom she spent weekends and vacations, prior to his death when she was 15. He treated her as “a princess,” buying her presents after sexually abusing her in the guise of affection.

It is unclear whether Amy was disorganized with her mother, but she seemed to have managed a coherent attachment strategy by becoming her caretaker. Perhaps this allowed her preoccupied self state to predominate, and prevented formation of fully dissociated self states with separate senses of identity. However, her mother’s role-reversal did heighten Amy’s need for attachment to her father and uncle, despite their abusiveness. The impossibility of reconciling these double-binds eventuated in formation of partially dissociated self states, with preoccupied and dismissing internal working models, that were activated mainly in relationship to men. She often idealized her father, saying, “He never hit anyone,” although at other times she described his violent
beatings. She could be verbally attacking with her husband, and she struggled not to assume her father's threatening role with her children. Her intense fear of him was dissociated until about two years into treatment, when she realized she was “dancing around him to keep him from rejecting me.” Craving her uncle’s “affection” versus revulsion at his narcissistic sexual use of her led to automatic procedural enactment of “pleasuring” any male who expected sex from her, often followed by extended, trance-like episodes of hair-pulling. Many of Amy’s relationships involved caretaking roles with people who could be exploitive.

Because Amy was able to minimize abuse from her father, her mother was not abusive, and her uncle’s sexual abuse was non-violent, her self states were only partially dissociated, and she was able to engage in therapy more readily than Dana or Jeremiah. She could imagine being helped by a woman without risking abuse, although she was emphatic that she dare not seek treatment from a male. She did transfer her fear of her father’s condemnation onto me by trying to be perfect. Nevertheless, she had a coherent internal working model with which to engage in therapy. Treatment could move more quickly helping her understand both sides of the dilemmas she experienced with her father and uncle. My role as relational bridge began by listening non-judgmentally while she told me how ashamed she felt for “allowing” her uncle to abuse her. By clarifying her inability as a child to deny him, and her desperate need for attachment, she began to see both sides of the double-bind she’d been in. Then she could direct her anger toward her parents for not protecting her, rather than at herself. Later on, after she had formed a stronger attachment to me, she began to accept that she was actually taking care of her mother, and not the reverse. Much of therapy centered on helping her to see her husband as a whole person, with his flaws and vulnerabilities. The more she could allow her husband to meet her attachment needs, the more she could identify her father as the source of her fear and relinquish his hold on her.

CONCLUSION

Treatment of persons with dissociated self states is complex. It is shaped, and limited, by the patient’s experience with both trauma and attachment relationships, especially when abuse has been a central part of those relationships. It has become increasingly clear that caretaking relationships that place the child in the irresolvable paradox of fright without solution are as important as trauma in the development of disso-
ciated self states. D attachment, and the double-bind characteristics of
the relationships that foster it, offer a means for understanding the de-
velopment of alternating, dissociated, victim and persecutor, self states.
The therapist’s relating in an even-handed way with both alternating
states forms a relational bridge, providing a medium through which the
patient can understand the survival value of both states and begin to in-
tegrate their incompatible attachment patterns into more flexible, adap-
tive models of being with others.

This article has attempted to illustrate how the double binds inherent
in abuse by a primary caretaker are likely to generate two or more disso-
ciated self states, with contradictory working models of attachment.
However, there are important questions that remain unanswered:

1. Can dissociated self states be created solely by trauma occurring
outside a significant attachment relationship, and if so, do these
states have discrepant attachment models?
2. Can D attachment alone lead to dissociated self states with contra-
dictory attachment patterns?
3. Is overt trauma necessary for the creation of fully dissociated self
states? For partially dissociated states?

Addressing these questions is critically important, because an under-
standing of the etiology of severe psychopathology such as BPD and
DID is essential not only to treatment, but to prevention efforts with
children and families.

NOTE

1. In this article, “self state” will be synonymous with Watkins and Watkins’ (1997)
definition of ego state, “. . . an organized system of behavior and experience whose ele-
ments are bound together by some common principle, and which is separated from
other such states by a boundary that is more or less permeable” (p. 25). In their use,
“ego state” is the focus of experience and agency, as “self” is generally understood to be.

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