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Challenges in the treatment of complex dissociative disorders

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“There are many walls to take down” is the motto of this conference. Karl-Heinz Bomberg has provided us with much insight into the political trauma inflicted on citizens of the GDR who dared to think for themselves and act independently. We can admire the courage that was needed in the GDR and is needed under every dictatorship to imagine more than currently exists; the forthrightness and rectitude to advance the cause of progress; and the empathy needed to be with and win others to the cause of change; in Germany that change finally took place in 1989. Karl-Heinz Bomberg has spoken of the necessity of mourning, and that new political visions are impeded as long as the political traumatizations of the last century in Germany are not worked through much better than they are today.

In our field in which we deal with complex trauma, we, too, need more than mere expertise to take down the walls of dissociation; we need persuasiveness and courage, candor and empathy, hope and close observation if we are to assist people who have suffered great harm as a result of long-term trauma and violence. At this conference, we will frequently be called upon to direct our attention to the victims, and we will hear about research and studies aimed at helping us to understand them better, and to offer them more effective support.

But we should never lose sight of ourselves, the helpers. We specialize in clients whom many professionals view as the most difficult of the difficult, patients with early and long-term trauma in their backgrounds, who developed a complex configuration of core symptoms, among them severe dissociative disorders and chronic affective and impulse regulation disorders. We should never forget that these people also dispose over an abundance of positive abilities and attributes that not only ensured their survival but not infrequently imbued them with special creativity, humor, intelligence, and life energy. In other words: We are working with special people and the work we do involves special challenges.

And what are these challenges? Interesting, but seldom studied question. Trauma therapy studies tend to concentrate on “easier” cases such as mono-trauma in adulthood. “Our” clientele consists of the typical dropout cases in trauma studies, as Marlyne Cloitre and others have pointed out: Our clients tend toward self-inflicted violence, suicidal crises, numerous addictions, contradictory inner tendencies and a lack of impulse control – in other words: the typical causes of exclusion from scientific studies. As long as we cannot rely on tons of good studies – some of the rare ones will be presented by Bethany Brand and others at this conference -, we have to rely on our own empirical clinical evidence. I would now like to tell you about my own way of seeing which has been honed by discussions, collaborations, and studies with colleagues like Luise Reddemann and Onno van der Hart -- neither of whom, unfortunately, could be here today. Numerous other colleagues in the ESTD and the German Association for Trauma and Dissociation have been instrumental in helping me forge my perspective – as have numerous papers written by colleagues based on their professional experiences.

Diagnosis -- too much or too little?

One of the challenges of our clinical work is that complex dissociative disorders are often under-diagnosed. Most of the cases are identified only in the clinical setting; the victims just think that they are “forgetful”, “crazy”, “borderline” and what other self-definition and “diagnoses” by others they might have internalized. And if practitioners are not adequately trained, for example in the use of the SCID-D, they will not be able to diagnose patients who are highly dissociated. On the other hand, dissociative identity disorder can be over-diagnosed because many practitioners, despite our best efforts at change, continue to over-interpret based on weakly formulated DSM and ICD diagnostic criteria and their own personal impressions, and diagnose as DID such cases in which there is one unitary everyday self but also an array of trauma-related states. Structural dissociation theory would say: one ANP and several EPs, but today we would not diagnose that as a dissociative identity but as DDNOS, that is, the personality has divided under toxic stress in the form of complex dissociation but it is not a multiple

personality. Even when we do ego-state work with emotional parts and the apparently normal personality, it is nonetheless not inconsequential whether one is diagnosed as having a dissociative identity disorder or complex trauma with DDNOS. Which leads directly to the next challenge.

Too few qualified psychotherapists; too many cracks in the helper and support network

Anyone with a diagnosis of DID who, for example, switches from an inpatient to an outpatient psychiatric or counseling setting will almost always have considerable difficulty finding qualified treatment, especially psychotherapy, in a timely fashion. And many practitioners are either inadequately or not at all familiar with the diagnosis of complex trauma and DID and classify severe dissociative disorders as bipolar or schizophrenic disorders or borderline (alone).

By the way: Up till now all etiological diagnoses – especially trauma diagnoses and attachment disorder diagnoses – are sort of political diagnoses, because many clinicians avoid any diagnoses that give hints to the origin of the disorder – here: trauma and/or attachment deficits. We should discuss this further in our professional networks.

Concerning early traumatized patients: Ideally, counseling, care, support services, psychiatry, and psychotherapy must work hand in hand with these clients because sometimes one practitioner may see a particular state in a patient as suggestive of a dissociative disorder, where another, at a different point in time, might see an episode of depression or a near-psychotic state. This is why the often numerous diagnoses may all be correct as far as they go -- but lack a coherent conceptual classification as a trauma-induced or structural dissociative disorder. And so what we end up with is a less than helpful situation in which, as victim organizations are constantly pointing out, the patients are shuffled back and forth between outpatient and inpatient psychiatric or psychotherapeutic or counseling or general medical care units. Add to this the problem and the cumulative effects of multiple medications, which may itself trigger iatrogenic dissociative states. None of this back and forth helps the patients to coordinate their dissociative states, or to transform their identity into a co-conscious and controllable one. This

process requires qualified long-term psychotherapy, usually on an individual basis. According to the treatment guidelines of the ISST-D, this course of treatment takes at least three to five years, but in practice it may take considerably longer. And, of course, health insurance reimbursements are completely inadequate in most European countries, which means that even if our clients actually get psychotherapy tailored to their specific disorder, it frequently has to be interrupted or therapists switched because only the fewest clients are able to pay for continuous psychotherapy out of their own pockets. Brief contact with an ever-changing succession of therapists is of little help because the victims need considerable time to engage seriously with their own internal processes to build a coherent personality system out of all the “pieces of the puzzle”; and to be able to do so, they need a role model for an accepting and friendly welcoming of everything inside – very often the therapist is the first person to do this. And this points toward another challenge.

Psychotherapy for complex dissociative disorders takes a long time and is attachment-intensive

Psychotherapy generally is primarily relational work – of course. Because complex dissociative disorders are the result of early trauma to the attachment system, psychotherapy must involve supportive work that builds internal structures and offers the patient a “safe terrain” through which to navigate. This is especially important if the patient’s life is currently full of crises and external chaos. Then again, it is very important not to confront at the outset of therapy, but to establish an easy and sensitive pace, without much “leading”, as hypnotherapists like to say. Pacing is necessary to establish a trusting working relationship. Some colleagues feel time pressure, perhaps understandable given the inadequate reimbursement, and urge their patients to confront their trauma directly, even though their therapeutic relationship has not yet achieved the requisite level of trust and the patient is not yet stable enough.

This reminds me of the story of the rice farmer who wanted to reap his harvest more quickly and went down to the field each morning to pluck his rice plants so that they would grow faster. What he got for his efforts

was crop failure. So it takes a long time for someone who has experienced early and long-term trauma to develop the sense of safety necessary to engage with a long process that roils up many intense painful emotions. The more precarious a person's equilibrium, the more that person will defend against change, as our American colleague Harvey Schwartz once wrote. Our clients are the most apt to drop out of therapy or suffer relapses -- for understandable reasons, as our next challenge amply demonstrates.

"Hardware" and "software" problems: brain structures must be built up and better networked

As Martin Teicher (in his cascade theory) and others have shown, the stress systems of children who have been neglected or violently abused by attachment figures are constructed differently from those of children who were fortunate enough to experience more or less secure attachment in their early years. We assume from epigenetic studies that important genes such as the glucocorticoid receptor gene may be switched off and rendered ineffective as a result of stress. This means that these genes are completely unable or only inadequately able to produce the proteins that form the nerve cells that enable the child to think. The timing of this damage is important: the earlier it occurs the more profound the effect. Among other things, early massive or long-term stress inhibits the formation of the prefrontal cortex (especially the medial prefrontal cortex); it impedes the formation of the left neocortex; it decreases the size of the corpus callosum, the bridge between the hemispheres; and it causes hyperreactivity in the feedback loops in the implicit memory area of the limbic system, among other things. Although some neurological centers in the brain are able to produce new cells over the lifespan -- the hippocampus, which is responsible for the storage of stressful memories, is an example --, many areas of the brain that were damaged during this early developmental window cannot be compensated for. And where they can, it is clear that good and secure attachment is necessary for the genes to be switched on again. Nonetheless, this is good news. Learning in a secure and supportive relationship can apparently help to switch genes back on, which means that good psychotherapy can potentially help to stimulate

underdeveloped systems in the brain and enable them to create better and more extensive networks. But this takes time, especially in terms of experienced safety. And this leads us to the next challenge.

The effects of destructive primary attachments are hard to undo

Normally, children attach to the adult person in their environment who is most sensitive to their needs -- and that may not necessarily be a parent. Anyone who has experienced the unshakable attachments that small children of busy working people form with their nannies or babysitters can testify to this phenomenon. It is clear that attachment does not necessarily have much to do with blood lines. But if no safe attachment figure is close by, a child will have to attach to adult caretakers who are incapable of maintaining a secure bond but offer only insecure-ambivalent or even destructive attachment patterns, as may occur with traumatized mothers or parents who neglect or violate their child (see the works of Liotti, Lyons-Ruth, Brisch, among others). Such children with damaged attachment systems often spend their entire lives longing for and clinging to the attachment figures from their own families of origin as long as they feel that at least some bit of their hunger for attachment is satisfied by these persons. If traumatized children, adolescents, and adults are constantly exposed to destructive attachment figures, they will not feel secure enough to benefit maximally from psychotherapy. In the face of persistent traumatic attachments -- where the person continues to be subject to violence or a high level of conflict in his or her relationships --, it is generally impossible to process trauma material; even stabilization is a Sisyphean task. And then there is another difficulty.

Those parts of the personality that imitate and are loyal to the perpetrator must be won over

In every victim of violence, there are parts of the personality that were forced in the most existential moments of terror to identify with or be absolutely loyal to the abuser; these parts must be won over in therapy before the difficult work of inner reconstruction can be successful, and the personality can free itself from dependent relationships. If destructive bonds cannot be loosened, trauma-specific psychotherapy will most

likely fail. Identification with the perpetrator's thinking and behaviors is often mirrored in self-destructive impulses and a lack of self-esteem. Sometimes patients may themselves become abusers, reenacting their old, destructive patterns with younger siblings or their own children. Here, too, longer-term support is necessary to transform such destructive impulses in a highly dissociative patient into constructive and protective behavior both internally and externally. This process is greatly helped when the therapist is able to mediate between the various parts of the patient's personality, acting as a proxy for the patient, who may not yet be able to stand conflict or contradiction, by extending a hand, so to speak, to those "difficult" parts of the personality that still identify with the perpetrator, engaging with them, and including them in the therapeutic discourse. If this course of action does not succeed or takes too long a time, the therapist may be plunged into ethically problematic and potentially splitting situations, which is the subject of the next challenge.

Enmeshment, splitting, and other transference-countertransference problems

Few clients have as great a propensity for eliciting intense countertransference reactions as do highly dissociative patients. Despair over why a patient shows so little improvement over long stretches of time; cynical defenses against his or her constant tendency toward destruction or self-destruction; diagnostic and treatment differences with insurance plans and colleagues; over-engagement when the patient is in existential distress for the umpteenth time and his or her support network is burned out and no longer responds -- not without reason did Judith Herman once state that traumatic transference possesses a "life or death quality unparalleled in any ordinary therapeutic experience". In too many clients, one crisis always seems to be chasing the next. Whether we become enmeshed in the perpetrator-victim-savior triangle that dominates the transference, or we find ourselves in the role of "powerless bystander" to the apparently inescapable downfall of the patient --, clients with a history of early trauma challenge us in the extreme. Being the "solid rock in the storm" for any period of time can succeed only when we as psychotherapists maintain a judicious balance between offering attachment while retaining careful neutrality, something

that the Cologne psychotraumatologist Gottfried Fischer called “empathic abstinence”. I tend to advise overzealous colleagues to be “more a coach than a mom”. Otherwise, they may succumb to burnout and a numbing of empathy called compassion fatigue, and some colleagues then become emotionally, or even sexually, abusive towards their patients, in an effort to “love them healthy”, or by giving in to their -- and or their own! -- neediness. Aggressive boundary violations on the part of the patient may also occur. Good supervision is absolutely crucial to prevent such therapeutic traps -- and in emergencies, legal sanctions.

Another transference and countertransference trap with complex trauma patients is the attempt by therapists to “exorcise” disagreeable parts of the personality. If a dissociated part of a patient identifies intensely with the perpetrator, and the therapist attempts to drive out or destroy that part of the personality, then therapy will probably be doomed to failure, at least in the long run. But if a patient acts out intensely, the question is raised whether (further) psychotherapy makes sense at all.

Psychotherapy -- is it even possible?

Psychotherapists need to determine whether psychotherapy is really possible at the moment, and that might produce an inner conflict in the therapist. Continuing contact with the abuser on the side of the patient may not be the most significant barrier however -- after all, when they begin treatment, most patients with complex dissociative disorders continue to have more or less regular contact with their families of origin or with other people who abused them or continue to do so. But if they are not given a chance to mentalize, as Peter Fonagy would say, that is, reflect intensely on their personal conditions and their lack of good and secure attachment, the situation is not apt to change. The fact is, that we will be called upon to do psychotherapeutic work with people who still have contact with their abusers. The patient’s capacity for psychotherapy, however, is determined by his or her willingness to engage in introspection and inner work. But if the patient is enmeshed in an addictive process, acutely suicidal, has extreme affective problems, or the parts that are managing the everyday life are too fearful of the emotional parts of the personality, we must ask at the outset whether psychotherapy makes sense; because psychotherapy means that the

patient must be willing to engage in working toward inner change. Those patients who are unwilling or unable to try, even only hesitantly at first; those who always seek to blame others for their plight and never pose questions of themselves; those who cannot keep appointments; those who cannot stand to be in a room with another person for three quarters of an hour or longer -- for them, psychotherapy will have to wait. And when we begin to do our work, simple socio-educational or simple therapeutic techniques will frequently be necessary, including training in how to deal with their disorder, assistance in orienting themselves in time and space, referrals to other support services, couples or parents conversations, simple listing and sorting of next steps, and the like. But eventually they must ask themselves what they can even begin to accomplish given the sheer number of different distressed “construction sites”.

How to plan and adapt therapy in the face of permanent crises?

Clinical experience with these clients shows that it is of little help to allow them simply to free associate as some psychoanalysts tend to do. Similarly, a strict regimen of behavior therapy is of little value as long as the patient is continually subject to life crises. What to do? Pragmatism is called for, which means always working on the material that appears most important to the patient. The operant question might be: “What do you think is most important for you to change today?” But to develop a treatment plan based on these urgent themes which, in collaboration with the patient, make discernable a long-term path leading out of the crisis, usually depends on the patient’s capacity for inner cooperation as well as the dissociative walls that must be taken down. Up to now, those walls enabled the patient to survive, but their disadvantage is that they define a life of constant internal battle and learned helplessness. Because of this, very small steps are recommended that have the potential to lead to small behavioral changes that are verifiable. The smallest successes should be celebrated, and work on the more difficult issues (social enmeshment, addictive behavior, sleeplessness, perpetrator introjects, etc.) should be arrived at through that process. The patient will don “seven-league boots” only later! Before we get that far, the patient must feel ever more comfortable with his or her own decisions.

Why not work through traumatic material right away?

First stabilize the structure of the personality, then process trauma material -- a principle important for working with all forms of trauma is especially so for complex dissociative disorders. But how much stabilization is enough stabilization? Four criteria have proven their worth:

1. There should be no ongoing trauma and abuse; that is, the patient must have been safely removed from or backed out of the grip of the perpetrator.

2. Safe places for traumatized inner parts of the patient's personality have been created, and these parts may be reliably cared for there.

3. The patient is able to be oriented in space and time, when requested.

4. Nothing in the patient's personality continues to sabotage the processing of traumatic experiences. This means that the parts of the patient's personality that identify with and are loyal to the perpetrator, that are addictive or injurious to self or others, have been placated, made safe, and won over to working through and integrating traumatic experiences.

Clinical experience has shown that a "linear" process is usually impracticable. Rather, phases during which trauma is worked through will alternate with phases of work on longer-term integration of the personality and phases of working on current issues.

Individual or group settings?

Normally individual therapy should be the method of choice. On the other hand, many patients benefit from the experiences of others as long as they do not get constantly triggered in the group therapeutic setting. This means that many can benefit from group settings in which psychoeducation; practicing stabilization techniques and skills; and art, ergo, and music or dance therapy are offered, along with carefully adapted body therapy. Because mindfulness is the opposite of

dissociation, as Daniel Siegel once said, techniques that increase mindfulness of mental, emotional, and physical states must be used with special care so that the dissociative barriers are not dissolved too quickly. This applies both to individual and group settings. This is why, in addition to talk therapy, non-verbal techniques like art therapy are recommended to augment skills trainings developed and adapted specifically for complex trauma patients and complex dissociative disorders.

Techniques for processing complex trauma or adapted to the needs of this clientele include EMDR, behavior therapy, and imaginative and hypnotherapy, including ego-state work and the screen technique. Processes that focus on the body such as tapping techniques and the targeted use of other types of self-touch are becoming increasingly prominent internationally. However, no technique can be really helpful if the relationship between therapist and patient is not sufficiently trusting and stable, and when the building up of resources, self-esteem, and good social attachments are not central to the endeavor.

Summary

Structural dissociation theory has given us an understanding of the fundamental divisions in the traumatized child's personality, and of the resultant dissociative disorders. Diagnostic instruments such as the SCID-D help us to understand and diagnose those disorders. Neuroscientists have demonstrated the extent to which the stress systems of children subject to multiple and long-term trauma are constructed differently from the very beginning than those of children who spent their early years in an environment of relative safety. Specialized therapeutic procedures are needed that afford these patients safety, the ability to find and use resources, and stabilization in a secure and trustworthy attachment setting. Only then can techniques like ego-state work be used followed by techniques for working through trauma material. Colleagues who work with complex trauma patients are frequently inadequately reimbursed for their work, and many still lack the necessary networks among colleagues who share the same concept of work. Finally, they must deal with the powerful phenomena of transference and countertransference that are stirred up by their clients'

early destructive experiences, and with their frequent enmeshment in destructive relationships, their lack of impulse control, their numerous episodes of amnesia between parts of their personality, and their use of strong stimuli to regulate affect. At the other end of the process, it is possible, even with children, adolescents, and adults who experienced numerous episodes of trauma early in their lives, to bring about a late maturation that enables them to realize their often astonishing creativity and wisdom under safer conditions. The fact that psychotherapy with complex dissociative patients actually helps; the fact that entire square centimeters of brain material grow out during psychotherapy in important areas of the brain such as the hippocampus - these facts make it clear that persons who have suffered early damage can heal. One patient of mine referred to the process as “growing healed” (“heile wachsen”). The position that these patients find themselves in has changed drastically for the better over the past 17 years, when we held the first international conference on dissociative disorders in Europe, the ISSD Conference, in Amsterdam. Unfortunately, better is still not good enough, as answers on patient questionnaires abundantly demonstrate.

So what would help?

1. Relationship: Without (adequate) secure attachment, at least one that is consistent with a good enough therapeutic working relationship, neither effective transparent diagnosis nor successful trauma work can be accomplished.

2. Stabilization: The power of self-healing must be stimulated; secure attachment experiences promoted; supportive networks stabilized; and destructive attachments brought under control, or ended if possible; and mentalization fostered.

3. Working through: Processing means support from mentalization to the point of integration, using simple techniques. My catchphrase is: “Recognize, understand, change” (Erkennen, Anerkennen, Verändern).

4. Integration: Integration processes constantly, and often surprisingly, take place by themselves; they seem to be a consequence of the tendency within the central nervous and other bodily systems to build coherence. Sometimes all we need to do is patiently stand by our

patients. It should be noted that co-consciousness is today viewed as more important than complete integration into one single personality.

In closing, it is my hope that all of us will continue to find the courage to help victims of early trauma - children, adolescents, and adults - to grow out of their distress and become fully coherent and creative personalities. My wishes for you and the conference here are: May the strength to do this important work grow in all of you; may you never lose your sense of anger and your sense of humor at poor working, social, and political conditions; may your engagement be steadfast; and though you may falter, may friendly colleagues be there to stand by your side and help you find once again your own sense of safety, your own internal resources, and your own recovery.

Thank you for your attention.