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Dependency in the Treatment of Complex Posttraumatic Stress Disorder and Dissociative Disorders

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Abstract

Dependency is a major and ubiquitous issue in the treatment of chronically traumatized patients, such as those with complex posttraumatic disorder (PTSD), trauma-related borderline personality disorder, and dissociative disorders. Within this context, the concept of dependency is often paired with pejorative adjectives, and is dichotomized and negatively compared to a preferred state of independence. This paper explores prevailing sociocultural and theoretical beliefs regarding dependency in the psychotherapy of trauma survivors, provides a working definition of dependency, offers an analysis of its complex nature, and describes the theory of structural dissociation, which helps illuminate the often contradictory manifestations of dependency in chronically traumatized patients. A distinction is made between secure and insecure dependency. Finally, this paper outlines the collaborative therapeutic process required to manage insecure dependency productively within a phase-oriented treatment model. Countertransference responses that interfere with a patient's conflicts regarding dependency are also discussed.

> *"Human beings of all ages are found to be at their happiest and to be able to deploy their talents to best advantage when they are confident that, standing behind them, there are one or more trusted persons who will come to their aid should difficulties arise."* -- John Bowlby (1973, p. 359)

Western culture, more than others, places high value on independency and early relinquishment of dependency, with a somewhat counter-phobic reaction to the necessity and inevitability of appropriate dependency and interdependency on social and interpersonal levels (Sampson, 1977). Dependency has thus been associated with weakness, emotionality, selfishness, entitlement, lack of character, laziness, childishness, manipulation, and secondary gain. Dalenberg (2000) reported that shame about dependency in therapy was "the most common shame-related theme in my own research" (p. 127), because it is considered so socially undesirable.

Walant (1995) believes North American society has placed excessive emphasis on separation and independence, and states:

> Our society's longstanding denial of merger phenomenon throughout the life cycle has actually increased the likelihood of personality disorders and addiction, precisely because autonomy and independence have been encouraged *at the expense of* attachment needs (p. 2)

There has also been little attention paid to gender differences regarding dependency and related needs. For example, Flaherty and Richman (1989) concluded that women were evolutionarily organized to be more sensitized to the need for social support for a sense of personal well-being. Some characteristics of dependency which are empirically correlated with well-being and positive emotional functioning in women are generally perceived as unhealthy due to negative social attitudes (Linehan, 1993; Wideger & Settle, 1987; cf., Unger, 2001). Thus not only women, but men in particular, experience shame over dependency, as it is viewed as a feminine and undesirable trait (Osherman & Krugman, 1990).

During the last decade in the U.S., managed care and emphasis on short-term therapy have promoted methods that actively discourage any dependency in the patient within therapeutic settings. And most recently, there have been some civil lawsuits against therapists which have claimed damages related to the therapist fostering dependency in the patient. Clearly, the social milieu, in addition to much of the professional literature, has added to therapists' biases that dependency is generally a negative, pathological, and undesirable state in an adult individual.

Research and clinical observations have shown that dependency increases in insecure attachments associated with trauma and neglect (Ainsworth, 1972; Barach, 1991; Birtchnell, 1997; Bornstein, 1998; Gunderson, 1996; Holmes, 1997; Sroufe, 1983; Sroufe, Carlson, & Shulman, 1993; Walant, 1995). One recent study demonstrated that dependency is more common and intense in survivors of childhood sexual abuse than in other clinical and nonclinical populations (Hill, Gold, & Bornstein, 2000).

Studies have also consistently demonstrated that strong social support following trauma (implying some degree of dependency) is essential to prevent further difficulties with trauma-related disorders (e.g., King et al., 1998; Runtz & Schallow, 1997). However, most chronically traumatized individuals do not receive such support until the time they enter therapy. Many, if not most chronically traumatized children live within a family system that denies, minimizes, or even encourages ongoing abuse and neglect, and that does not provide the child with adequate support following traumatic events. Such a relational environment leads to insecure attachment, which involves *insecure dependency* (Bowlby, 1988). Insecure dependency may take the form of excessive dependency or excessive independency (a counter-phobic stance toward feared or rejected dependency), as the basic trust needed for secure dependency never develops or is destroyed.

It is well known that chronic trauma patients generally experience moderate to extreme dissociation. However, although strong dependency has been related to chronic traumatization in particular, there is no literature on the relationship between dependency and dissociation. As insecure attachment develops in traumatized individuals, intense and unfulfilled dependency can be managed in various ways, according to the type of insecure attachment pattern (e.g., Hesse, 1999). Those who develop resistant or preoccupied attachment styles (cf., Hesse, 1999) will demonstrate excessive dependency.

Those who develop avoidant or dismissing styles (cf., Hesse, 1999) will exhibit counterdependent or overly independent styles. It is hypothesized that the majority of dissociative patients have developed preoccupied or disorganized/disoriented attachment styles (e.g., Hesse, 1999; Liotti, 1995, 1999; Main & Morgan, 1996) with various dissociative personalities exhibiting dependency styles that are unmodulated, thus extreme and contradictory. Alternations among dissociative personalities may therefore involve vacillations between excessive dependency and counterdependency. These patients may also be unaware of or confused by dependency needs and behaviors that are dissociated. This essential relationship between dissociation and variations of insecure dependency is vital to understand in the treatment of trauma survivors.

Successful navigation of dependency conflicts is essential to achieve the therapeutic goals of integration and adult intimacy that includes autonomy and interdependency. We will briefly review the literature, then elucidate a concept of dependency relevant to work with chronically traumatized and dissociative patients. The contributions of the theory of structural dissociation (Nijenhuis, Van der Hart, & Steele, in press; Steele, Van der Hart, & Nijenhuis, in press; Van der Hart, Van der Kolk, & Boon, 1998) to dependency issues will be highlighted, since our focus is on dissociative individuals. Within this theoretical frame, we will propose that dependency is a manifestation of the attachment emotional system (Bowlby, 1969/1982; Panksepp, 1998), but is also closely related to defense as expressed in the separation cry (Panksepp, 1998; Van der Kolk, 1987). Finally, therapeutic processes with dependency issues within a phase-oriented treatment model will be described, as well as countertransference responses.

Brief review of the clinical literature on dependency

A review of the literature reveals confusion regarding the definition of dependency. First, the terms “dependence” and “dependency” are both used, as their definitions are synonymous, though this has not been noted before. For consistency, we have chosen to use the term “dependency.” The term dependency is sometimes used interchangeably with regression, symbiosis, attachment, helplessness, passivity, lack of autonomy, and an infantile developmental phase of oral and symbiotic needs. There are

also widely divergent theoretical views regarding the appropriate treatment of dependency, mostly related to confusion of concepts, and to the ongoing psychoanalytic debate regarding the value of "the rule of abstinence" versus gratification. Unfortunately, clinicians and authors often pair the term with pejorative adjectives, such as "unhealthy," "malignant," "regressive," "manipulative," "resistant," or "immature." Furthermore, it is dichotomized and negatively compared to a preferred state of independence, with the implication that all traces of dependency should disappear in the healthy and mature adult.

The only complete agreement regards the fact that the patient's issues related to dependency are very important in relationship to the therapist (Adler & Buie; Chu, 1998; Gunderson, 1996; Janet, 1897/98; Modell, 1963; Steele & Van der Hart, 1997). Janet (1897/98, p. 492) defined the patient's dependency within the therapeutic context as a need for direction from the therapist, which was heightened by the "illness of isolation"—now referred to as intolerance of aloneness (e.g., Gunderson, 1996). In the treatment of hysterics (the majority of whom were women), Janet (1897/98) noted that dependency in clinical cases was merely an exaggeration of *natural* human dependency. He insisted the development of an intense period of dependency on and need of the therapist was necessary and was not iatrogenic, but a naturalistic occurrence; not only a symptom, but the *means* by which cure took place (Janet, 1897/98; Steele & Van der Hart, 1997; Van der Hart & Friedman, 1989).

In cases of trauma, dependency on a parent (and in therapy, on the therapist) may be healing and protective. For example, observations have indicated that in children exposed to war, psychological effects are more serious when the parents or nuclear family are adversely affected (McCloskey & Southwick, 1996), and even more important to the issue of dependency, Green and Kocijan-Hercigonja (1998) indicated that mothers act as a buffer against trauma. In this study, children who did not remain with their parents showed greater rates of serious problems such as PTSD and major depression.

Dependency as pathological. Many theorists regard dependency as pathological, i.e., as an early infantile stage (0 – 18 months) in which patients are developmentally arrested or to which they become regressed (Erikson, 1950; Freud, 1916/17; Mahler, Pine, & Bergman, 1975). Fairbairn (1946) believed that infantile dependency, rather than

the Oedipal complex, was the cause of all psychopathology. Confusion between dependency and regression emerged from these and other theorists who emphasized the regressive and pathological nature of dependency in adults, and promoted independency as a linear and final stage of adult maturity. Regression consists of many phenomena, of which dependency may be only one, and there are other theories that assert dependency is not necessarily a developmental fixation or regression, so the terms “regression” and “dependency” are not synonymous.

Continuing along the lines of developmental arrest theory, a number of clinicians, notably the British object relations group, have supported controlled therapeutic “regression”—which includes the notion of dependency—as a necessary part of therapy with severely troubled individuals (Balint, 1968; Buie, 1981; Kernberg, 1975; Kohut, 1971; Little, 1987; Searles,1955/65). Guntrip (1969) focused on regressive pathology, but agreed that not all regressions are dangerous: “Regression is a flight backwards in search of security and a chance of a new start. But regression becomes an illness in the absence of any therapeutic person to regress with and to.” (p. 86). Here he implies, like Kernberg (1975), that dependency on the therapist is a necessary component of therapy with certain patients, albeit still regression.

On the other hand, some authors actively discourage regression, and by association, dependency. Freud (1916/17) cautioned that activating dependency would increase the demand on the analyst for immediate gratification of need, thus interpretation was the only appropriate response to the analysand’s longings and cravings. Van Sweden (1995) indicated that some analysts subsequently actively limited dependency in reaction to Freud’s admonition, convinced that dependency was synonymous with acting out and was “the patient’s attempt to resist the analytic work” (p. 30).

Much research has examined dependent personality *traits,* with the notable finding that level of dependency predicts risk for psychopathology (Bornstein, 1992, 1995). However, these findings may be mistaken for the larger effect of insecure attachment, since extreme dependency and independency are manifestations of insecure attachment, which has been consistently demonstrated to be associated with various types of psychopathology (e.g., Dozier, Chase Stovall, & Albus, 1999; Slade, 1999).

Depathologizing dependency. A number of recent authors have attempted to depathologize dependency through clarification of the construct and examination of contradictions between empirical research findings and theoretical beliefs (Bornstein, 1992, 1994, 1995; 1998 a&b; Bornstein & Bowen, 1995; Holmes, 1997; Santor & Zuroff, 1997; Van Sweden, 1995; Walant, 1995). Most notably, Bornstein has pointed out that dependency is not synonymous with passivity and submission, but may also be *active*, with high levels of activity and assertiveness in certain situations (1995). He thus makes a distinction between *passive* and *active* dependency, and asserts that variants of both types of dependency may actually lead to adaptive, health-promoting behavior (Bornstein, 1995). Research findings indicate that dependency is associated with some attributes that enhance therapeutic movement, such as cooperativeness, compliance, suggestibility, help seeking, and interpersonal yielding (Bornstein, 1995). Dependency may also lead to more social attachment and helping behaviors: dependent children are apparently not only active in seeking support and guidance from adults (Sroufe, Fox, & Pancake, 1983), but are also more active than other children in providing support and nurturance to others (Hartup & Keller, 1960).

Most importantly, Bornstein (1995) conceptualized both active and passive dependency as conscious and unconscious strategies to attain a central underlying goal: "*obtaining and maintaining nurturant, supportive relationships*" (p. 71), thus firmly linking dependency with attempts to attain secure attachment. As noted above, Bowlby (1988) made the distinction between *secure dependency*, which allowed autonomy because of felt security, and *insecure dependency*, in which autonomy and exploration are inhibited by lack of felt security with an attachment figure.

There has also been controversy regarding whether difficulties in theorized life stages correlate to specific adult psychopathology. For example, Bowlby (1969/82) stated that it is "extremely misleading for the epithet 'regressive' to be applied to every manifestation of attachment behavior in adult life" (p. 208). He (e.g., Bowlby, 1969/82, 1988) was central in describing outcomes related to lack of secure attachment, which includes elements of excessive dependency or independency.

But here, and in other places, there developed confusion between dependency and attachment. Although there have been attempts to clarify differences between attachment

and dependency, these have not been entirely successful (cf. Ainsworth, 1972; Bowlby, 1969/82; Birthnell, 1997), and the exact nature of the relationship remains somewhat unclear. For example, Birthnell (1997) theorized that dependency was the adult version of infant attachment. However, attachment involves much more than dependency, particularly in adult relationships. It is likely that dependency represents one type or aspect of attachment.

Attachment is a particular type of a broader range of affectional bonds. Affectional ties have several criteria: (1) they involve a specific person for whom another cannot substitute; (2) they are persistent rather than transitory; (3) the relationship is emotionally significant; (4) close proximity or contact is desired with the person; and (5) there is distress at involuntary separation (Cassidy, 1999, p. 12). The additional criterium required for attachment is that felt security and comfort is sought as a primary goal of the relationship by one individual from the other (Ainsworth, 1989). Dependency includes affect, cognition, and behavioral strategies (conscious and unconscious) that seek to achieve this particular goal of felt security within a secure attachment and active care taking from another until felt security has been attained.

Attempts have been made to provide some balanced perspective regarding dependency, without polarizing it with independency. *Interdependency*—the capacity to function in an autonomous manner while simultaneously being able to engage in balanced and reciprocal dependency with significant others, has been emphasized by clinicians such as Balint, (1968), Guntrip (1969), Fairbairn (1946), and more recently by authors who emphasize the mutuality of the therapeutic relationship and the primacy of the relational rather than the separate self (Jordan, 1992, 1995; Notma et al., 1986).

Consistent with several other theorists (Bowlby, 1969/82, 1980, 1988; Holmes, 1997; Nesse, 1990; Panksepp, 1998), our view is that attachment is one of several innate psychobiological emotional systems, or *emotional systems* that direct animal and human behavior. These evolutionary prepared systems have received increasing attention in recent years (e.g., Cassidy, 1999; Panksepp, 1998; Siegel, 1999). Behavior is generally directed by these emotional systems, both as unconditioned response patterns and as responses conditioned and shaped by learning experiences (including trauma). Dependency is one component of instinctual behavior designed to maintain a consistent

degree of felt security, and as such, may be conditioned to become more or less excessive than usual. Dependency is as necesssary as autonomy in maintaining individual and social homeostasis. It is thus not phase-specific, but includes experiences that are "naturally occurring, lifelong possibilities" (Walant, 1995, p. 61).

Dependency as wish *and* need in chronically traumatized patients. Dependency is both a wish and a need in chronically traumatized patients, creating a complex challenge, as treatment must meet some degree of need (a physiological or psychological requirement for well-being), but not necessarily of wish (a desire not inevitably based on need). Dependency appears to be related to genuine attachment and care taking needs. Intense dependency wishes seem to emerge from the chronically unmet need for secure attachment, and serve as an "internal guide" to direct the individual toward secure attachment. However, such wishes are often replete with cognitive errors and overwhelming affects, and thus often direct the individual to behaviors (and people) that actually decrease the possibility of secure attachment.

Akhtar (1999) has proposed the theoretical notion based on clinical observation that frustration of wishes causes dynamic shifts, but frustration of need leads to structural disintegration of the self. It is thus imperative to understand whether elements of a patient's dependency may be representative of need, and whether some defensive beliefs and fantasies (wishes) regarding dependency are futile attempts to have genuine needs met in the past, to avoid the painful grieving of previously unmet needs (i.e., during trauma and its aftermath). Of course, dependency wishes are invariably present in chronically traumatized patients, and they may be acted out or disavowed and dissociated. Such wishes (e.g., "the golden fantasy" of the person who will perfectly meet one's every need) and related behaviors play an important role in the dynamics of patients and their relationships. However, we would state that genuine need *in the present* usually underlies these wishes and fantasies and their behavioral expressions in severely traumatized patients.

We must therefore consider the impact of trauma and neglect on basic psychological and physical needs. Laub and Auerhahn (1989) make a strong case for the presence of need in the psychotherapy of severely traumatized individuals and the therapist as a need-mediating object:

> When the world of people proves malignant on a massive scale, the internal representation of the need-mediating context is destroyed, the individual loses the capacity for wish-organized symbolic functioning (Cohen, 1985), and wishes regress to being dangerous biological needs. (p. 387)… The traumatic state operates like a black hole in the person's mind because…in the absence of representation of need-satisfying interactions, there is no basis for symbolic, goal-directed behavior and interaction. (p. 391).

Cohen (1985) was emphatic that "the traumatic state cannot be represented (sensorimotor affective state) therefore cannot be interpreted….[It] can only be modified by interactions with need-mediating objects" (p. 180). Patients may thus experience dependency as *directly related to survival needs*, therefore may sometimes act as though their very lives depend on urgently having needs met by the therapist. These clinicians thus support the idea of a need for secure attachment and dependency in therapy for severely traumatized patients. Mitchell (1991) concurred, stating that dependency desires expressed in therapy can represent ego needs, not symbolic wishes or fantasies. These needs must be met and gratified before anything else can happen in therapy, and the therapist should engage in active participation with the patient in discovering and meeting these needs within appropriate therapeutic boundaries (Connors, 1997).

If dependency represents need in the traumatized patient, we would again assume those needs are related to emotional systems, as needs are biologically derived, even though they may (also) have psychological manifestations. As Laub and Auerhahn (1989) stated above, the symbolic wish to depend upon another for care is replaced by basic survival needs in the face of overwhelming trauma.

Recovery from such trauma would require that therapy meet essential needs. The primary need would be the attainment of emotional and physical safety, i.e., absence of threat to bodily integrity. Although many survivors enter therapy at a time when they are no longer being traumatized, they experience oscillations in sense of safety due to re-experiences of the trauma, phobic responses to internal states related to trauma, self-destructive impulses, and, for some, a general inability to cope with the vicissitudes of normal daily life. The secondary need would be the attainment of secure attachment with the eventual achievement of felt security in relationship with a consistently responsive

and caring individual, i.e., the therapist. The secure base developed in the therapeutic attachment provides a catalyst to develop other satisfying and consistent attachment relationships with others in daily life, and to function adaptively in normal life.

A working definition of dependency

Throughout the life cycle there is a tension between dependency and autonomy, and the basis for autonomy is ongoing secure attachment. In this view, dependency is not a regressive phenomenon. Instead, *dependency is a manifestation of attachment that includes a wide-ranging set of conscious and unconscious behavioral strategies* (Bornstein, 1995, 1998), *and related affects and cognitions. The purpose of dependency, as opposed to attachment in general, is specifically to procure care taking, i.e., needed direct support and guidance--from an attachment figure within a secure attachment, such that adequate activation of inborn emotional systems designed to maximize adaptation to normal daily life can be promoted*. Attachment is a broader concept, in that attachment behaviors may not necessarily specifically involve procurement of direct care-taking, but may, for instance, just involve proximity or merely an internal sense of felt security derived from the attachment. Dependency is not confined to a particular developmental phase, but changes in nature and expression from cradle to grave. It varies in intensity and manifestations according to situational and interpersonal factors, and to alterations in the individual's capacity for higher levels of integrative activity that normally promote balanced levels of interdependency, intimacy, and autonomy. *Insecure dependency* tends to be expressed as excessive dependency or excessive independency. Dissociative patients will often exhibit a mix of the two types.

Dependency may be *active* or *passive* (Bornstein, 1995). Beneficial manifestations of active dependency in therapy include cooperation, active help-seeking, and positive attachment to the therapist; this may be true of both secure and insecure dependency. Negative manifestations include a sense of entitlement, extreme demanding behavior, and high degree of neediness that cannot be processed or contained. These behaviors are considered negative because they are not adaptive, generally creating a situation in which attachment figures withdraw. Such negative behaviors are indications of insecure attachment, and thus indicative of the need for secure attachment. *Passive* dependency

includes helplessness, positive or negative submissive behaviors, passivity, indecision, and general suggestibility (although the type of suggestibility has not been specifically defined in the literature, and may be an important factor to consider in treatment of dependency). Positive aspects include compliance and positive suggestibility. Negative aspects of passive dependency include inability to act, indecision, and global suggestibility. We propose that both active and passive dependency are designed to attain secure attachment that promotes activation and balance of the daily life emotional systems of the individual, and are especially activated when an important relationship with a care taking figure seems threatened (Bornstein, 1995), or when separation anxiety otherwise occurs, inducing panic and a subsequent separation call (Panksepp, 1998).

Caveats regarding dependency in psychotherapy

Although we attempt to normalize the concept of dependency in this paper, we are mindful of the extraordinary difficulties that may arise in managing the extreme and maladaptive dependency behaviors sometimes displayed by chronically traumatized patients. There are valid caveats reported in the literature regarding dependency: most of them are directed toward excessive dependency, but they may also apply to excessive independency. Management of dependency requires an exquisite and skilled balance of maintaining maladaptive dependent *behaviors* within a therapeutic window of tolerance for the therapist and patient. If this does not occur, there are a number of potentially disastrous outcomes. For example, Balint (1968), who supported regression in therapy for deeply troubled patients, wisely questioned “how much dependency constitutes a good starting point for successful therapy, and when does it turn into an obstacle?” (p. 40). Janet (1897/98) also indicated there must be a balance of dependency on the therapist, with the therapist initially taking a more active role in guidance, and gradually decreasing it as the patient is ready. In fact, this principle guides many forms of directive therapy.

Excessive dependency or counterdependency sometimes has the potential to heighten disruptions and maladaptive behaviors both in and out of therapy. They create a high possibility for suicide, especially if the therapist does not properly accept and deal with the patient’s insecure dependency (Modestin, 1987; Gunderson, 1996). The patient may experience severe deterioration in functioning, self-destructive acts, and

disintegration (Gunderson, 1996; Linehan, 1993; Modell, 1985; Van Sweden, 1995). Too much reliance (and "too much" should be defined therapeutically for each patient/therapist dyad) can lead to an increase in insecure dependency behaviors (Birthnell, 1997; Bornstein, 1994; 1995; 1998a, b; Klein, 1937/75), and temporary or no gains in treatment (Gunderson, 1996; Janet, 1897/98; Steele & Van der Hart, 1997; Van der Hart & Friedman, 1989). On the other hand, a patient who cannot depend on the therapist at all is not likely to progress either. The activation of dependency means increased demands on the therapist by the patient, sometimes for immediate gratification, leading to strong countertransference pressures (Van Sweden, 1995). If the therapist responds erratically or with detachment or enmeshment, dependency will increase further rather than resolve, since unpredictable responsiveness prolongs dependency (Main, 1990). Finally, the therapist must be aware that at times dependency and counterdependency can serve as a resistance to grieving and working through (Kernberg, 1975, 1984; Stark, 1995; Van Sweden, 1995).

The theory of structural dissociation and dependency

The theory of structural dissociation – a conceptual framework for understanding and treating a wide range of posttraumatic conditions—has been extensively described elsewhere and has been revised and refined over time (Brown, Scheflin & Hammond, 1998; Nijenhuis & Van der Hart, 1999; Nijenhuis et al., in press; Steele et al., in press; Van der Hart, 1995; Van der Hart, Van der Kolk & Boon, 1998; Van der Kolk, Van der Hart & Marmar, 1996). We will give a brief overview of the theory in its current form to explain the intensity, chronicity, and oscillations of dependency in the dissociative patient, and specific therapeutic approaches to dependency.

Integrative capacity. Mental health is characterized by a high capacity to integrate events (Janet, 1889; Janet 1919/25; Nijenhuis et al., in press). Integrative capacity is the ability to distribute and utilize psychic energy that allows for reflective thought and action.(Steele et al., in press). Low or poor integrative capacity is likely related to the effects of neurochemicals released during stress that are highly concentrated in brain

regions associated with integrative mental action, such as the hippocampus and the prefrontal cortex (Nijenhuis et al., in press; for a review, see McGaugh, 1990).

High levels of integrative capacity enable use of the available level of mental energy to produce reflective thought and action, leading to adaptation, integration, and related to the topic of this paper, modulated levels of dependency. High integrative capacity is needed for daily life emotional systems to be consistently activated. Low levels result in poor and inconsistent activation of daily life emotional systems, with reflexive action based on emotionality and impulsivity, avoidance, and lack of critical thinking, with lack of integration in one's life (the "classic" borderline or DID presentation). Dependency in the traumatized individual is often related to low integrative capacity and resulting inability to engage in critical thinking and reflective action. The individual thus needs to rely to a more or less degree on another (the therapist) to guide and support until integrative capacity can be raised in therapy.

Failure to adapt in trauma. Very high levels integrative capacity are required to realize and integrate trauma (Janet, 1919/25). *Vehement emotions* (Janet, 1909; cf., Van der Kolk & Van der Hart, 1989), i.e., overwhelming fear, helplessness, horror, rage, shame, etc. occur during or directly after trauma, and a person is thus unable to respond adaptively to trauma. Individuals may subsequently become more dependent as vehement emotions overwhelm them and they are thus unable to function, activating systems of attachment to a care taking individual. Individuals who suffer from posttraumatic conditions often have chronically increased activation of the defensive system in which survival-based needs are experienced as paramount. This subsequently dampens activation of emotional systems that promote daily life adaptation. Thus, such individuals have more difficulty with autonomy and adult functioning, and also experience the need of a secure attachment to ameliorate the helplessness experienced during the trauma and the difficulties that arise in therapy during attempts to resolve the traumatic disorder.

Structural dissociation. Structural dissociation of the personality may occur in trauma, with the pre-traumatic personality fragmenting into what Myers (1940) referred to as an "apparently normal" and an "emotional" personality. Although we will now describe a theory of structural dissociation with separately functioning "personalities," we recognize the metaphoric nature of this description. Yet, dissociated mental and

somatic contents, however rudimentary, do not exist in a vacuum, but are always a part of "*some* personality" (Mitchell, 1922, p. 113). We therefore prefer the term "personality," despite its history of being misunderstood and reified in DID. Thus the terms "apparently normal" and "emotional" personalities not only refer to the classic understanding of DID alters, but also to the dissociation in PTSD characterized by alternation between the numb, avoidant, but more or less functional personality ("apparently normal"), and the personality that relives the trauma ("emotional"). The difference is primarily the fact that in DID there is fragmentation of the apparently normal personality in addition to the emotional personality, and in the degree of autonomy and elaboration present.

Structural dissociation is not indiscriminate, but follows along the lines of the innate emotional systems, as described above (Panksepp, 1998). The "emotional personality" (EP) is directed by the defensive emotional (sub)systems in particular, and is characterized by fixation in the trauma, hypermnesia, somatosensory experiences of the trauma, retraction of the field of consciousness to the trauma and related stimuli, and disorientation to the present time.

The "apparently normal" personality (ANP) is directed by emotional systems related to daily life, including attachment. The primary function of the ANP is to adequately function in daily life, which would not be possible if unintegrated trauma was intruding. Thus, the ANP is fixated in avoidance of the trauma, detachment, some degree of amnesia or other lack of realization, retraction of the field of consciousness to issues of daily life that excludes trauma and related stimuli, and emotional and physical numbing. The dissociation of a single EP and a single ANP is termed *primary structural dissociation*, and is found in acute stress disorder and simple PTSD. If trauma is prolonged and severe, further fragmentation occurs along *defensive* subsystems, resulting in two or more EPs and a single ANP. This so-called *secondary structural dissociation* is found in complex PTSD, trauma-related borderline personality disorder and dissociative disorder not otherwise specified. Finally, *tertiary structural dissociation* occurs *only* in DID, and includes not only fragmentation of EPs, but also fragmentation of the ANP. Dissociation of the ANP results from the burden of avoiding trauma and attempts to manage daily life, which become increasingly overwhelming due to intrusion of trauma

and low integrative capacity. Patients with DID can, of course, also fulfill diagnostic criteria for borderline personality disorder and Complex PTSD.

It is important to note that ANPs and EPs represent a wide range of dissociated contents, ranging from rudimentary and single states (e.g., a feeling or behavior) to much more elaborated and autonomous set of states (e.g., clearly distinguished aspects of DDNOS and DID). They occur along all three levels of structural dissociation, each more or less directed by a particular emotional system or set of systems, and which are dissociated from each other. The more rudimentary personalities, particularly EPs, are sometimes called “ego states.” However, on a diagnostic level, if an ANP was also dissociated into rudimentary “ego states” that could take executive control, such a presentation would still constitute tertiary structural dissociation, i.e., DID.

Psychobiological emotional systems and dependency. Attachment is one of several innate psychobiological systems that direct behavior toward survival and daily functioning in animals and humans. These so-called “emotional systems” have received increasing attention recently (e.g., Cassidy, 1999; Panksepp, 1998; Siegel, 1999), including their relationship to trauma (e.g., Nijenhuis et al., 1998; Nijenhuis et al., in press; Steele et al., in press). Although these systems are inborn, they may be conditioned and shaped by learning experiences, including trauma. Thus dependency may be conditioned to more or less activated than usual in response to insecure attachment.

Emotional systems that promote adaptation to daily life include *attachment, exploration, play, energy management, sociability, reproduction,* and *care taking* (Panksepp, 1998). In the ANP, dependency is related to the attachment system primarily as a social function to maintain reciprocal relationships, which is normally integrated into a process of social and intimate interdependence in secure attachment. But when insecure attachment prevails, the ANP will become dependent in ways that are not typical for the securely attached individual. For example, lack of knowledge in understanding and managing feelings would create a dependency on the therapist for guidance and assistance in the ANP. In this example, dependency is necessary, not only for basic psychoeducation and skills building, but also because secure attachment with the therapist initially provides a regulatory function for emotions.

The emotional system designed to ensure survival of the individual when under threat is the *defensive* system (Fanselow & Lester, 1988). The defensive emotional system is comprised of several subsystems related to perceived imminence of attack. These include hypervigilance, freezing, stilling, and analgesia, flight, fight, and total submission and anesthesia. Attachment and dependency would not be relevant behaviors during extreme threat, so EPs who are fixed in these defensive positions would not be concerned with dependency and attachment, but rather with imminent survival.

However, one particular form of attachment seeking behavior that appears in close proximity to defensive systems—because the young have more risk of attack when left alone-- is called the *separation cry or call* (Panksepp, 1998; Van der Kolk, 1987). It is highly relevant to dependency and will be observed in EPs rather than ANPs. It is directed by the so-called panic system due to perceived loss of attachment security rather than by attachment systems per se (Panksepp, 1998). Thereafter, attachment activation *decreases* as threat increases. The separation cry is an emission of a "cry for help"–often manifested in crisis behavior—to elicit the help and support of an attachment figure when the threat of attachment loss is perceived. It is evoked by the absence of a soothing, nurturing other in the face of internal (e.g., overwhelming affect, pain, hunger, being alone in situations of potential threat) or by the sense of external (trauma) threat (Van der Kolk, 1987). Traumatized patients chronically feel threatened by such internal and external sources, and separation cry behaviors in the EP such as clinging, crisis calls, and other attempts at frequent contact with the therapist are attempts to attain safety via care taking and attachment prior to the activation of further defensive states. EPs may become fixated in these failed or rigidly repetitive attempts.

When the attachment and defensive systems must compete or are chronically activated in rapid succession when a child is being abused or neglected by an attachment figure, these systems may become structurally dissociated, and both involve EPs, while ANPs are only involved with the attachment system.

A developmental pathway to structural dissociation and dependency. Of particular importance to the topic of dependency is an early developmental pathway to secondary and tertiary structural dissociation that hinders the natural progression toward integration of emotional systems (Putnam, 1997; Siegel, 1999). Many secondary and tertiary

dissociative patients have experienced not only abuse, but considerable neglect and attachment disruption from an early age (Draijer & Boon, 1993; Nijenhuis, et al., 1998; Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997; Putnam et al., 1986; Ross, Norton, & Wozney, 1989). It is within secure attachment that infants and children begin to develop, regulate and integrate inborn "discrete behavioral states," each including a rather distinct sense of self (Putnam, 1997; Siegel, 1999). Thus, an infant's discrete states, which in our view are directed by various emotional systems, may remain structurally dissociated due to neglect and trauma. In a context of chronic traumatization, we propose that these rudimentary states eventually gain higher degrees of autonomy and elaboration, becoming ANPs and EPs, depending on which emotional systems direct them. If the defensive system of a child is chronically activated by neglect and trauma, it will be difficult to develop mature, flexible, and cohesive daily life systems. Patterns of insecure attachment develop concurrently, most commonly, a disorganized/disoriented style (e.g., Liotti, 1995, 1999; Main & Hesse, 1990; Main & Morgan, 1996). This attachment style involves simultaneous or proximate alternation of defense and attachment emotional systems (EPs involved with both systems and ANPs with the attachment system), manifesting in intense insecure dependency with a phobia of detachment, and intense disavowal of dependency and phobia of attachment. We would suggest that the earlier and more chronic the trauma, and the greater the attachment disruption or absence from a care taker, the more extreme the dependency and the more maladaptive the dependency behaviors will be for the individual. Securely attached individuals alternate between secure dependency, and interdependency and autonomy.

Since there is supposedly an innate movement toward integrative flexibility among emotional systems (Siegel, 1999), we must briefly examine reasons why structural dissociation tends to remain chronic, and why dependency issues often remains unresolved in the traumatized patient.

Maintenance of structural dissociation. The maintenance of chronic dissociation is chiefly the result of internal classical conditioning (cf., Nijenhuis et al., in press). When the ANP is intruded upon by the EP, this represents an internal classical conditioning event since it exposes the ANP to highly aversive stimuli unconditioned (traumatic memories contained in the EP). The ANP will tend to respond to this intrusion by

mentally avoiding the aversive stimuli, i.e., by dissociating itself from the EP and its memories, a complex response that may be mediated by the release of stress hormones, among others. To the extent that the ANP does not re-dissociate from the EP, more or less integration may take place: this is an essential principle that guides treatment. Stimuli that precede or accompany the intrusion of the EP become conditioned stimuli for the ANP. Thereafter, these conditioned stimuli will tend to evoke ANP's avoidance responses. The ANP will attempt to avoid traumatic memories, but cannot succeed completely in that structural dissociation is not perfect. In this context, sensitization rather than extinction is a probable outcome. Thus, the ANP becomes ever more sensitized to the EP and associated stimuli, leading to increasing phobic avoidance of the EP. Both classical conditioning with respect to these internal stimuli, as well as to external stimuli, results in a series of particular phobias that must be addressed therapy, several of which are directly related to insecure dependency and its management.

Evaluative conditioning (Baeyens, Hermans, & Eelen, 1993) is a powerful form of associative learning that causes the evaluation of a stimulus to be changed in the direction of the evaluative tone of the stimulus with which it is coupled. For example, when a child is ridiculed, shamed, hurt or ignored when she experiences and expresses a legitimate dependency need, she will later be inclined to attach those same affective tones to her dependency. Thus, she will experience her own (and perhaps others') dependency as ridiculous, shameful, painful, or denied.

Up to this point, dependency has been discussed in a theoretical, abstract manner– a necessary precursor to pragmatic therapeutic issues. Now a more practical discussion of phase-oriented treatment that addresses dependency in the context of these phobias will follow.

Phase-oriented treatment of dependency in dissociative patients and dependency issues

Many clinicians use a phase-oriented approach to the treatment of complex posttraumatic and dissociative disorders (Brown, et al., 1998; Courtois, 1999; Herman, 1992; Horevitz & Loewenstein, 1994; Kluft, 1993; McCann & Pearlman, 1990; Van der Hart, 1995; Van der Hart, et al., 1998). Some have stated this is the standard of care (e.g., Brown, et al., 1998). A dual strategy of a problem-solving and a relational approach to

issues is essential (Brown, et al., 1998; Steele et al., in press). Phase 1 is symptom reduction and stabilization and includes a focus on alleviating several phobias: (1) *phobia of attachment issues, particularly related to contact with the therapist*, (2) *phobia of mental contents* (feelings, thoughts, wishes, needs, fantasies, physical sensations), and (3) *phobia of dissociative personalities* (EPs and ANPs). In Phase 2—treatment of traumatic memories—focus is primarily on (2.1) *phobia of traumatic memories* and (2.2) *phobia of attachment, particularly related to insecure attachment to the perpetrator*. Phase 3 is personality (re)integration and rehabilitation, directed toward (3.1) *phobia of intimacy*, i.e., more mature forms of attachment, (3.2) *phobia of normal life*, and (3.3) *phobia of healthy-risk taking and change*. Phase-oriented treatment is not linear, but takes the form of a spiral, with various phases alternating one with another, depending on the current integrative capacity of the individual.

General therapeutic strategies. The therapist may employ a number of strategies and relational approaches in the management of intense dependency in the patient. The psychoanalytic perspective on dependency as pathological, and as driven by wish rather than need appears to have been accepted as a prima facie assumption by many experts in the trauma field, thus much of treatment has been directed by analytic principles of therapist neutrality and abstinence, and relatively little attention has been given to the counterdependent patient. Over time, it became apparent that at least some modification and flexibility were necessary, particularly for chronically traumatized patients. For instance, recently there has been much debate within analytic groups regarding Freud's admonition that dependency must always be interpreted rather than gratified, with a number of mainstream analysts now viewing some level of gratification with more troubled and traumatized patients as necessary (e.g., Connors, 1997; Davies & Frawley, 1994; Fox, 1984; Hamilton, 1984; Lindon, 1994; Mitchell, 1991; Schachter, 1994).

Outside psychoanalytic theory there also remains much debate regarding which measures constitute countertransference errors of enmeshment or of withholding, and which are within a range of therapeutic utility (e.g., Chu, 1998; Dalenberg, 2000; Kinsler, 1992; Wilson & Lindy, 1994). Most authors state that flexibility and warmth are essential, followed by warnings about maintaining good boundaries. For example, Chu (1998) states:

> Particularly in times of crisis, it may seem reasonable for therapists to extend themselves to an extraordinary degree. However, any significant alteration of the normal structure of therapy should be made with caution. Blurred boundaries and lack of limits will almost certainly result in the experiences of the lack of boundaries and limits in the patient's abusive family-of-origin. (p. 187)

Our view is that a careful balance is needed, based on strong theoretical grounding, reflective thinking and interventions, close collaboration between therapist and patient, and consultation with colleagues. Some trauma clinicians have discussed the need for boundary negotiation rather than boundary maintenance (Pearlman & Saakvitne, 1995). Dalenberg (2000) has referred to this as "boundary crossings" for therapeutically beneficial purposes versus "boundary violations" which are harmful to the patient (p. 229). We also believe it crucial for therapists to be aware of their own experiences, belief systems, and cultural contexts that enter therapy consciously or unconsciously, and that may have positive or negative effects on the traumatized patient.

The therapist must recognize the central role of the therapeutic relationship in work with chronically traumatized patients with insecure attachment (Chu, 1998; Cohen & Sherwood, 1991; Connors, 1997; Dalenberg, 2000; Davies & Frawley, 1994; Farber, Lippert, & Nevas, 1995; Gunderson, 1996; Laub & Auerhahn, 1989; McCann & Pearlman, 1990; Olio & Cornell, 1993; Pearlman & Saakvitne, 1995; Steele & Van der Hart, 1997). An empathic acceptance and understanding of the sometimes intense, desperate, and painful nature of the patient's dependency, or conversely, the shame and vehement disavowal of dependency is essential, as it is the basis for resolving insecure attachment and dependency. The therapist must stimulate the development of a secure attachment with the patient, thus the therapist should be *dependable*. This requires collaboration, consistency, predictability, genuineness, warmth, empathy, and clear and flexible boundaries and limits. It also means the therapist must be congruent or transparent in his/her approach to the patient. In other words, what the therapist says and does should match, and respect for the patient as a human being should be reflected not only in session, but when discussing the patient with colleagues. The therapist's dependability enables the patient to face the challenge of developing secure attachment

that will raise integrative capacity and support activation of emotional systems that support daily life functioning.

Within the context of this relationship, dependency may emerge in its various manifestations, both adaptive and not. From the delicate balance between meeting basic needs and healthy limit-setting, the therapist should keep in mind that dependency should be *goal-directed*, i.e., it should not be merely for the sake of the patient having a dependent experience, but should be directed to motivate and support the patient to engage in therapeutic work that promotes integration, adaptation and flexibility in normal life, including a good balance between autonomy and interdependence.

Patients often have difficulty verbalizing dependency, either due to shame, lack of words, or the fact that early attachment trauma is pre-verbal. Thus, dependency is often not amenable to verbal interpretation, especially in early treatment. Thus, the therapist must ensure that the therapeutic relationship and the therapy frame support secure attachment and dependence, regardless of whether the patient can discuss or process dependency. It is essential that the therapist begin to help the patient by explaining and normalizing secure dependency, and by helping to identify insecure dependency behaviors, thoughts, and feelings, and raising the patient's integrative capacity to support the ability to reflectively think through intense conflicts regarding dependency.

The therapist has a responsibility to regularly discuss the therapeutic relationship and how the patient (including each ANP and EP) experiences it. Each personality should be supported to become aware of other personalities' views regarding dependency, and subsequent conflict resolution should move the patient toward integration. It is necessary to be acutely aware of the caveats mentioned above regarding dependency, so that further maladaptive dependency or independency is not promoted by the therapist's ignorance or countertransference. Finally, attachment issues related to family perpetrators must be addressed in order to process dependency issues, since there is invariably intense insecure attachment to family abusers. Apart from these general therapeutic issues regarding dependency, each separate treatment phase requires specific adherence to therapeutic principles in dealing with dependency.

<u>Phase 1: Symptom reduction and stabilization</u>. Initial therapy will be directed toward alleviating some of the patient's more intense and/or self-destructive behaviors

and symptoms. Phase 1 goals have been extensively described elsewhere (e.g., Boon, 1977; Brown, et al., 1998; Chu, 1998; Courtois, 1999; Kluft, 1993, 1997; Steele et al., in press; Van der Hart & Boon, 1997; Van der Hart, Brown, & Van der Kolk, 1989). These goals primarily include strengthening ANPs for more adaptive function in daily life (i.e., raising integrative capacity), containment of traumatic reexperiences, alleviation of severe symptoms, establishment of relative safety, building an early therapeutic alliance with ANPs and with persecutory and angry EPs that often are self-destructive, as well as skills building in areas of affect management, impulse control, and development of basic social support. Gradual movement toward these goals provides a sound basis for management of dependency in secondary and tertiary dissociation.

The phobias that must be overcome in this first phase of treatment often relate to dependency. First, *phobia of attachment and contact with the therapist* are central to the issue of dependency. These phobias may manifest either in the patient maximizing or minimizing attachment with the therapist, according to which attachment style is prevalent. In the case of disorganized/disoriented attachment, there will be simultaneous or rapid alternation of attempts to attach and detach from the therapist. These styles, and a more secure style of managing dependency are described in Table 1.

[Place Table 1, Manifestations of dependency, about here]

Treatment of phobia of attachment, whether it manifests in extreme attachment or detachment, requires the therapist first to form a basic alliance with the ANP(s) who function in daily life. Early in therapy we recommend beginning with problem-solving approaches, along with general empathic attunement that demonstrates the therapist's dependability. Gradually the topic of the therapeutic relationship can be broached, with the therapist giving normalizing information and even bibliotherapy for those patients for whom it would be helpful (recommended books include Lott, 1999, and Miller & Stiver, 1997). In this context, the patient can begin to be supported to examine the *phobia of mental contents* (feeling, wishes, needs, thoughts, fantasies, physical sensations) related to dependency. Cognitive distortions should be consistently corrected, e.g., "Dependency is bad and shameful;" "Dependency is the only thing that will make me better;" "If I am

independent, then I will have nobody;" "Someone must always take care of me." The patient is gradually supported to accept internal states, as they can be feared and shameful. This process is basically one of desensitization with prevention of further avoidance and structural dissociation.

The *phobia of dissociative personalities* (ANPs and EPs) is directly related to phobia of mental contents, in that they are often laden with evaluative conditioning effects, causing them to be phobic of each other, and have more or less intense negative affects (e.g., hatred, dread, fear, disgust, shame) toward each other. ANPs and EPs include a wide range of dependency behaviors and conflicts. Certain ANPs and EPs may be excessively independent and avoidant of attachment; some may have little or no awareness of dependency needs but exhibit low integrative capacity so that maladaptive dependent behavior (e.g., demanding, crisis-oriented) behavior occurs; some may have higher integrative capacity and awareness, so more adaptive behavior occurs. EP intrusion of dependency into ANP may create confusion, phobic avoidance, and alternation of adaptive and maladaptive behaviors. An EP fixated in the separation cry would engage in extreme dependent behavior. On the other hand, many angry and persecutory EPs (related to the "fight" emotional defensive subsystem) usually have complete phobia and vehement disregard and disgust for dependency. Conflict between dissociative personalities then arises regarding the expression of dependency. For example, an EP with a propensity to fight may punish the EP fixed in the separation cry; an EP fixated in flight may intensely avoid attachment and dependency that is expressed by another, as they signal closeness to the abuser, who is the threat. In tertiary structural dissociation (DID), certain ANPs may also have conflicts among themselves regarding dependency. ANPs dedicated to attachment may be conflicted with ANPs dedicated to work, for instance. Avoidance, shame and abhorrence of dependency can be exhibited by certain ANPs. Thus internal conflicts regarding dependency and independency may be extreme and dissociated in the traumatized patient. Patients may be so avoidant of these conflicts that they "hand over" dependent ANPs and EPs to the therapist to "take care of," with unbridled dependency ensuing. Or they may avoid the therapist in attempts to keep dependency at bay.

Due to these highly conflicted and dissociated dependency issues it is crucial that the therapist not push the patient into further extremes of dependency *or* independency early in treatment. Usually neither ANPs nor EPs have the integrative capacity to tolerate the force of need, yearning, grief, disappointment, shame, rage, and self-hatred that accompanies dependency. Instead, there should be a slow, paced progression that includes gradual work to support affect and impulse regulation, acceptance of ANPs and EPs by each other, diminution of avoidance of mental contents, and an increasing capacity to verbalize mental contents within a safe therapeutic relationship. The relationship itself should be discussed, with the therapist being genuine and present.

For patients who begin therapy with intense dependency, there needs to be safe and empathic containment with clear boundaries. The therapist should not be used as a substitute for therapeutic work. Yet, the underlying dependency needs must still be addressed, even though the behaviors are maladaptive and evoke strong countertransference. Therapists can do this best when they can generally maintain their own high level of integrative capacity that allows grounding, mindfulness, genuine presence with the patient, and the ability to think and act competently and clearly when the patient is driven by urgent need.

For example, a patient with DID began making daily emergency phone calls, some late at night. It was clear that the patient's anxiety was escalating with the calls. During the next session the therapist brought up the phone calls in the following manner: "I notice you've called me every day this week in quite a state of distress. Some calls have been late at night, which lets me know you are having trouble sleeping on a regular schedule, and makes me wonder what is giving you such a hard time at night. It seems that neither our sessions nor the phone calls are addressing some very important need, and I've been doing a lot of thinking about what that need might be, especially within our relationship. Would you be willing to work on that together and help me understand more about it?"

Notice in this scenario the therapist does not begin with confrontation. That may well be appropriate and necessary, but should usually (not always) occur afterwards, when empathic attunement has been established. Dalenberg (2000) has stated that the therapist "needs to 'shout' his or her attachment to the trauma client, and 'whisper' his or

her comments about the client's disturbing and distancing behaviors (p. 230). However, all boundary negotiations must take into account not only the patient's, but the therapist's needs.

The patient was then able to talk more freely about her deep need of the therapist and her intolerance of aloneness that was expressed by several ANPs and EPs. There was detailed discussion regarding what helped and what did not help about the crisis calls for each personality. She was given clear instructions about emergency calls, and her sessions were increased from once to twice a week for a trial of six weeks, with the agreement that she could call the therapist up to twice during the week for a check-in when not in crisis. She requested an audiotape of relaxation and affect regulation from the therapist, which was done in session with her, serving as a transitional object. Thereafter, sessions focused on normalizing her need of the therapist, modulating her self-hatred related to dependency needs that was expressed by several ANPs and EPs, improving self-soothing skills, forming an alliance with a persecutor EP who was punishing her for dependent feelings, and other more effective ways to manage aloneness (cf., Gunderson, 1996). Two session per week were very effective, and she was gradually able to stop the check-in phone calls (first by calling in to the therapist's voice mail, then journaling instead of calling, then writing herself notes to bring to session to discuss with the therapist). Crisis calls diminished to no more than one or two per month, were more appropriate, and there was evidence that the patient was more involved in some areas of her life.

Patients who enter therapy with a counter-phobic response to dependency must be helped to normalize dependency, vulnerability, and need. At the same time, trust in the therapeutic relationship is an issue that requires careful and sustained attention, as the fear is that one will become dependent and the therapist will not be dependable. Such patients often fear dependency so much that they fantasize that they will "fall apart," "be crazy," or "not be able to do anything." Thus dependency in very small "doses" is appropriate.

For example, a very high functioning man with complex PTSD avoided any dependency on the therapist. In four years of treatment, he never called, asked for an extra appointment, or otherwise requested anything outside the set therapeutic

boundaries. He maintained dominance of his ANP, who was rather alexithymic and numb, and was apparently unable to receive verbal comfort or support from the therapist. He strenuously avoided EPs, though therapy gradually supported him in being less avoidant. During one session, he began to cry due to intrusion of a frightened and sad EP and made a vain attempt to stop. He became furious at his vulnerability and inability to "keep it together." The therapist did not attempt to encourage his crying or verbally comfort him, as she felt those interventions would create more shame and anger for the ANP. Instead, the therapist simply sat quietly, maintaining eye contact when the patient was able to do so, thus supporting the EP indirectly. The EP continued to cry, but with diminished anger in the ANP. After a few more moments, the ANP asked for some tissues. It was the first request he had ever made in therapy. Several years later, after the patient had been able to accept his painful dependency that was dissociated in several EPs, and had formed a secure attachment with the therapist, he stated that the therapist's simple presence during that session had been as much as he could tolerate and was a pivotal moment. If the therapist had offered him encouragement, reassurance, or comfort he said, "I [ANP] would have run out and never come back. Instead, for the first time, I felt safe to have those feelings with someone else-at a distance, but still there." Here the ANP's earlier shame and avoidance of dependency that was contained in EPs is expressed by the integrated patient.

Session length and frequency must be adjusted to what works for the patient, meaning what best supports therapeutic progress that improves the patient's daily life and decreases crisis. Session length is generally accepted as one hour, though a number of trauma patients maintain better containment and functioning with an hour and half. The session should not be longer than the patient's tolerance for the work, nor shorter. Most importantly, sessions should always begin and end on time, affirming the dependability of the therapist. Session frequency is generally set at once, sometimes twice a week, and seldom at three times a week (e.g., Chu, 1998; ISSD, 1997). The more frequent the sessions the more dependency emerges as a core feature of the relationship. Many patients need more than one session per week to maintain and improve functioning. Thus, frequency should take into account the patient's tolerance for dependency, as well as the therapist's capacity to maintain dependable attachment and flexible but consistent

boundaries. Generally, adequate frequency and length has been achieved when the patient is able to move out of crisis and into more productive therapeutic work.

Phone calls are an important intervention to consider. Generally, crisis calls should be minimized or eliminated and check-in calls, if necesssary, should be substituted. Check-in calls should planned, time-limited, brief, and therapy should not be done during them. They should be used in a stepwise movement toward establishing object constancy and internal self-soothing for the patient. Again, an adequate balance is attained when the patient is less crisis-prone and able to better engage in therapy.

A team approach is often helpful, when it is possible to create. The patient then has two or more people on which to depend on various levels, and has access to at least minimal support and contact when the primary therapist is not available.

Dependency in daily life is a separate matter. Though patients may wish for the therapist to "take care" of them, the reality is that patients must manage their own lives outside of therapy. However, some patients come to therapy with such compelling basic life needs, such as lack of adequate housing, clothes, food, employment and money, medical problems, severe substance abuse, etc., that dependency takes on a more literal connotation. Some therapists are skilled in case management, and as a precursor to therapy can support the patient with auxiliary contacts such as shelters, vocational rehabilitation, food banks, etc. Other therapists might refer such a patient to a mental health center for a case worker and keep that work separate. However, in no case should the therapist engage in direct care taking such as searching for a job for the patient, allowing a patient to stay in the therapist's home, giving the patient money, etc.. Such basic survival needs must be met before therapy can proceed.

A certain degree of stability and integrative capacity must be achieved before initial Phase 2 work. Contraindications to Phase 2 have been extensively described elsewhere (Boon, 1997; Kluft, 1997; Steele & Colrain, 1990; Van der Hart & Boon, 1997; Van der Hart, Steele, Boon, & Brown, 1993).

Phase 2: Treatment of traumatic memories. Once the patient is more stable and has adequate integrative capacity to begin work on trauma. Traumatic memory is treated in several stages (Van der Hart, et al., 1993): (1) *preparation*, in which careful planning occurs; (2) *synthesis*: the resolution of dissociation regarding components of traumatic

memories, and a beginning narrative accounting that eventually includes all personalities. Synthesis of particular memories, or portions of memories are *planned* events that occur within a session or series of sessions; and (3) *realization* and *integration.* This last stage is much more process-oriented and will occur over a period of time. Of prime importance is the inclusion of ANP(s) in this work, i.e., the personality that functions in daily life. This personality (or personalities in the case of DID) is highly avoidant and phobic of the trauma, and it is an easy mistake for the therapist to begin working with EPs regarding the trauma while the ANP(s) remain dissociated from the work. However, there may be occasional times when synthesis and various levels of realization may first occur among EPs, e.g., when several defensive subsystems might be integrated prior to work with the ANP on realization of the trauma.

Dependency may become much more intense during this period. There are several reasons for this increase. First, is the “agonizing desire of the trauma patient for a witness to interpersonal trauma” (Dalenberg, 2000, p. 228). At some point following synthesis, the need to share becomes compelling once the relationship has been well-established. The patient needs the therapist to bear witness (Laub & Auerhahn, 1989; Van der Hart & Nijenhuis, 1999), meaning the therapist must be steady in genuine presence and be an active listener/participant not only with the head, but with the heart. Such contact allows the therapist to be a “need-mediating object” (Cohen, 1985, p.180) who becomes a bridge from the world of the trauma where needs were desperate and life-threatening to a world where needs can not only be modulated, but also fulfilled.

Second, patients have a chronic tendency to reexperience the helplessness, confusion, and chaos of the trauma in which synthetic and organizing capacities are lost. As the trauma is approached, various EPs will display these characteristics. The therapist must provide external grounding, orientation, support, and guidance so that such experiences can become integrated and no longer intrusive. The patient will also experience the profound dependency and attachment needs of the past, which are often described as nearly intolerable and unending. The therapist must be firmly in the present to bear witness and support the patient in experiencing not only the past, but the present in which now there *is* attachment and help. This will gradually support the patient in the painful and inevitable grieving that must be done, but cannot be done completely alone.

Third, there is vehement avoidance in ANPs of traumatic memories and salient trauma-related stimuli such as external triggers, particularly trauma-related mental contents, and EPs. Fear and avoidance of the trauma is called the *phobia of traumatic memory*. The patient will experience extreme conflict about telling, and become dependent on the therapist for a paced and modulated approach to traumatic material.

As the traumatic memory is approached, the ANP will experience a sense of threat. Threat first evokes attachment need, and there will be heightened insecure forms of attachment both to the therapist *and* manifestations of insecure attachment to the perpetrator, again evoking *phobia of attachment.* Increased insecure attachment to the therapist may take the form of increased fears of abandonment; fear of being found repulsive or disgusting once the trauma is revealed; fear of "contaminating" the therapist; fear of being blamed; fear that something dreadful will happen to the therapist, etc. Insecure attachment to the perpetrator may take the form of vacillating belief about what happened; intense guilt about "betraying" the perpetrator; increased self-hatred, shame and self-blame to minimize the perpetrator as a bad object; intense fear of telling; identification with the perpetrator; idealization of the perpetrator; strong urges to see or communicate with the perpetrator (which should be processed but not prohibited); and intense fantasies (which may be presented as reality by certain EPs) about an ideal family.

The therapist must begin work with traumatized EPs, who until this time, have been contained. It is essential to note that many EPs are not attachment-based, but are *defense*-based. It is vital that the EPs and ANP(s) gradually become more securely attached with each other. Otherwise, the fantasy of rescue by the therapist may intensify with the building alliance. Thus attachment to the therapist will not be an initial intervention with defensive EPs. Instead, EPs must first be assisted to connect with other EPs within the defensive emotional system. For example, a submissive EP and a fight EP could be paired to begin working together to promote more internal empathy about both positions, and for each to modulate the other's rigid position with a different set of skills. Flexibility then gradually develops among previously fixated EPs. As they become more oriented to the present there is less need for defensive action. Once the defensive system

has become more integrated within itself dependency issues can be broached in small steps.

Orientation to the present, correction of cognitive distortions, containment and modulation of affect and impulses to self-harm, eventual and consistent attachment work all EPs and ANPs, avoidance of good/bad splits regarding ANPs and EPs and perpetrators, work with traumatic rage, and prevention of avoidance and dissociation by pacing the treatment within the tolerance of the patient (at times returning to Phase 1) are essential. These interventions will not only provide a safe and workable therapy, but will minimize the patient's oscillations regarding dependency.

Specific interventions regarding the processing of traumatic memories is beyond the scope of the paper, but can be reviewed in many other publications (cf., Brown, Scheflin, & Hammond, 1998; Chu, 1998; Courtois, 1999; Davies & Frawley, 1994; Kluft, 1997; Steele & Colrain, 1990; Steele, et al., in press; Van der Hart, et al., 1989; Van der Hart, et al., 1993).

Phase 3: Personality (re)integration and rehabilitation. Dependency in Phase 3 generally begins with great intensity, and gradually diminishes as the patient is able sustain high degrees of integrative capacity and engage in normal life with new coping skills and relationships. Often more involved work related to severe neglect is approached in this phase, for it is only when the therapeutic relationship has achieved a certain high level of stability and security that such painful material can emerge in a tolerable way. Also, it is quite common for additional dissociated trauma to emerge as the patient's integrative capacity becomes more sustained. At such times it is appropriate to return to Phase 2.

Dependency will emerge in relation to the various phobias addressed in Phase 3. First, the *phobia of normal life*, resulting from severe constriction related to avoidance of traumatic stimuli and the inability to adapt to and integrate a wide variety of complex experiences, creates a natural inclination for the patient to cling to the therapist rather than experience normal life. However, at this point, the defensive system and related EPs should be less activated, leaving more room for activation of normal daily life systems that can lead to a more normal and balanced life. The continued support of the therapist

as a secure attachment figure is paramount, allowing emotional dependency that assures the patient that the therapist is available should difficulties arise.

The patient will struggle with fears of leaving the therapist, which evokes dependency yet again. The therapist should encourage the patient to have gradual exposure to new situations in which adaptation and learning can occur (involving activation of the exploration system) and be genuinely interested in the patient's experiences and struggles. Thus, the patient gradually experiences "leaving" the therapist and safely returning to the secure base.

The phobia of normal life is related to the *phobia of healthy risk-taking and change*. Trauma resolution is essential to resolving this phobia, since the onset of change and feelings associated with risk often evoke the defensive system, with change perceived as a severe threat. The patient can easily become overwhelmed and turn to the therapist in a dependent state. At this point in treatment, the therapist supports the patient in working through the threat and continuing to engage in healthy risk-taking. Additional treatment consists of correcting cognitive distortions regarding change (e.g., it is dangerous, is intolerable, will induce helplessness and incompetence). Practice, graduated exercises, increased awareness of safe changes that have occurred throughout therapy, and continued support for sustained mental effort are important interventions. As the patient gains more mastery and competence, insecure dependency will gradually be replaced by a more secure dependency, and the emergence of interdependency and autonomy, albeit over a long period of time in many cases.

Finally, there remains the need to overcome the *phobia of intimacy*: this is perhaps the zenith of successful treatment, since it requires integration, flexibility and adaptation across all emotional systems and the highest levels of sustained integrative capacity. Dependency in a healthy intimate relationship should be secure. To a large degree the phobia of intimacy will have been addressed within the therapeutic relationship, with the development of a relatively secure attachment. However, the patient must realize that his or her capacity for intimacy is not limited only to the therapist, but can be expressed with others in daily life, where the risks are greater and more uncertain. The patient may again cling to the therapist and avoid more intimate contact with others.

The therapist again allows the dependency while continuing to utilize it on the patient's behalf to move forward with support.

Eventually, dependency issues should be resolved to the point of the patient experiencing secure dependency, at least the majority of the time. Generally, the frequency of sessions has decreased, crisis calls have stopped, and the patient is busy living normal life. However, the therapist may still need to be available as a secure base. There are many variations of therapy during the latter part of Phase 3. Some patients will be ready to move on and terminate, some will need sporadic contact, and others will need a regular contact with the therapist that is supportive in nature. Each is an option according to the patient's need and level of functioning.

Countertransference and dependency

A number of excellent resources are available for in-depth examination of countertransference in working with trauma patients, and these should be carefully read by every clinician (cf., Courtois, 1999; Dalenberg, 2000; Davies & Frawley, 1994; Figley, 1995; Kluft, 1994; Loewenstein, 1993; Pearlman & Saakvitne, 1995; Tauber, 1998; Wilson & Lindy, 1994). Virtually every publication on trauma, including special forms of trauma (e.g., torture, war, rape, natural disasters, workplace violence, genocide, childhood abuse) mentions countertransference, emphasizing its central role in treatment. There are also the innumerable "classic" publications on transference and countertransference, which are also highly recommended, but are not listed here due to space limitations.

Table 2 describes the enmeshed, distanced and balanced countertransference positions of the therapist. These positions are not a stable therapist variable, but may be quite different with the same therapist at different times in the same therapy, or vary according to different patients.

[Place Table 2, Countertransference positions in relation to dependency, about here]

Clearly, the intensity and demands of dependency in traumatized patients are a difficult, taxing and challenging process for the therapist. Often dearly held theoretical frameworks must be adjusted. The intersection of personal and therapeutic boundaries and limits must be revisited time and time again. The strongest empathy will be taxed and patience mightily tested. Intense affects ranging from sadness, hopelessness, confusion tenderness, love, hatred, rage, and disdain in the therapist must be contained and processed. The therapist must consistently work to keep his or her integrative capacity at the highest level possible. An essential capacity of the therapist is the ability to maintain simultaneous consistent and dependable attachment and therapeutic boundaries, with a minimum of vacillation, because inconsistency promotes further dependency. Enmeshment and distancing countertransferences can both have negative effects on consistency and attachment security. It is extraordinarily difficult to maintain a steady balance of maintaining a "good enough" secure attachment without moving into the territories of enmeshment or distancing. Therapists are human; they will lose their balance. The essential principles for success are (1) early recognition of situations that tend to evoke the therapist into moving too far in one direction or another; (2) the ability to quickly regain therapeutic balance with humility and honesty; and (3) the ability to stay within moderated parameters of enmeshment and distancing, i.e., not moving too far out on either continuum that therapy becomes irreparably damaged. Enmeshment and distancing countertransferences can both have negative effects on consistency and dependability. Both types of countertransference can be equally damaging if the therapist takes action on them.The advantages of therapeutic teams, peer supervision, and consultation should be noted. However, given the intensity of countertransference, there is also the possibility that a therapeutic team may engage in parallel processes with the patient, creating impasses. In such cases, an outside consultant who can objectively observe the team process is generally helpful.

Conclusion

Dalenberg (2000) has stated that "as we encourage deep and at times regressive and dependent relationships to develop, to facilitate transference and therefore deeper change, we also implicitly agree to honor the depth and felt life-saving quality of that

attachment"(pp. 189-190). This paper has been an attempt to understand and respect dependency as a necessary component of life, and to understand the extremes of dependency that are part of insecure attachment that results from trauma and neglect, and its central role in psychotherapy. Despite the confusion and negativity that surrounds it, dependency is obviously a ubiquitous component of therapy with traumatized patients. We have presented a conceptual overview and offered a specific meta-theory, the theory of structural dissociation, which in our clinical practice is very helpful in understanding and treating insecure dependency. A variety of interventions have been discussed within a phase-oriented treatment that can be used with any number of theoretical approaches. Various presentations of dependency and related countertransference have been described.

However, dependency still remains a somewhat elusive and poorly understood phenomenon, with continued disagreement over its exact definition and relationship to attachment. Thus, the conceptualizations offered in this paper should be regarded as tentative. The psychoanalytic and object relations literature has much to offer regarding dependency, but does not acknowledge the role of structural dissociation in attachment and dependency. Given the complex structural dissociation of many chronic trauma patients, with its inherent contradictory attachment styles, this dimension of treatment must also be taken into account, which was attempted in the description of the theory of structural dissociation and phase-oriented treatment of trauma. Furthermore, the pathologizing of dependency in much of the clinical literature is an impediment to a more comprehensive understanding of the role and treatment of dependency in traumatized patients. This article has adhered to the literature that promotes dependency as having both positive and negative aspects. It is our hope that this article will stimulate further study and discussion of dependency, and the further development of much needed sound clinical guidelines regarding treatment of dependency in chronically traumatized populations.

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Table 1

Manifestations of Dependency*

Extreme Dependency	**Counter Dependency**	**Secure Dependency**
Insecure attachment: resistant or preoccupied type	*Insecure attachment: avoidant or dismissing types*	*Secure attachment or approximations toward it*
Disorganized/disoriented attachment type may alternate between extreme dependency and counterdependency	Disorganized/disoriented attachment type may alternate between extreme dependency and counterdependency	Acknowledges and has empathy for own dependency needs/wishes
Lower integrative capacity	Lower integrative capacity	Higher integrative capacity
Under-regulation of affect, cognition and behavior related to attachment	Over-regulation of affect, cognition and behavior relevant to attachment; inhibition of positive and negative affects	Accepts limitations of therapy and grieve losses
Hyperactivation behaviors ensure ongoing comfort and care	Minimizes attachment disruption that would result from affects	Empathically relates to dissociated (ANP & EP) dependent and counter-dependent states
Preoccupied with status of therapist's availability; constant seeking of availability	Denial of needs or wishes	Controls dependency behaviors within a window of tolerance the majority of the time
Enmeshment and intensity in relationships	Inability to ask for appropriate help	Allows deep dependency on therapist while maintaining normal life
Sometimes extreme entitlement	Pseudo-independency	Dependency can be distinguished from erotic feelings
Inability to function well in daily life	Disgust and shame regarding dependency in self or others	Able to discuss dependency issues with awareness and insight
Attempts to rely on therapist for daily life activities rather than support for engaging in therapy	Unable to allow a therapeutic dependency on therapist because of need to avoid situations that stimulate attachment needs	Dependency on therapist promotes functioning and improvement in daily life
Unwilling/unable to accept limitations of therapy and therapist	May be eroticized and unrecognized as dependency, but without attachment, e.g., sexual addiction	Able to move toward intimacy in relationships
Dependency may be eroticized and unrecognized as dependency by patient or therapist	ANPs with emotional systems not directly related to attachment (e.g., exploration, play, energy management) and EPs with defensive emotional systems of fight, flight, freeze and submission	Increased or full integration of emotional systems of daily life and of defense
ANPs with attachment emotional systems and EPs in separation cry		

*Adapted in part from Slade, 1999

Table 2

Countertransference Positions in Relation to Dependency*

Enmeshed	Distanced	Balanced
Overidentification	Disavowal and denial of patient's needs	Reflective thinking, consultation, and congruent interpersonal boundaries
Helplessness, hopelessness	Helplessness, hopelessness	Empathy
Attempts to control own internal anxiety by "fixing" patient's need	Revulsion, shame, fear, anger	Non-urgent response to patient's urgency, but with care and empathic attunement to patient's distress
Pity/sympathy	Unresolved dependency needs of therapist	Boundary "crossing", i.e., flexible boundaries that are carefully considered and processed before changing
Unresolved dependency needs of therapist, with vicarious satisfaction in meeting patient's needs	Intellectualization of therapy	Empathic attunement with patient
Reflexive response to patient's need in the moment	Shaming or preventing patient for expressing need	Awareness of countertransference
Boundary violations	Overly rigid and/or punitive boundaries; excessive limits	Allows deep dependency by "caring about" rather than "caring for" patient
Poor and inconsistent limits	Reflexive avoidance of patient's need in the moment	Separates dependency on therapist in therapy versus dependency on therapist for daily life
Failure to process patient's dependency conflicts	Failure to process patient's dependency conflicts	Verbally processes dependency issues with patient when appropriate
Unable to withstand intensity of patient's demands and appeases	Unable to withstand intensity of patient's demands and withdraws and/or punishes	Ability to distinguish between insecure and secure dependency
Involvement in daily life of patient in concrete ways (e.g., loaning patient money)	Lack of adequate involvement in patient's struggle to live daily life	
Sexualization of dependency	Objectification of dependent patient with sexual exploitation	
Inability to set therapeutic goals regarding dependency	Inability to set therapeutic goals regarding dependency	
Promotes excessive regression in patient and sometimes in therapist	Promotes excessive independency in the patient and sometimes in the therapist (e.g., not seeking consultation or support)	
Unable to meet patient's needs with therapeutic interventions	Unable to meet patient's needs with therapeutic interventions	
Inability to distinguish between insecure and secure dependency	Inability to distinguish between insecure and secure dependency	

*Adapted in part from Wilson & Lindy, 1994