

DISSOCIATION AND SUBSEQUENT VULNERABILITY: A PRELIMINARY STUDY

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ABSTRACT

Recent reports by D. Spiegel, F. Putnam, and others demonstrate that dissociation is a common response to severe trauma, serving to provide some degree of acute insulation against overwhelming stressors. This quite preliminary study explores certain of the consequences subsequent to the establishment of dissociative defenses, and illustrates that their successful employment is a two-edged sword, rendering those who develop an adaptation relying on dissociation vulnerable to rather than protected against subsequent revictimization. Of eighteen carefully studied incest victims who had developed dissociative disorders and had been sexually exploited by psychotherapists, 14 (78%) had been raped as adults. One hundred percent were found to suffer ongoing dissociative symptoms that disrupted their sense of mastery and control of themselves and their lives. One hundred percent demonstrated that the defensive ablation of memory of crucial information rendered them incapable of perceiving and reacting to actual danger situations appropriately. Ninety-two percent became frozen or withdrawn under stress, and met situations best avoided by decisive action with passive compliance and learned helplessness. The same percentage had suffered a shattering of basic life assumptions. In all cases, traumatically-induced dissociative deformation of the observing ego and debasement of cognitive functioning had occurred, leading to a decontextualization of traumatic experiences. The outcome of these sequelae, which offer acute protection, is a syndrome of chronic impairment which, in severe cases, predisposes those who suffer it to repetitive revictimization. These findings are duplicated in a larger series currently under study. Therapeutic implications and useful strategies are reviewed.

INTRODUCTION

Dissociation is a widespread and essentially normal phenomenon, familiar to us from the most mundane of our everyday experiences. We often drive home, lost in thought,

and, upon arrival have no recollection of either the trip itself or of the complex series of thoughts and behaviors that we know were necessary to bring us home in safety. Nonetheless, we can be confident that these mental activities have in fact occurred, despite our preoccupation with other matters and our lack of awareness of them.

Clearly separate and transiently segregated streams of mental activity have been at work. This quite pedestrian and familiar capacity has the potential to become employed in the service of defense. Conditions in which this commonplace propensity plays a prominent role in a patient's psychopathological adaptation are called dissociative disorders. In these conditions, important aspects of self-referential material with regard to memory and/or identity become segregated from the individual's otherwise relatively intact and continuous ribbon of experience and memory; i.e., from one's experience of one's own self and one's own life.

DSM-III-R (1987) defines dissociation as a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness. Putnam, after conducting an exhaustive review of the literature, defined dissociation "as a complex psychophysiologic process, with psychodynamic triggers, that produces an alteration in the person's consciousness. During this process, thoughts, feelings, and memories are not integrated into the individual's awareness or memory in the normal way" (1985, p. 66). Spiegel observed that: "In dissociation, specific subsets of material seem to contain rules excluding other subsets of material from conscious awareness, although. . . these rules are not absolute and the boundaries can be breached" (1986, p. 124).

The intrinsic drama associated with conditions such as amnesia, fugue, and multiple personality disorder (MPD) often proves so compelling that attention is diverted from what drives these arresting phenomena. The ready induction of many dissociative phenomena with hypnosis has led many to trivialize the naturally occurring dissociative disorders and symptoms. However, the bulk of available data suggests that dissociation occurs most commonly in connection with severe trauma. With the exception of depersonalization disorder, all of the DSM-III-R dissociative disorders have proven highly correlated with histories of trauma (Putnam, 1985). This is demonstrated most persuasively by the findings that 97% to 98% of patients with MPD give histories that indicate that they are the survivors of child abuse (e.g., Putnam, Guroff, Silberman, Barban, & Post, 1986; Schultz, Braun, & Kluft, 1985, 1989). Furthermore, many of the symptoms of post-traumatic stress disorder are clearly dissociative; and dissociative symptoms are quite common in

victims of rape. In fact there is a sufficient number of acutely overwhelmed persons whose response is dominated by dissociative phenomena for a new classification to be proposed for inclusion in DSM-IV (Spitzer, R., unpublished materials and personal communications, 1989).

It is hardly surprising that dissociation would be such a common response to overwhelming events. By sidetracking unacceptable and/or intolerable aspects of life experience, either en bloc or along the cleavage planes of Behavior, Affect, Sensation, and Knowledge, as described in Braun's (1988) BASK model of dissociation, the ongoing executive apparatus of the mind is buffered in whole or in part from the impact of the trauma. The primary gain of dissociation becomes the diminution of some sort of dysphoria or the exclusion of some sort of information that was perceived as overwhelming. Secondary gain may follow readily if either desirable attention, the alleviation of stressors, or the mollification of responsibility follow as consequences.

However, the price of this type of relief is costly. One can easily infer the primary loss incurred—a shattering of the cohesion of one's life experience and one's sense of self (Putnam, 1985; Spiegel, 1986; Ullman & Brothers, 1988) are clear consequences. However, there is secondary loss as well. Individuals attempting to function after they have dissociated important data must attempt to comprehend themselves, their lives, and their environment deprived of crucial information. Consequently their efforts to do so often are ill-informed, and build in systematic biases that further compromise their efforts to cope. This would appear to lead to the potential for those who have had dissociative responses to trauma not only to fail to learn from experience, but also to remain impaired and/or to become more impaired in that connection.

There is an increasing body of data to the effect that certain groups of trauma victims, far from learning from experience to protect themselves more effectively, are differentially vulnerable to revictimization. Elsewhere (1989, 1990) I have summarized observations from numerous original sources that incest victims, for example, are differentially vulnerable to rape, masochistic behavior, involvement with abusive partners, participation in prostitution, and becoming substance abusers and psychiatric inpatients. More unsettling still are data to the effect that they are differentially vulnerable to sexual exploitation by mental health professionals (summarized in Kluft, 1989, 1990). Feldman-Summers and Jones (1984) found that the experience of incest is the most powerful predictor of therapist-patient sexual exploitation, and the presence of severe symptoms was the second most potent predictor. Hence, the incest survivor with dissociative psychopathology has a double loading for further mishap.

In an earlier study (1987, 1989, 1990) I studied a group of incest survivors who had been sexually exploited by a psychotherapist as well, and attempted to characterize a constellation of features that appear to be associated with revictimization, the sitting duck syndrome. The sitting duck syndrome consisted of (1) severe symptoms and dysfunctional traits which frustrated therapy and led to regressive dependency; (2) individual psychodynamics that favored revictim-

ization; (3) socialization to atypical object relations and family dynamics; and (4) the deformation of the observing ego and the debasement of cognition.

The current study enlarges the previous data base to 18 subjects with dissociative disorders who had endured both incest and sexual exploitation by prior therapists. It is preliminary in form, and admittedly utilizes a rather distressed group of individuals. Therefore its findings may not apply to all traumatized populations. However, this cohort is ideal for the exploration of the impact of extreme dissociative responses to trauma.

METHODS

I searched my files for the records of patients who had developed dissociative disorders in connection with incestuous experiences and had suffered sexual exploitation by at least one psychotherapist. All files in which the patient requested not to be included in any research or publications were excluded. With that exclusion criterion, thirty-one such patients were identified, and their records studied for evidences of connections between the phenomenology of their dissociative disorders and their subsequent revictimization. Twelve of these patients are part of a series reported elsewhere (Kluft, 1987, 1989, 1990), but the remaining 19 are among those who have been seen subsequently, many having been referred or having sought me out subsequent to my making presentations on the subject of therapist-patient sexual misadventure.

Of the 31 such patients, 13 had been seen in brief consultations and could not be studied in depth and at length. This left 18 patients who had been evaluated thoroughly and observed over a period of therapy.

The definitions used in this study have been specified elsewhere (Kluft, 1990). The thrust of this study was clinical in nature, and decidedly preliminary in scope. The documentation of the phenomena in question consists of no more than the author's clinical observations. Since I usually take verbatim notes early in therapy and periodically thereafter in order to monitor the flow of core conflictual relationship themes (CCRT) (Luborsky, 1984), these materials were available and served as valuable resources for appreciating the patients' stated perceptions of their circumstances and relationships.

FINDINGS

The patients included 17 females and one male. They averaged approximately 33 years of age at first assessment. Seventeen were caucasian, one woman was black.

They reported sexualized situations with 32 therapists, or 1.8 per patient. Although half had had a single such event, the other half had more than one such experience (seven with two, and one each with three and six). Over three-fourths of these liaisons resulted in consummated intercourse. As reported elsewhere (Kluft, 1990), for the patients seen longest, confirmation of the patient's allegations often proved possible, but there was no documentation for the six most recently seen patients. Eighty-two percent of the wom-

en had been raped, as adults.

With regard to diagnosis, Table I conveys the data with regard to major Axis I diagnoses in this group. Seventy-eight percent fulfilled criteria for borderline personality disorder, but it is quite likely that the overlap of the diagnostic features of this condition with those of dissociative disorders and PTSD artificially inflated this category. This is an area that requires considerable additional research.

Table 2 recounts the types of dissociative disturbances of memory that were encountered in the study population. All subjects experienced amnesia both for periods of time and for certain aspects of periods that were otherwise recollected. In addition, all experienced what I have chosen to call source uncertainty (a construct borrowed from the work of Evans and Thorn [1966] on source amnesia). They would recount a remembered experience, and wonder how it had come to their minds—was it a dream, a fantasy, something that they had read, etc. This was encountered even in patients whose abuse allegations had been confirmed by ancillary sources. Object-coercive doubting was described in 1983 by Kramer. In essence, the patient retrieves a recollection or describes a feeling, and attempts to place the burden of its validation upon the therapist, allowing him/herself to maintain a detached and skeptical stance toward his/her own material, and to disavow its implications. In derealization, a recollection is present but not accorded validity. Instead it is considered ego-alien and doubted. Resequencing and omen formation, described by Terr (1979, 1983) occur when a traumatized individual does not recall an event as it occurred, but instead comes to feel that some later events occurred earlier than they actually did, and should have constituted omens of what was to occur. By self-blame for not having reacted appropriately to such warnings to avoid harm, the individual retroactively takes responsibility for what befell him.

Table 3 indicates what percentage of patients' memories of incest was dissociated at the onset of their current therapy. Since different incidents of incest and different aspects of the incest were dissociated differently, most patients had several patterns of dissociation. In brief, these individuals, by blocking out their incest histories or regarding them as unlikely to have been real, were unable to approach life experiences consciously in light of what had befallen them. It is also worth noting that some patients had also blocked out their sexual exploitation by therapists. It would appear that these patients' tendencies to disavow what had befallen them impacts unfavorably upon their capacity to assess ongoing events.

It was characteristic of these patients that they experienced extreme difficulty in perceiving and reacting to danger signals appropriately. It was heartbreaking to find that many of those who had been raped had in their minds useful but inaccessible data that would have allowed them to perceive the circumstances under which they had been raped as dangerous, and appropriate to avoid. However, these data were dissociated along with the recollection of the incidents in the course of which they had been learned. This was most dramatically apparent, of course, with regard to the patients with classical MPD, in which one element of the mind would

TABLE I

Number and Percentage of Patients Meeting DSM-III-R Critical for Selected Axis I Disorders

Depression NOS	18 (100%)
Anxiety Disorder NOS	18 (100%)
Dissociative Disorder (Total)	18 (100%)
{DDNOS	10 (56%)}
{MPD	8 (44%)}
Post-traumatic Stress Disorder	17 (94%)
Psychosexual Disorders	16 (89%)
Somatoform Disorders	15 (83%)
Eating Disorders	13 (72%)
Psychoactive Substance Abuse	13 (72%)

TABLE 2

Prevalence of Selected Dissociative Disorders of Memory in Eighteen Survivors of Incest and Therapist-Patient Sexual Exploitation

Psychogenic Amnesia	100%
Localized	100%
Selective	100%
Generalized	0%
Continuous	0%
Source Uncertainty	100%
Object-Coercive Doubting	83%
Derealization	83%
Resequencing/Omen Formation	83%

TABLE 3

Patterns of Dissociation of Incest Experiences in Eighteen Patients who Also Suffered Therapist-Patient Sexual Exploitation

Psychogenic Amnesia	
Global	83%
Partial	100%
Selective	100%
Source Uncertainty	67%
Object-Coercive Doubting	63%
Derealization	83%
Resequencing/Omen Formation	83%

TABLE 4

The Presence of Cognitive Distortions in Eighteen Patients with Dissociative Disorders Who Suffered Both Incest and Therapist-Patient Sexual Exploitation

1. Dichotomous Thinking	83%
2. Selective Abstraction	100%
3. Arbitrary Inference	83%
4. Overgeneralization/Undergeneralization	83%/100%
5. Catastrophizing/Decatastrophizing	77%/100%
6. Time Distortion	50%
7. Distortion of Self-Perception	100%
8. Excessive Responsibility/Irresponsibility	100%/50%
9. Circular Thinking	77%
10. Misassuming Causality	100%

often protest that it could see disaster about to strike but, because it and its memories of traumata were disavowed by other elements, it could not sound a warning. Every patient recounted numerous incidents in which it was clear that the price for remaining amnesic for traumata was an impoverishment of normal alerting devices.

The patients' subjective experiences of such incidents evoked thoughts of the work of Seligman (1975) on learned helplessness. These individuals did not appear to feel able to undertake appropriate assessments of their circumstances and plan evasive action. Shorn of the knowledge of what had befallen them, they had no context in which to evaluate their current experiences, which were, in effect, decontextualized (Carmen & Rieker, 1989). They were prepared to accept the illusion of a more palatable pseudoreality as explained by their exploiters. (Kluft, 1990).

The vast majority of these patients had had innumerable experiences in which they felt they had found no strategy by which they could evaluate what was occurring. No matter how they attempted to figure out their circumstances, they felt cognitively impotent (see Fine, 1990). Unable to organize themselves, they became frozen or withdrawn under stress, and met situations best avoided by decisive actions with passive compliance with learned helplessness. Clearly masochism, reenactments, and disorganizing anxieties played a role, but cognitive lesions secondary to the dissociation of important self-referential information offered them no strategies with which to assess what was going on with accuracy and respond accordingly. For example, an individual without such impairment was approached sexually by her therapist. She was briefly stunned and even tempted as she was in the throes of an erotic transference. Nonetheless, she terminated treatment at once. In contrast, an incest victim with profound dissociative difficulties was approached by her therapist. She was confused, and felt unable to comprehend what was befalling her. She decided to believe, as she had with her father, that whatever she was told to do by someone who held such a position in her emotional life probably was

all right. She derealized the experience of having had intercourse with her therapist, and ultimately ablated it from her memory. The therapist later admitted his actions to me.

It is difficult to characterize the cognitive lesions that follow in the wake of the use of dissociative defenses. Fine (1988, 1990) has inaugurated the fledgling study of these phenomena. Nonetheless, a tentative effort was made to do so after the model of Fine (1988) by noting the presence of the cognitive distortions enumerated by Beck, Rush, Shaw, et al. (1979) in the CCRT episodes identified in the patient's verbatim process notes. In brief, I made the assumption that the presence of such distortions in a patient's description of their object relations and interpersonal interactions might be indicative of the actions that the patients might take or fail to take in their dealings with others. Table 4 indicates the percentage of the patients who made the various types of cognitive distortions during the

sessions for which there were verbatim notes. Observe that no effort was made to enumerate the relative frequency of such distortions. This was an unsystematic and preliminary effort, which could only hope to indicate if the types of distortions seen in depressives might also be seen in dissociators. The presence of co-existing depression argues against drawing any firm conclusions. It is my experience that the presence of the cognitive lesions described by Beck and his colleagues is not specific for depression—it is more the thrust of the distortions that is more indicative of particular mental disorders. For example, a depressed person's cognitive distortions usually reveal a preoccupation with loss and negativity, while the patients in this series usually distorted along the themes of betrayal and anticipation of harm, or the negation of such concerns.

1. Dichotomous thinking is a response set in which there is a tendency to classify experiences into one of two extreme categories. Approximately 83% of the patients demonstrated this trait. Furthermore, they found it very difficult to move beyond such polarization. In the vast majority of these patients the perpetrator of the incest was subjected to defensive idealization, and data to the contrary were not entertained. Likewise, if a therapist had shown kindness, he or she was decreed to be good, and data to the contrary (such as sexual advances) often were rejected. This was most pronounced in patients with formal MPD.

2. Selective abstraction occurs when certain elements or characteristics of an event are taken out of context. Other salient features are not integrated into perceptions of the event. Therefore, meaning is derived from incomplete data. One hundred percent of the patients showed this tendency. Bereft of the full context of events, dissociating patients let the part stand for the whole, and often confabulate to obscure discrepancies. One result is that many of these patients give idealized histories that have relatively little connection with actual events. One patient, long before she recalled sexual involvement with her prior psychiatrist and

he admitted as much to me, had given me a glowing endorsement of his care of her during a long and difficult hospitalization. "He never gave up on me!" she exclaimed. With the amnesic gaps removed, it became clear that he had repeatedly violated her in her room, and, when she had protested, he threatened to have her committed to a state hospital. His "dedication" really was to the perverse activities in which he persuaded the patient to participate.

3. Arbitrary inference involves the drawing of specific conclusions without having evidence in support of them. This was a very common finding (83%). It might be regarded as the cognitive expression of confabulation. These patients experienced a strong pressure to make their lives meaningful and to render their sense of the world cohesive. Their efforts were often quite data remote.

4. Overgeneralization occurred when responses were drawn from a restricted sample or non-existent data. These patients routinely did so, perhaps to avoid dealing with the uncertainty that would have to be faced if their limited awareness of their lives was confronted. Undergeneralization was ubiquitous at times, when other cognitive distortions apparently prevented the patients from drawing the appropriate conclusions from available information. It often was at the core of episodes of profound helplessness, when available information simply was not applied toward the resolution of the problems at hand.

5. Catastrophizing and decatastrophizing occur when dire consequences are inappropriately assumed to be imminent and, conversely, when important warnings are not accorded appropriate weight. The presence of decatastrophization was universal. A common expression of this was an incest victim's allowing his or her victimizer to babysit for his or her own children. In this series it was of note that decatastrophizing usually was done vis-a-vis the perpetrators, and catastrophizing with regard to dealings with others.

6. Time distortion in cognitive terms means that individuals think they are in a different time and/or place and behave accordingly. While this was universal in flashbacks, in terms of its presence in interaction, it was ubiquitous in patients with a formal MPD diagnosis, but seen only in one other patient.

7. Distortion of self-perception was universal. It is part of the MPD constellation, and all of the other patients reported feeling at times like a little child and briefly acting accordingly. They varied widely as to whether, at such times, their cognitive functioning was affected. Many felt and acted as if young, but clearly expressed themselves in a more mature manner.

8. Excessive Responsibility/Irresponsibility are response sets in which there are excessive self-blame and guilt and, conversely, their absence when such self-critical self-assessment would be in order and might possibly mobilize more adaptive behavior. The former was ubiquitous, the latter noted almost exclusively in the cohort with formal MPD.

9. Circular thinking occurs when the premise for a conclusion becomes the conclusion and conclusion can become the premise over and over. This was very common, and associated most clearly with the patients with the most severe histories of abuse.

10. Mis-assuming causality maintains a fallacious connection between putative causes and events. It was universal in this patient group, and usually followed in the pattern of what abusers had said to the patient about why the patients had been exploited. It was highly correlated with excessive responsibility and circular thinking.

DISCUSSION

The individual who dissociates in the face of difficulty is spared the short-term dysphoria of confronting an unpleasant reality or is able to palliate an intolerable affective burden. However, a review of the long-term consequences of dissociative coping would appear to suggest that the exclusion of subsets of material from conscious awareness sets the stage for the development of faulty cognitions that, by failing to alert the sufferer of possible dangers, facilitate subsequent revictimization. The patients in this study entered exploitive relationships with therapists whose advances they usually failed to assess appropriately. Without a solid appreciation of their prior exploitation and its consequences, they were prone to minimize and distort in myriad ways the full scenario in which they had become involved. In Piaget's (1970) formulation, the growth of the human mind requires both assimilation and accommodation. Assimilation means the incorporation of new experiences into existing schemes and structures. Accommodation occurs when the assimilated structures are modified and changed to correct for the differences between what is assimilated and what is present in reality. When information is not assimilated, the data cannot be processed with existing mental structures, nor can those structures be modified to reflect the impact of new information. When information remains dissociated, a cohesive and reality-based view of the world and an experimental or "always learning" model of human experience is forfeited. Reality may be distorted in the service of defensive processes. To use the words of Carmen and Rieker (1989), persons who have this problem remain in a decontextualized world. Their minds adopt cognitive strategies that are not informed by all of the data to which they have been exposed, their strategies often replicate the dissociative defenses' exclusion of unsettling materials. In many cases, these patients' attitudes and notions of their life histories represent confabulations in which the gaps of excluded material are replaced or evaded with more pleasing versions of events and relationships.

By the dissociative obliterating or disconnecting of knowledge that relates to his or her abuse, the incest victim who copes in this manner remains able to maintain powerful attachments to those who had abused him or her. In addition, he or she is likely to form affectionate ties with persons who resemble the abuser(s), and to block out or minimize information that might give reason for caution. By systematically failing to process and respond appropriately to evidences that could correct the initial faulty cognitions and assessments, the incest victim whose dissociative defenses remain robust is often condemned to repeat rather than to learn from painful experiences. With the decontextualization of significant materials and events, there is pressure to accommodate to a more palatable pseudo-reality, and to reconfig-

ure both perceptions and cognitions in that light. The use of dissociative distortions of memory, from frank amnesia through resequencing and object-coercive doubting, etc., leaves the incest victim without the accurate information with which the world may be more accurately assessed.

The remarkable proclivity for incest victims with such defenses to suffer further exploitation at the hands of unscrupulous therapists is evidence of their ongoing vulnerability to danger. Small wonder that such individuals are likely to interpret the warning signs that most of us would appreciate as ominous and menacing as attractive and reasonable. Small wonder as well that the unscrupulous practitioner's inappropriate advances and demands may be experienced as a reasonable and even compelling invitation to comply with a redefinition of reality that most of us would take vigorous steps to avoid.

What can be said of the treatment of such individuals in the light of these and other findings of a similar nature (Fine, 1988, 1990; Fish-Murray, Koby, & van der Kolk, 1987). Clearly cognitive lesions secondary to or associated with dissociation are not the only problem facing the trauma victim. Therefore, the observations made below should be understood as referring to steps that might be considered in the context of an overall therapeutic approach rather than as overall therapeutic strategies.

In my work with such patients I have not been impressed that such distortions "come out in the wash." Although there have been some exceptions, the majority of the patients in this study continued to repeat their distorted ways of assessing the world and to suffer the consequences thereof. I found that it usually required direct efforts to challenge and modify these patterns. The frequent confrontation of the distortions, the interpretation of the functions they serve, and the reconstruction of their origins is effective within the psychoanalytic/psychodynamic paradigm. Formal cognitive therapy is often of use, although the addition of some cognitive strategies to an ongoing therapy of another sort appears equally productive in most instances.

It is often helpful for the therapist to verbalize his or her problem-solving efforts within the therapy (not from his or her personal life) in order to model an experimental and data-oriented approach to the patient's difficulties. I find that many such patients, accustomed to thought processes that are circular and data-excluding, are impressed in a constructive way by my forcing them to work with me on collecting enough information to offer a reasonable answer to questions and concerns. The therapist who has come to value the distorting and story-telling techniques of the Ericksonian movement within hypnosis must be particularly careful lest these techniques further obfuscate the situation.

Hypnosis, despite its known potential for distortion and the formation of pseudomemories, is the most valuable tool for the accessing of segregated data banks and facilitating their blending. It is often capable of effecting dramatic and lasting resolutions of many of these debased cognitive styles. A certain number of these patients can make substantial gains in groups that focus on their issues of concern, and teach as well as demonstrate the skills that they are trying to acquire. ■

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