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Frontiers in the Psychotherapy of Trauma & Dissociation

*The Official Clinical Journal of
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Study of Trauma and Dissociation*

**Attachment as a Second
Language: Treating Active
Dissociative Identity Disorder**
Adah Sachs, PhD

**International Society
for the Study of Trauma
and Dissociation**

Frontiers in the Psychotherapy of Trauma & Dissociation

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ARTICLE

ATTACHMENT AS A SECOND LANGUAGE: TREATING ACTIVE DISSOCIATIVE IDENTITY DISORDER

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Evidence is accumulating (Brand, Classen, McNary, & Zaveri, 2009, Brand, Loewenstein, & Spiegel, 2014; Brand et al., 2013; Brand et al., 2012; Dorahy et al., 2014) to show that by and large, Dissociative Identity Disorder (DID) is well amenable to psychotherapeutic intervention along the lines of the International Society for the Study of Trauma and Dissociation (ISSTD) Guidelines for treatment of DID in adults (ISSTD, 2011), based on the Three Phase Approach (Van der Hart, Nijenhuis, & Steele, 2006). In this paper, however, I would like to draw our attention to those cases where improvement is not reached, despite high-quality, dedicated therapeutic efforts. I refer particularly to patients with Active DID (Sachs, 2013c, 2017): patients who remain persistently victimized and apparently unable to establish even the most basic safety needed for the therapeutic process (“phase one” of the three-phase approach). I suggest that the therapeutic problem in these cases may lie in mis-attunement (Stern, 1998) between the therapist’s and the patient’s attachment language; and that this mis-attunement is due to a uniquely disordered attachment-pattern which characterises people with Active DID. I thus propose that, in these cases, phase one needs to be substantially modified and focus on therapeutic attunement rather than on safety. “Attachment as a second language” is proposed for treating people with persistent (“Active”) DID, while considering the clinical, theoretical and practical aspects of this therapeutic approach.

KEYWORDS *active DID; attachment language; Concrete Infanticidal Attachment (IAC); attunement; three phase approach*

ACTIVE DISSOCIATIVE IDENTITY DISORDER (DID): A CYCLE OF ABUSE, DISSOCIATION AND ATTACHMENT

People with *Active DID* (Sachs, 2013c, 2013d, 2017) have been subjected to severe and repeated childhood victimization, typically by multiple perpetrators. However, unlike other DID patients, their abuse did not stop in childhood (Middleton, 2013a, 2013b) but continued into their adult life, into the present, and into the spaces between their therapy sessions.

Distressingly, these patients seem unable to reach even the most basic safety in the present. Despite all efforts to support and encourage less risk in their lives, they seem to be in an almost perpetual state of emergency, which “bursts” into the consulting room with its pressing needs for real-life and real-time responses. Patients come to their sessions injured (though often unable to recall how the injuries occurred); they report that their car has just been smashed, their pet was gruesomely killed, that they have been followed. They (and sometimes their therapists) receive threatening phone calls. They have accidents, get raped, get arrested. They call their therapist from prisons, from hospitals, from places they cannot recognize. They attempt suicides¹. The therapist who is trying to establish some safe space for a shared reflection, as a starting point for facilitating an in-depth trauma work, finds that this work can never start because safety cannot be reached, and the work can easily reach an impasse or even break down.

The repetition of Rona’s abusive contact with her family had already destroyed several of her attempts at therapy. Sometimes it was Rona who held back because she was afraid of being punished by her family or of appearing repulsive to the therapist, and sometimes the therapist had become exasperated with her inability to stay away from abuse and ended the work. Yet Rona, desperate as she was to be free of hurt, has never been able to stop these incidents, and, as she was largely dissociated from these occurrences, she could never really explain to the therapist why.

I propose that the *Active DID* presentation is produced and then maintained by two interconnecting vicious cycles: a cycle of abuse and dissociation, and a cycle of abuse and attachment. I further suggest that in order to help people like Rona the therapeutic process must address all the key points of these cycles: their abuse, dissociation and their specific pattern of disordered attachment.

¹The DSM-5 finds that 70% of people with DID have attempted suicide. My clinical experience with people with *Active DID* is that suicide attempts are universal.

FIGURE 1 The Abuse and Dissociation Cycle.

THE CYCLE OF ABUSE AND DISSOCIATION

As severe abuse often results in dissociation (as a defense mechanism), the repetition of such abuse is likely to result in repeated dissociative episodes. Unfortunately, while dissociation protects the mind, it exposes the body to further victimization. Because the dissociative person is not fully aware of their experiences of abuse, he or she is rendered blind to the signs of danger and is unable to learn from past experience and to protect themselves from further hurt (e.g., the person may be happy to accept an invitation to an abuser's home).

The Cycle of Abuse and Attachment: Concrete Infanticidal Attachment (IAC) in a Nutshell²

Attachment is our earliest and most basic survival instinct (Bowlby, 1958, 1969, 1973, 1988; Liotti, 2017). It works by making the young (in all animals) stay close to and engage the attention of an adult—the attachment figure—when protection is needed so the adult can save the young from danger. This instinct is activated by danger, persists while danger continues and is deactivated when gaining the full attention of the attachment figure.

Most attachment figures (most commonly, but not exclusively parents) are generally attuned to the state of their young: they readily engage with a wide range of infant behavior, from play to cry, and are quick to attend to signs of danger or distress. Once the problem is resolved, the infant's distress signs or *attachment behavior* (e.g., shrieking) stop fairly quickly, and the infant's attention returns to other interests (e.g., exploring, playing, feeding). The repetition of this process (exploring/playing–distress–attachment behavior activated–parental response–attachment behavior deactivated–exploring/playing) results in the infant developing a secure Internal Working Model (Bowlby, 1969, 1973, 1988) regarding the world around them, their relationships with others and their own capacity to manage: this is a “secure attachment.”

However, if the attachment figure is not attuned and does not notice or attend to the child's distress, the child's attachment behavior will persist,

²For a full discussion, see Sachs, 2007, 2013a, 2013c, 2017.

FIGURE 2 The Abuse and Attachment Cycle.

increase in intensity or take on different – sometimes odd – forms, until it finally succeeds in gaining the full engagement of the attachment figure.

Examples of “odd” or counter-intuitive forms of attachment behavior are withdrawal, self-harm, high risk behavior, unusual sexualized behavior, aggression, dissociation, violence, or suicide. In all cases, the behavior aims to fit with the limited range of ways (or the only way) in which the unattuned attachment figure can be engaged (Sachs, 2013c). Each of these forms of behavior, once established, become the person’s life-long attachment pattern (Kahr, 2007; Liotti, 2006; Main, 1995; Main, Kaplan, & Cassidy, 1985; Main & Solomon, 1986).

The most severely distorted of these “odd” attachment patterns is Concrete Infanticidal Attachment (IAC). IAC occurs when the *only* way through which the attachment figure becomes fully engaged with the child is while abusing him or her in a sadistic, extreme and life-threatening way. When such child is distressed, he or she, like any person, instinctively reaches for their attachment figure, but unlike most people, they reach out to a person or persons who severely harm them. Furthermore, as the attachment figure(s) only fully engages with the child while harming him or her, the child, paradoxically, can only feel safe while being harmed. For this child, there is no other safety, as there is no other way to fully engage the attachment figure. The severe distress of being sadistically abused reactivates the attachment instinct, thus further intensifies the child’s reaching towards hurt.

In people with Active DID both cycles operate together, and both cycles perpetuate victimization. While the dissociation cycle perpetuates it in a passive way (dissociating when in distress, thus not realizing present pain and future danger), the attachment cycle forces the person to actively seek abuse, as the only remedy to intense distress. Both cycles are instinctive, unconscious, and are activated faster than thoughts. Their combined effect is extremely powerful and renders the person helpless to stop abuse in their lives.

The double cycle model explains the great difficulties in establishing even a basic level of safety in the lives of some patients, and the lack of

progress in their therapy; their most fundamental survival instinct, attachment, is pitched against safety. The implication of this statement is that our hopes and attempts to engage such person through the safety that we offer in our attitude and our consulting room are thus fundamentally untenable, because for this group, *engaging* means danger, fear and pain; a calm environment may be pleasant but has no bearing on their activated attachment system.

THE THREE-PHASE APPROACH AS AN ATTACHMENT-BASED INTERVENTION

Although not explicitly stated, the three-phase approach (Van der Hart, Nijenhuis, & Steele, 2006; International Society for the Study of Trauma and Dissociation [ISSTD], 2011) utilizes attachment principles throughout, consistently emphasizing the importance of reliable, responsive and responsible attitude, such as would support a secure attachment. The emphasis (central to this approach) on a phased, gradual progress to match the developmental readiness of the patient further demonstrates an attachment sensibility. The importance of starting the work by fostering secure attachment in the therapy is clearly stated:

The phobias of attachment and attachment loss are pervasive in survivors of chronic traumatisations and manifest in the therapy relationship through all phases of treatment. Overcoming these phobias is essential for further therapeutic gains, as attachment is the matrix in which all therapy takes place. (Van der Hart et al., 2006, p. 278)

However, in patients with IAc it may not be possible to achieve this goal. This is because for this group, the problem is not “overcoming the phobia of attachment” but their desperately intense way of attempting to reach the attachment figure, which is through some form of extreme suffering.

The three phases do address the three elements of the cycle: *Phase 1* focuses primarily on facilitating secure attachment: establishing basic safety in the therapy relationship and in the patient’s life, reducing anxiety and stabilizing symptomatic and unhelpful behavior patterns.³ These conditions are deemed essential for supporting *phase 2* in which the traumatic memories of the patient (the abuse) and the phobia of remembering (the

³Phase 1 includes psychoeducation regarding the patient’s condition, identifying and avoiding risk factors and triggers, learning practical ways to improve the safety of everyday life (e.g., locking doors, calling friends), learning self-soothing methods (e.g., Eye Movement Desensitization and Reprocessing [EMDR]) in order to reduce extremeness of anxiety and its associated risks of suicidality, substance misuse, self-harm or other destructive behavior. Therapeutic boundaries are agreed, to promote a sense of predictability and safety in the therapy room, resulting in trust and depth within the therapy relationship, which teaches, offers and facilitates safety, attention and development: a secure attachment.

FIGURE 3 The Double Cycle of Abuse, Dissociation and Attachment.

dissociation) become the focus of the work, and finally *phase 3* where co-consciousness or integration may occur, allowing the person fuller engagement with all their alters (internally) as well as with society (externally).

The double-cycle (Figure 3), however, gives insight into the central obstacle in reaching phase 1 with these patients: danger, pain and near-death moments are their attachment language, their instinctive response to distress, the only way they can feel truly engaged and thus truly safe. For these patients, the ongoing danger and hurt in their lives are not troubling side issues to be resolved early so as to be able to get to the main part of the work. For these patients, ongoing abuse is the very essence of their disorder: their disordered attachment language. For them, the phase 1 concept of starting therapy through careful pacing within the *window of tolerance*⁴ is not a sane and reassuring approach. Instead, it feels irrelevant, superficial, shallow or rejecting. As the attachment language of these patients is inextricably linked to traumatic experiences, they are unable to connect to a therapist (or anyone else) without the heightened stress that accompanies trauma. And without phase 1, there is no phase 2 or 3.

This raises a vexing clinical question: how can we work with a patient who cannot feel any real engagement other than in the presence of extreme trauma? I suggest that the answer to this conundrum is that the key to engagement is not a sensible and warm behavior, but attunement; and that secure attachment is not driven by any particular, “secure” way of parenting, but by the level of attunement that the parent has with the child. It thus follows that in order to enable this patients’ group to engage us, we must start by attuning to their trauma. In most cases, this would look like starting the work at phase 2.

⁴The concept of “window of tolerance” was described by Van der Hart, Van der Kolk and Boon (1998), suggesting that therapy should largely remain within that window.

Clinical example: Helen

On her second session, Helen suddenly switched into Pauline, a 15-year old alter. Pauline looked at a point above my head and said quietly, "You don't know anything about us. We are monsters. We have killed 11 babies. Helen doesn't know."

Helen and Pauline clearly did not seek a careful introduction into therapy. They did the introductions in their own way, in the IAC's language of horror. I reeled with shock; my mind raced between "is this really true?" to "should this be reported?" to "why does she trust me with this information?" to "how can she survive this?". In the most sickening way, I was engaged.

Ten years later, Helen's therapy ended. She is now mostly "merged" (her preferred word to "integrated"); she is safe, deeply absorbed in her art work and writing, and has a few friends. She is also very insightful about her therapeutic process: according to her, the key to our successful work has been my initial willingness to follow her into her world of darkness, at her dizzying speed and (up to a point) on her terms. That included out-of-hours phone calls and emails, escorting her to the police to make statements, and continuing her therapy while we both knew that she was still fully involved in a life of abuse. Had I insisted on "taking things slowly" on that second day, she said, my message would have been read by her as "I don't want to come near you."

Clinical example: Olivia

Olivia taught me some of my earliest lessons about dissociation and infanticidal attachment. Tragically, I knew too little at the time to be of help to her.

I first met Olivia in the day-room at the hospital. She had just been transferred from a surgical ward, after a stomach operation to remove a kitchen knife that she had swallowed. She was lying on a sofa, wrapped in a blanket, and looked very small, pale and fragile.

I said hello, and that I had come to help her to come to my room for her therapy session. She looked at me, and said, "I swallowed a knife." Looking her in the face was different from reading her file. Imagining her actually doing it made my skin crawl; and all the words wilted on my lips, seeming trite and irrelevant. Shuddering at the thought of the pain, I finally said to her, "It must have hurt a lot."

"Yes," she said softly. And then, to my shock, her face lit up. She looked at me again, this time radiant, and whispered, "Yes, it did. But it was worth it."

Olivia, too, did not seek a well-paced introduction, as her first sentence to me showed. Months later, she said to me that she had only told me the truth (“it was worth it”) because I had told *her* the truth (that I was horrified by the physical pain). In my language today, I would say that she sensed her engaging me, which made her feel safe.

Olivia and I spent countless hours together. I gradually learned about her horrendous childhood. I learned about dissociation, and how one can swallow a knife: different parts of her described it in detail, as by the time we had first met, Olivia had done it four times. I also learned, with bewilderment, that there was something deeply cherished and precious for her about that act; she talked about it making her feel at peace, completely safe, and “elated.”

It took years before I began to consider that when she pushed the knife in she felt safe because it fully engaged her attachment figure, who was excited and thrilled by her and loved her. Because when she was in agony and nearly dead, she and her attachment figure were deeply bonded. They were bonded by the extremeness of their shared practices, the extremeness of the sadism, the obedience, the fear and the pain. She was the most special girl in the world, loved, admired and totally safe.

Olivia’s attachment was truly and very concretely infanticidal. She followed it to the end. And she did not survive.

A bond of this intensity will not dissolve by sensible discussions, by gentle persuasion, by the patient’s willpower or by a demonstration of what secure attachment looks like. Such a bond may never dissolve at all. It has been my clinical experience, however, that it is sometimes possible to build a *second* attachment language, *alongside* the first, infanticidal one. As the second language develops and grows in strength and in its capacity to reassure, the reliance on the original one may gradually lessen.

LEARNING ATTACHMENT AS A SECOND LANGUAGE

The process of learning attachment as a second language will be described here as a two-fold process which involves both aspects of attachment – survival and the development of the (independent) Self. Like the two faces of the same coin, both are essential.

The face of survival: dependency.

An attachment language (or attachment behavior) always develops in relation to a specific person, the attachment figure, and it is shaped by the specific responses of that person. A new attachment figure is thus needed in order for a new language to develop.

A new attachment relationship can develop at any point in one's life, not just in infancy. The process, however, requires more than good will, wisdom or kindness. Like the original attachment bond between parent and infant, the formation of a new attachment (in contrast to other warm, friendly or caring relationship) involves *dependency*, *distress*, *being saved*, and *a relief from distress*. These conditions can occur in a variety of abusive⁵ and non-abusive⁶ life situations, including psychotherapy. Bowlby, talking about the desirability of a supporting a secure attachment, puts it very simply: "We have to be the patient's attachment figure. . . we have to be a companion who gives them courage" (2013, p. 40).

Secure attachment, however, is not reached by any specific behavior on the part of the attachment figure (note the huge variations in parenting methods and styles among cultures), but by the ability of the attachment figure to respond in a way that mirrors the baby's communication (Kohut, 1977; Schore, 2003; Winnicott, 1967). If we model therapy on the principle of building a (more) secure attachment in the therapy space, an essential aspect of the work must be mirroring or attuning with the patient, that is, listening and responding to their way of expressing their calls of distress, as the "good enough mother" would do (Winnicott, 1960).

In the case of persons with IAc, attunement means responding to their IAc language, rather than acting with the sensibility of secure attachment. This is because the latter, though better in every way, may not mirror the patient's experience. Mirroring will include following the patient's lead regarding communication with and between alters, and regarding the timing for processing traumatic material; tolerating discoveries of current involvement in abuse; responding to out-of-session, out of hours expressions, as far as practically manageable; supporting the patient during police interviews and other similar measures. Indeed, it appears that most clinicians intuitively act in these ways and respond to the attachment calls of this group (Sachs, 2013b).

However, while attuning with and responding to the existing attachment language is key to making an initial deep contact, it is fraught with very serious problems. In the long run, continuing to respond on an IAc level is unsustainable, clinically, theoretically and practically.

On a clinical level it is unsustainable because it conveys the message that only the patient's suffering and death-risk are of real interest to us. By frequently responding with "pulling out all the stops" at the moments of danger, we are, as well as helping, also perpetuating this attachment

⁵Distressingly, these conditions put abusers in good position to become attachment figures: not only does the abused feel dependent on the passing moods of the abuser regarding their moment-to-moment safety, but also, at the moment that the abuse stops, the abuser becomes the person who had saved the abused and relieved the distress.

⁶e.g. mountain climbing

pattern: we state that the way to our heart, to our deepest engagement, is through the patient's repeated trauma, continual pain and extremeness of suffering. We may appear, like the abusers, to be thrilled or seduced by pain, fear or blood, no matter how much we speak to the contrary, and we may end up inducing a "negative therapeutic reaction" by causing the patient to fear that the attachment connection will be broken or lost without being regularly re-fuelled by fresh trauma.

On a theoretical level, it fails because if we model the therapy on the idea of building secure attachment we will naturally expect that the patient will grow in confidence and begin to explore the environment, thus becoming gradually more independent (like the "secure" infant in the strange situation procedure [Ainsworth & Bell, 1970]). A therapeutic stance of perpetual rescuing and of permanent "being there" creates an unnatural situation of a baby who does not grow, despite all the care. Such a therapeutic relationship will become stale: like a child who loses interest in her doll because the child grows, but her doll does not, therapists become disillusioned when years go by, the therapist grows older, but it appears that the patient has not been able to grow, and their level of dependency on the therapist has not lessened over the years.

On a pragmatic level, this stance is unsustainable because the therapist will eventually become exhausted by this level of demand. Indeed, professionals working extensively with this group suffer a significantly higher rate of burnout than their colleagues (Sachs, 2013b). The eventual rejection by an exhausted therapist will inevitably be perceived by the patient as betrayal and increase their long-term hopelessness and mistrust.

The problem lies in the fact that the therapist has, intuitively and successfully, stepped into the role of an attachment figure. But finding him- or herself in that role, became trapped by it. Examples of being "trapped" include an overwhelming sense of futility in the therapist, a mixture of guilt and resentment towards the patient for the lack of progress, the exhausting burden of care and the many broken boundaries in the therapy. These feelings are compounded by professional embarrassment about one's futility and seemingly bad practice, embarrassment which often makes clinicians hide elements of their work, thus deprives them of receiving help and support. And clinicians working with this group, more than any others I know, need the robust support of a "professional secure attachment."

Furthermore, the burden of secrets, shame, isolation and fear mirrors much of the patient's affects. This mirroring is one face of the attachment relationship. But fostering the emergence of a new attachment language requires us to turn our attention to the other face of the coin, where, beyond the trauma, we look for the patient's unique Self.

The face of the unique Self: permission to grow

Observing the behavior of the “ordinary good enough mother” (Winnicott 1960), we see two basic dynamics. The first is her⁷ attunement to the baby’s safety. The second is her engagement and absorption in the baby’s development and emerging personality.

The ordinary mother looks at her baby. She listens. She is immensely interested and is attuned not only to baby’s needs and distress but also to what baby enjoys and follows. She knows what baby likes and dislikes, what she is interested in, what makes her laugh. Mother is fascinated by and absorbed in learning who baby is, and her affective responses, *mirroring* (Winnicott, 1967) the baby’s affects, help to teach the baby about the realness of her own experience. And baby, through mother’s fascination, attention and learning, makes the most important discovery of her life: her own Self (Winnicott, 1960, 1967). The baby learns that she exists because she is seen, heard and understood; because mother is passionately interested; and because it feels good.

Mollon (1993, p. 110) sums it up: “the basis of the sense of Self is the capacity to evoke a thoughtful emotional response in the other (originally the principle caregiver).” So baby seeks mother’s interested eyes, and grows through finding in her facial expression, her actions or her voice the recognition, the affirmation of baby’s independent Self.

By sharp contrast, babies who are severely neglected or abused are not objects of fascination. Their uniqueness, discoveries and development do not engage the attention of their attachment figure. The only meaningful connection between them occurs while the attachment figure expresses and satisfies its sadistic, narcissistic, murderous or sexual urges, with the child’s mind and body serving this purpose. Expressions of fear or pain increase and intensify the connection between abused and abuser. No other areas of the child’s life or personality are of interest, and changes to the rut are deemed an act of rebellion and get punished. The relationship is thus kept static, throughout childhood and often into adulthood. This negative attitude to change is ubiquitous in people with IAc.

In the therapeutic relationship, the constant emergencies, pain, fear and suffering of the person with IAc tend to focus the therapy relationship on “putting out fires,” and often result in the therapy, too, becoming unchangeable, static, spinning round various vicious cycles that do not allow real development and change. Dealing with that which is *urgent*, all too often takes precedence over dealing with that which is *deep*.

The sense of Self, of one’s existence, and therefore the possibility of development and change is further narrowed through dissociation, in its

⁷I use “mother,” “her” and “she” to follow Winnicott’s phrase “the ordinary good enough mother.” However, this is just a shorthand for whoever is the attachment figure.

different forms: amnesia takes away one's past, derealization and depersonalization take away one's present, by making it unreal or not belonging to oneself; DID splits one's experience into many fragments, frozen in time, pigeon-holed into narrow roles. Most deeply, the sense of Self is destroyed through IAc; it means that one only really exists, for the attachment figure and thus for oneself, as a nearly-dead body.⁸

I therefore propose that the "other side of the coin," the face that is needed in order to help the Self evolve out of the deadness of IAc is to *notice and foster any sign of individuality, personal preference, interest or uniqueness*, so as to help these fragments of the Self grow. Like the other "face of the coin," this face requires *empathetic mirroring* (Kohut, 1977) and *attunement* (Stern, 1998), this time with the sense of Self and the experience of growth and discovery.

For people with IAc, this may be alien and frightening; they may not know anything about their own uniqueness or Self, having spent years cultivating only their near-death affects. We may have to look hard to find where some individuality has been retained, and the most likely place, in DID, is under the cover of dissociation: in the person's alters. As alters have been separated by their trauma at different points in time, and because each of them copes with different aspects of memory and of functioning, the differences between them are often easy to see. And as each alter ultimately holds memories, abilities and qualities of the whole person, becoming aware of these will, in the long run, enrich the person as a whole.

Clinical example: Clare

I gradually got to know Clare's alters; there were over a hundred of them, of both genders and of all ages, from babies to ones who were 200 years old. Some introduced themselves as animals, monsters, spirits or computers. Two of them had had trouble with the law and had served a prison sentence. Most of them knew that there were other alters who shared the same body and hated these "others." Some had no notion of any "others," and when I once phoned and asked to speak to Clare a different alter answered and said to me very impatiently that I should check the number I had got, that there was no Clare living there, and it was tiresome to always answer people asking for her.

Contrary to this colorful picture, the "publicly known" Clare was a shy, non-descript woman in her forties who worked as a cleaner. Fairly early in

⁸For some survivors, being punished brought them so close to death that the very sensation of change or of a Self is too devastatingly terrifying to be tolerated. With these patients, attuning may fail. This may reflect our own limitations, or it may reflect the permanent disabilities that their IAc had left.

her therapy she made the connection between her “feeling dirty” through years of abuse to her becoming a cleaner. She knew she was still hurt sometimes; she also knew she had some “others” in her but was ashamed of that and had no interest in finding out more, or in communicating with them.

Most of her therapy time was used by her alters. They were not shy, and certainly not non-descript. Two teenage boys admitted to jointly beating up a policeman who caught them mid-burglary; this was the offense for which they had served a prison sentence. Another alter was blind, deaf and mute. A dog alter could only eat dog food, which had to be served in a dog bowl on the floor. One of them professed to be the consort of Satan. Another one lived in a different address to Clare.

In therapy, I made a point of relating personally to each alter, noting any shred of Self that I could notice and highlighting their special qualities, abilities and personal life experience. Though much of these qualities seemed very negative at the start (e.g., the alter who always got raped, the alter who lost all her babies), being seen for who they knew themselves to be created a first sense of “I-ness,” a sense of a real existence. My keen interest in the particular characteristics of each one of them, even if it was only their strength to withstand their lot, made them see themselves as worthy, interesting, or powerful choice-makers; I highlighted their selflessness in stepping forward to be hurt, and by doing so sparing another alter from hurt. When an alter told me of how he hurt another child because “they would have killed me if I didn’t,” I noted his commitment to staying alive. The huge burden of shame which both abused and abusers carry, which deepens dissociation, became laced with a sense of pride which made them want to be seen. They were already seen by me; now, presumably due to the good feeling that this brought, Clare started noticing “them,”; that is to say, aspects of herself which were relegated to deep dissociation because their existence was unbearable, became more acceptable and even interesting to her.

The limited, usually negative points of contact which started the relationship between Clare’s alters and the outside world developed and increased, as they felt themselves valued as indispensable for Clare. Encouraged by my interest in who they were and enjoying the recognition, they became more confident and interested in the exploration, and their pleasure in having a relationship with another person after years of isolation made them reach out of their “trauma-only” mode of life and into the richer arena of “thinking together.” One of the most moving moments to me was the first time that an alter, rather than acting his one-dimensional role of cigarette-burning another alter, started to feel that he had several feelings (which he called “parts”) in him that were not all the same, and then sensed an *internal conflict*. He said to me: “part of me just wants to burn Billy (another

alter) for what he'd done, but I also understand why he'd done it. Maybe I shouldn't burn him."

Internal conflicts imply choices and responsibility for these choices, which replace the dissociative pathway underpinning the splitting, which allocates all bad experiences to other alters. Alters with some internal movement (e.g., conflicts, empathy, doubts), rather than fixed roles, develop as a result of this internal movement. They develop complexity, memories, considerations, likes and dislikes. All of these come closer and closer to the mental and emotional functioning of a non-dissociative person; they constitute an *evolution* of the Self.

Clare is now a published author, and her poems are moving, beautiful and sometimes funny. They express her trauma but also her pride of and compassion for herself, and her gratitude to her Selves; she certainly knows them well. In terms of the phase approach, I would say she is now working within Phase 3.

Phase 3

Phase 3 in the phase approach is concerned with the challenges of normal functioning in the world, a particularly challenging task for people who always lived in a high state of isolation from the rest of society. While I propose that phases 1 and 2 need to be modified substantially when working with people with Active DID, this diversion can re-merge at the point of phase 3.

SUMMARY

It is my view that, in order to help people with IAc, the first and most *urgent* step is to attune and respond to the trauma and danger in their lives, so as to become a new attachment figure. This means to follow the patient into their world of trauma, be horrified by the cruelty, the pain and losses they have suffered, and be guided by our professional knowledge, common sense and compassion in doing what we can to help their survival. But if we stop there, we will keep the patient in a perpetual traumatic childhood and forever speak their attachment language of extreme suffering. It is thus essential that we also attune with the other face of the coin, and connect deeply not only with their intense suffering, but also with their individuality, which has hitherto been of no interest to anyone, in order to help them evolve and grow. The place where individual qualities are the most visible, in a person with DID, is their alters. I, therefore, suggest that it is important to use this pathway into the matrix of the patient's complexity and develop a meaningful and personal relationship with as many alters as we can. Ultimately, their combined characteristics will enrich the whole person.

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