Dissociative Identity Disorder: The Internalization of Disorganized Attachment

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Dissociative Identity Disorder (DID) is a mental disorder in which an individual has two or more separate, alternate personalities. Often, DID and the switching of personalities involves memory lapses, wherein the person cannot remember what they did while they were in the state of an alternate personality. DID is closely linked to early and pervasive childhood trauma, particularly sexual trauma (Barach 1991). People with DID reported dissociating when they experienced this trauma, as a mechanism of coping with the situation (Barach, 1991). Extreme, constant dissociation early in life eventually gives way to the fragmentation of one's inner schema and sense of self—certain personalities take over for certain situations, as the individual is unable to integrate or cope with their experiences (Blizard, 1997). This fragmentation, perhaps the most definitive aspect of DID, can be closely linked to the early attachment styles an individual had as a child with their abusive caretaker(s) (Krakauer 2014). Children who are abused often show a "disorganized" attachment—that is, inconsistency of attachment behaviors (upset when left alone, happy when the caretaker returns, seeking comfort from the caretaker) due to fear of the caretaker and knowledge of the caretaker's unpredictability and reactions to the child's needs. In fact, observational research has shown that children and infants with disorganized attachment styles display dissociation as a method of self-protection, because they have learned that the caretaker is not available to support and nurture them (Barach, 1991). There is a strong, perhaps inextricable link between disorganized early attachment and the development of DID later in life. Therefore, it can be argued that DID is a manifestation of disorganized attachment within the self, due to extreme early childhood trauma and disorganized attachment styles with one or more abusive caretakers. In this paper, I will review the evidence for the link between these two topics.

Barach (1991) explored DID through the lens of DID as an attachment disorder. This study is qualitative, with literature reviews of attachment theories (specifically Bowlby) and strategies for therapeutic alliances in patients with DID. Barach hypothesizes that children detach from reality (detach, in this article, is synonymous with dissociate) when their caretaker chronically and consistently fails to respond to the child's needs. Barach argues that this kind of detaching is the same mental process that occurs during active abuse, and that both give way to the development of fragmented sense of self and multiple personality states. Therefore, detachment due to disorganized attachment styles and caregiving may eventually give rise to DID and disorganized relationship of the self to the world around it. Barach also discusses the projection of attachment styles by a DID patient onto the therapist. He recounts personalities that alternated between trust and hostility, as a means of self-protection from perceived abandonment by the therapist. This fear is originated in the disorganized attachment the child had with their caregiver and is the natural assumption by the individual in adulthood that all relationships are characterized by eventual abandonment. Barach notes that patients may cling to the therapist as an attachment figure by frequently calling and requesting extra appointments, among other attempts at proximity. This was evidenced in a case study included in the paper of a woman with DID who was chronically afraid that the people she knew would forget about her, as her mother had. This manifested in anxiety, panic attacks, and frequent attempts at contact with the therapist. Her main coping mechanism in dealing with this anxiety was to switch into one of her alter personalities. From these observations, we can conclude that the lack of secure infancy and childhood attachment relationships, also known as disorganized attachments, prompt the DID patient to detach as a method of coping with an internal or external absence of security.

Therefore, the experiences and coping behaviors associated with disorganized attachment early in life can be closely connected to alternating personalities as coping behaviors in DID.

In another qualitative study, Blizard (1997) explored DID as an attachment and object relations disorder. She believes that in early childhood, the attachment object, or caregiver, sets the stage for how the child represents itself and relates to the world around it. She also gave a review of attachment and object relations literature and concludes that the development of alter personalities in DID is a result of disorganized, unstable attachment to caregivers (the object). When a child is abused, it must nevertheless seek attachment from the caregiver as a basic means of survival. She argues that when faced with this dilemma, the child must fragment the object into "good" and "bad" to endure abuse and simultaneous "nurturance" from the caregiver. Because perception of the caregiver is fragmented, the child's self-representation and inner schema is therefore disjointed. Blizard analyzes the personalities of one patient with DID, who was severely abused by both her parents. In response, this patient developed benign and abusive personalities based on each parent as a response to her attempt to identify with them as attachment objects. Because of her abuse, she was unable to relate to her parents as individuals who had both good and bad attributes. Their abusive relationship towards her resulted in splitting herself (as extensions of them) into "good" and "bad" parts. Therefore, this case study helps to establish a direct link between disorganized attachment style, the splitting of abusive caretakers as a coping mechanism, and eventually developing split personalities within the self.

In a quantitative study, Scroppo et. al. (1998) compared a group of 21 female DID patients to a control group of 21 women in order to confirm whether people with DID exhibit a consistent pattern of behaviors and cognitive processes. The women were of similar age and median income. Participants were administered multiple assessments, such as the Dissociative

Experiences Scale (DES), the Dissociative Disorders Interview Schedules (DDIS), and the Childhood Trauma Questionnaire (CTQ). Findings and descriptions of symptoms were consistent with other studies of DID. A higher percentage of DID patients experienced sexual or physical abuse in childhood compared to the control group, and many had multiple psychiatric diagnoses and a history of substance abuse. One particularly significant finding in this study was that DID patients reported "significantly" higher rates of sexual abuse and earlier age of onset of abuse when compared to the control group. Even among control members who had experienced early abuse, the prevalence of trauma and age of onset was still considerably different in DID patients. As mentioned previously, attachment as a model of the self and relation to the world is most prevalent in infancy and very early childhood. Pervasive trauma from an early age significantly contributes to an infant or toddler's attachment style to their caregiver during this time period. If they are, in fact, abused at an early age, their tendency to dissociate in the style of disorganized attachment and to relate to this world through fragmented self states can be considered a much more "adaptive" and readily used coping mechanism than in children who were abused less frequently or later on in life. The earlier the age of onset of constant dissociation, the less integrated the child is in it's attachments, sense of self, and understanding of the world. The most extreme form of dissociation is DID. Therefore, the study provides evidence for a clear link: the earlier the age of onset of extreme traumatic experiences, and therefore disorganized attachment styles between the child and the abuser, the higher the likeliness will be that a person will develop DID later in life.

In another quantitative study, Ross and Ness (2010) compared a large group of patients with DID (302 people) to a general population sample (502 people) to assess whether the symptoms of DID was a normal adaptive response to extreme early trauma, as opposed to the

sociocognitive model which contends that DID arises from suggestion in individuals prone to fantasy or socially incongruent beliefs. Using the DES and DDIS, along with structured interviews, the authors concluded that DID was in fact a "normal" human response to inescapable early trauma. This conclusion relates directly to the definition of early attachment in and of itself, wherein the child seeks attachment with a figure that can protect them. Ultimately, attachment is a survival mechanism, and the development of DID is in response to the child's desperate and ultimately fallible attempt to protect itself. By determining that DID is not the result of personality or natural traits such as temperament and proneness to certain behaviors, this study helps to conclude that DID is almost directly related to early trauma, and may be an inevitable reaction to traumatic experiences that are frequent and extreme enough.

One counteractive argument to the hypothesis is the description by Krakauer (2014) of a patient with DID who did not have a disorganized attachment style with her caretakers growing up. Rather, it was defined by the author as avoidant attachment, wherein the child deactivates awareness of and acknowledgment of attachment behaviors. As a child, she was actively abused by her adoptive parents and as a result often hid from her family to avoid both physical and emotional abuse. As an adult, she presented towards Krakauer as depressed, isolated, and detached, with no friends or memberships in any types of communities. Krakauer reports that at the end of the therapeutic relationship, the patient's personalities had been successfully integrated after intensive and prolonged therapy. Although the patient was not classified as having a disorganized early attachment, she was nevertheless severely abused and created a fragmented self to cope with her traumatic experiences. Her attempts to reconcile her caretakers manifested in good and bad personalities that were modeled after them, the same coping method seen in disorganized DID patients. While she may have presented with avoidant tendencies, her

sense of self was still severely disorganized which profoundly affected her life and ability to form close relationships. Furthermore, this study is a firsthand, qualitative account of a therapist and her patient. Although it has been peer reviewed, it is necessary to argue that the therapist's clinical assessment of the patient's attachment may have been made in error or was based upon a specific, individualized bias. If this article had multiple contributors or was quantitative, the determination that the patient was avoidant may have been more reliable and harder to disprove. The case study described, however, may be the statistical equivalent to an outlier. DID is a rare disorder in and of itself, and the case study describing a non-disorganized patient with DID may have many causes of origin. The most probable explanation is the fact that this sole case study may illustrate the fact that the relationship between avoidant attachment and DID has not been appropriately or thoroughly explored in psychological literature.

The studies included in this paper provide clear definitions and assessment of the symptoms and causes of DID. Specifically, DID is most directly related to early childhood trauma. A child reacts to a hostile environment and lack of safety provisions by detaching itself from reality and abuse. This detachment is an extension of the child's attachment style to its caregiver(s). Detachment from the caregiver, or disorganized attachment, is almost always present in abusive caretaker-child relationships. A child detaches as a coping mechanism because the abusive caregiver has failed to provide the child with safety and nurturance. Constant detachment creates a fragmented world for the child, where they cannot fully integrate and relate themselves as a whole, singular, independent entity. DID is a manifestation of this fragmentation as the individual develops and becomes more emotionally and cognitively complex. Often, personality states are employed to deal with different daily situations, and to keep the memories of such horrifying traumas at bay.

Because DID is an exceptionally rare disorder, the field of those who study it is small within the realm of psychology. However, the population of psychologists who study it generally hold a coherent consensus as to what causes DID, as well as it's close relationship to early attachment styles. These agreements are a general strength of these studies, as they provide a strong foundation upon which one can build an argument further exploring the specifics of DID, as this paper has aimed to do. Furthermore, the qualitative characteristics of many of the included studies hold potential promise for therapists with patients who have been diagnosed with DID as a resource for how to explore the person's past as well as the therapist's ultimate goal to achieve reintegration of identity in the patient. Finally, the quantitative studies included have large sample sizes, and therefore provide interesting and reliable insight into an already very small population of trauma victims with DID.

There are also multiple limitations when studying the connection between attachment in early childhood and the development of DID later on in life. Most notably, there are few studies in the first place specifically investigating the relationship between disorganized attachment and DID. Furthermore, there are even fewer studies within this realm that are peer reviewed and quantitative. While it is worthwhile to read qualitative studies about attachment and DID to gain general knowledge of the topic, as well as therapist-client relationships and therapies in the context of DID, evaluating this thesis with limited quantitative studies proved to be difficult. Another limitation is the lack of physiological or otherwise biological data on this topic. Additionally, all of the studies found were published by Western (mostly American and Canadian) authors studying patients in first-world countries.

There is a need for at least one quantitative study that incorporates biological data in patients with DID as well as multiple surveys (such as the DDIS and DES) and structured interviews to attempt to establish a connection between differences in biology and brain structure

in patients with DID exhibiting disorganized attachment. Specifically, how does brain activity change when the patient discusses or is prompted to remember their relationship(s) with abusive caregivers? Do patients with DID have different brain structures? Does their brain activity change when they are in the state of an alter personality? The scientific data found when attempting to explore these questions may help to foster and support the hypothesis that DID is inherently an internalization of disorganized attachment caused solely by early trauma.

One important implication of the current studies analyzing disorganized attachment and trauma as main indicators for the development of DID later in life is using this connection in the context of social service intervention in homes where there is potential active abuse. Would it be plausible to get to the point where the "diagnosis" or observation by a trained clinician of a disorganized attachment between a child and caregiver would be enough criteria to remove a child from a home? Conversely, would the observation of early DID-like symptoms (a child displaying one or more personality) be criteria to remove a child from their home? Obviously, these questions need much more substantial data to back them up—currently, the literature on this topic is not numerous or quantitatively strong enough. It also begs the question: is the relationship between disorganized attachment and DID only observable later in life, when a patient has already developed DID and is able to speak more coherently about their past abuses and relationships than a child?

As previously mentioned, the most persistent issue of this review is the lack of quantitative and biological data on the connection between disorganized early attachment and DID. Additionally, only five studies were reviewed. In order to truly make a discernable argument about any topic in the psychology field, one should truly review as many peer-reviewed studies on the topic as possible, instead of five. Additionally, it would be interesting to

review papers that are written from a perspective that is not attachment-based. How would the author interpret their results, or others' papers when not considering DID to inherently be an attachment disorder? What are other valid arguments for the cause of DID that are not solely attachment based? This again raises the importance of including hard biological data in a review like this. Finally, the prevalence of high comorbid diagnoses in patients with DID poses a limitation in studying DID from a singular point of view. When studying and diagnosing DID, it is always important to observe the patient's behaviors in regards to depressive, neurotic, and borderline behaviors, among others. How do these comorbid illnesses affect the person's attachments? How do they affect the person's memories, proneness to dissociation, and types of alter personalities? Why are there high rates of comorbid diagnoses in the first place, when compared to the general population?

DID is a manifestation of disorganized attachment within the self, due to extreme early childhood trauma and disorganized attachment styles with one or more abusive caretakers. Multiple qualitative and quantitative studies draw the connection between early, all-encompassing trauma (particularly sexual trauma) and the development of DID later in life. Children who are abused experience disorganized attachments with their caretakers, where their responses to their caretakers are unsystematic and irregular. These children, who cannot consciously cope with their traumas, often dissociate to an extreme quantity to psychologically survive while simultaneously trying to ensure survival and to gain "nurturance" from their caregivers. This extreme dissociation leads to the fragmentation of reality and ultimately the self, which manifests as multiple, disintegrated personalities later in life. It is important to note, however, that the relationship between disorganized attachment and DID are not static; there have been studies on patients with DID who did not have early disorganized attachments with

their abusive caretakers. Moving forward in studying this topic, it is important to note the need for more quantitative, scientifically-backed (rather than interview and survey-backed) studies directly hypothesizing the link between disorganized attachment and DID. It is also important to think about how the conclusions drawn from these studies can be used to identify abusive households by authorities, as well as staging appropriate interventions for disorganized children at risk for DID. This review helps to directly draw connections with DID and disorganized early attachment, but it is also important to note that neither DID nor disorganized attachment are permanent afflictions. Moving forward from studying this topic, it is essential to develop therapeutic techniques that treat patients with DID from a predominantly attachment-related perspective. By helping the patient to integrate their personalities while fostering a secure relationship, it is possible for these people who against all odds survived unthinkable horrors to live a healthy, fulfilling life.

Citations

Barach, P. M. (1991). Multiple personality disorder as an attachment disorder. Dissociation: Progress in the Dissociative Disorders, 4(3), 117-123. Retrieved from http://search.proquest.com/docview/618157581?accountid=12261

Blizard, R. A. (1997). The origins of dissociative identity disorder from an object relations and attachment theory perspective. Dissociation: Progress in the Dissociative Disorders, 10(4), 223-229. Retrieved from http://search.proquest.com/docview/619416271?accountid=12261

Krakauer, S. Y. (2014). Must internal working models be internalized? A case illustrating an alternative pathway to attachment. Journal of Family Violence, 29(3), 247-258. doi: http://dx.doi.org/10.1007/s10896-014-9580-y

Ross, C. A., & Ness, L. (2010). Symptom patterns in dissociative identity disorder patients and the general population. Journal of Trauma & Dissociation, 11(4), 458-468. doi: http://dx.doi.org/10.1080/15299732.2010.495939

Scroppo, J. C., Drob, S. L., Weinberger, J. L., & Eagle, P. (1998). Identifying dissociative identity disorder: A self-report and projective study. Journal of Abnormal Psychology, 107(2), 272-284. doi: http://dx.doi.org/10.1037/0021843X.107.2.272