DEPENDENCY IN THE PSYCHOTHERAPY OF CHRONICALLY TRAUMATIZED INDIVIDUALS: USING MOTIVATIONAL SYSTEMS TO GUIDE EFFECTIVE TREATMENT

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Abstract

Drawing upon Giovanni Liotti's enormous contributions to the field, this article will discuss the role of motivational systems in the challenging issue of dependency in therapy with individuals who experience complex trauma and dissociation. The central role of the separation cry in highly dependent clients will be explored, along its intersection with other animal defenses, attachment, collaboration and exploration, competition, sexuality, caretaking, and predatory motivational systems. The corresponding activation of the separation cry in the client and the caretaking system in the therapist will be highlighted as a natural but ultimately non-therapeutic pairing. When the therapist can recognize this counter-intuitive dilemma and make a harmonious shift to the collaboration system, dependency issues are more likely to be addressed therapeutically.

Key words: attachment, caretaking, dependency, motivational systems, trauma

LA DIPENDENZA NELLA PSICOTERAPIA CON INDIVIDUI CON TRAUMI COMLPESSI: COME UTILIZZARE I SISTEMI MOTIVAZIONALI PER ORIENTARE UN TRATTAMENTO EFFICACE

Riassunto

Attingendo all'enorme contributo di Giovanni Liotti sul tema, il presente articolo discuterà il ruolo dei sistemi motivazionali nella difficile questione della dipendenza in terapia con individui che hanno avuto esperienza di trauma complesso e dissociazione. Si esplorerà il ruolo centrale del *separation cry* in pazienti fortemente dipendenti, considerando le intersezioni con gli altri sistemi motivazionali difensivi, di collaborazione ed esplorazione, competitivi, della sessualità, dell'accudimento e della predazione. L'attivazione complementare del sistema dell'attaccamento nel paziente e dell'accudimento nel terapeuta verrà evidenziato come una forma di coordinazione interpersonale naturale ma in definitiva non terapeutica. Quando il terapeuta può riconoscere questo dilemma contro-intuitivo e produrre una transizione armoniosa verso il sistema della collaborazione tra pari, sarà più probabile che i problemi di dipendenza vengano affrontati terapeuticamente.

Parole chiave: attaccamento, accudimento, dipendenza, sistemi motivazionali, trauma

Introduction

We are naturally dependent on others for a degree of mutual sharing, for relational connection and regulation in our lives, for enjoyment and emotional support, for help making difficult decisions, and to see us through both good and bad times. Bowlby (1988) called these experiences of seeking support *adaptive dependency*. They are based on the assumption the secure attachment is in place. But even as we seek support, we value our own capacities, which offer positive feelings of dignity, adequacy and competence. Adaptive dependency should enhance and support these latter experiences.

However, many highly traumatized clients do not experience adaptive dependency. They lack a sense of felt security, which is the basis of adaptive dependency, and do not have adequate capacities to cooperate, mutually regulate, or share emotional connection and support. While adaptive dependency supports activation of prosocial motivational systems in a harmonious way, relationally traumatized individuals struggle with adaptive and context-appropriate shifts in these systems. For this reason, Liotti and other colleagues (Brown and Elliott 2016; Cortina and Liotti 2010; Liotti 2009, 2014, 2017; Steele et al. 2017) have emphasized the importance of avoiding further activating the attachment system of relationally traumatized clients, since they generally have an over-activated attachment system, caught between a phobia of attachment and also of attachment loss (Steele et al. 2017; Steele et al. 2005; Van der Hart et al. 2006). Personally, Liotti's work helped me seriously reformulate ways to work with dependency. In turn, it has helped countless other therapists who have come for consultation on this very challenging and central issue.

Research indicates that dependency is felt more chronically and intensely in adults who were abused as children (Hill et al. 2000). While dependency has long been described in the clinical literature as a kind of maladaptive regression and viewed as a resistance in therapy, motivational systems offer an entirely new perspective that is compassionate and more helpful in guiding treatment. There is a growing acknowledgement of the value of recognizing these systems in therapy, both the prosocial (for example, attachment, collaboration, competition, caregiving) and the defensive ones (separation cry, flight, fight, freeze, faint), and more recently, the predatory system. In particular, Liotti's reflections on the conflicts and interactions among these systems in chronically traumatized individuals have been invaluable.

The separation cry as the basis for intense dependency in chronic trauma

The separation cry is the motivational system associated with panic and loss (Panksepp 1998). It is activated by the absence of the caregiver and directs the individual to frantically seek out a (stronger, wiser) person who will provide support and solace, which is not the same as the felt security that is the foundation of attachment. The separation cry activates the corresponding caregiving system in the responder, not the attachment system. The separation cry is organized by several primary affects: panic at separation, sadness at the loss, and joy at reunion. It also involves a sense of profound helplessness that carries over into the experience of dependence (Steele et al. 2017). The intense affects of separation cry can become chronic or inhibited in traumatized individuals, preventing the harmonious completion of this cycle that begins with panic, leads to grief at the loss, and ultimately finds resolution and pleasure in re-connection.

The genuine unmet needs of the child in the absence of a responsive caregiver can be a catalyst that activates separation cry. When traumatized clients experience the therapist as unavailable

for any reason, the separation cry can be activated (Steele et al. 2001; Steele et al. 2017). Clients may then substitute other motivational systems instead of attachment, primarily with controlling caregiving and controlling punitive strategies (Liotti 2011), but also sometimes with submissive and sexualized or even predatory behaviors (Liotti 2017). These are briefly discussed below as they relate to dependency.

Dependency and the defense motivational system

The defense system includes both mobilizing (flight and fight) and immobilizing (freeze, flag and faint) defense strategies. Often when clients experience intense dependency needs, a defense subsystem is activated. One client would often freeze during sessions for no apparent reason. It was only after months of exploration that the therapist was able to determine the freezing occurred as a way to deactivate attachment and distance from these intolerable needs. The therapist learned to focus less explicitly on attachment and emotional connection and more on collaboration, and the freezing response diminished.

Dependency and the caretaking motivational system

From the collapse of strategies that results from the dilemma of needing to simultaneously attach to and defend against an unsafe caregiver, some clients develop caregiving strategies to substitute for attachment. This is the controlling-caregiving strategy mentioned above. These clients may do their best to take care of the therapist, always solicitous of what the therapist needs. Such individuals are attempting to simultaneously avoid awareness of their own dependency needs, while trying to get those needs met indirectly by caretaking the caregiver.

Dependency and the competition / ranking system: submission and dominance

The competition or ranking system is concerned with social hierarchy and competition for resources. There are two important features of the submissive component of the ranking system in dependency. The first is appeasement and pleasing behaviors. These can be easily coupled with the caretaking system. However, some clients may be less caretaking of the therapist, but are certainly focused on pleasing and appeasing out of fear. The implicit and perceptible underlying schema is: "*If I don't do what my therapist says, I will get hurt (or not get what I need)*."

The second relevant feature of the submissive ranking system is activation of shame (Gilbert 1989; Liotti 2017; Steele et al. 2017). Shame has important social functions that help keep us with the bounds of social acceptability. But shame also serves to inhibit emotion, both the positive emotions of attachment, but also the negative emotions associated with separation cry and unmet needs. Many clients feel intense shame of their dependency, both because they believe it violates the social contract of being an independent, functioning adult, and because shame serves to inhibit the intensity of their yearning.

Unfortunately, while shame may inhibit separation cry emotions, it is also intolerable in its own way. Thus, clients often engage in defenses against shame (Nathanson 1987). These defenses may then activate (or deactivate) yet more motivational systems. For example, clients can isolate themselves as a reaction to shame, further deactivating all the prosocial motivational systems. They can avoid their own inner experience, deactivating the exploration system and curiosity, leaving them feeling empty and devoid of connection. Chronic shame often involves

profound hypoarousal, indicating the activation of the dorsal vagal feignt defense system (Steele et al. 2017).

Other defenses against shame involve aggression, either against self or other. Aggression may be in reaction to dangerous attachment, and it can emerge as the controlling-punitive strategy. It may involve competitive social punishment and submission ("*You are bad for not meeting my needs, so you deserve punishment; I will force you to meet my needs*"). For example, one client refused to pay for a session, saying that the therapist had not met her needs, thus she did not deserve the fee. It may also involve self-directed punishment: "*I am bad for having needs, so I deserve to be punished; I will force myself to not have needs*"). Inner directed controlling-punitive strategies are common in traumatized individuals.

Dependency and the predatory motivational system

In more extreme cases, anger turns to rage and may emanate not from a social ranking position, but from the predatory motivational system (Liotti 2017). This rage is not directed toward punishment and submission for not meeting the individual's needs, but toward the desire to injure or kill the person who is not meeting the needs. In rare cases this may be coupled with pleasure or enjoyment in sadistic clients. A client began having intense fantasies of killing his therapist and would actually salivate with pleasure when doing so (an anticipatory behavior related to eating prey). When predatory aggression is present, the therapist should not attempt to activate prosocial systems such as attachment or collaboration, but first seek to establish safety for both client and therapist.

Dependency and the sexual motivational system

Sexual abuse creates intermingling of attachment and sexual behaviors leading to confusion between the two. Some clients who have been sexually abused activate the sexual motivational system in reaction to perceived emotional needs and dependency. The perpetrator typically exploited the child's needs as an avenue to abuse, for example, starting the abuse with a warm hug that appears to meet the child's attachment needs. Such clients may behave seductively toward the therapist, or the felt experience of sexuality may be more implicit in the session. One client wanted a hug, but when a sideways hug was initiated, she suddenly pulled the therapist to her and kissed him on the neck in a highly sexual way. The therapist was later able to help the client realize that she was substituting sexual behavior to prevent activation of attachment. Months later, the client was able to realize, "*I felt so much need in the moment of that hug, I felt compelled to kiss you to stop it*". In this way, she attempted to both express and inhibit her dependency needs.

Clients with complex dissociative disorders

As Liotti (1992, 1999, 2006, 2009) and others (Steele et al. 2006; Steele et al. 2017; Van der Hart et al. 2006) have noted, disorganized attachment is, in itself, dissociative. In clients with severe dissociative disorders, motivational systems serve as primary organizers of dissociative parts of the personality (Van der Hart et al. 2006). This complicates therapeutic work with motivational systems, as various dissociative parts of the client serve to activate or deactivate particular systems and have a highly conflicted internal organization. Dissociative parts are

typically organized internally in a similar way as the original family, with victim, abuser, rescuer, and neglectful bystander dynamics (Liotti 2017; Steele et al. 2017).

Separation cry is often sequestered within particular dissociative parts, so that the client can, to some degree, keep dependency needs at bay. However, this leaves certain dissociative parts of the client in a perpetual state of desperate separation cry, which creates regular internal distress and need for further strategies to manage the dysregulation. A chronic "need-shame-rage-despair" cycle ensues (Boon et al. 2011; Steele et al. 2017) that inhibits the regulation and mentalization capacities that support more harmonious and adaptive transitions between motivational systems, and that ultimately help the client move toward greater integration. The more the therapist can help resolve these conflicts between need, connection and safety, the more shame about need can be mitigated, and the less conflicts among dissociative parts will occur. Practically, this means that the therapist should not engage in caretaking with dissociative parts fixated in separation cry, nor encourage attachment seeking in more defensive parts. Rather, the therapist supports the whole system to engage in safety, curiosity, collaboration, and mutual goal sharing (Steele et al. 2001, 2017).

Motivational systems in the therapist

By definition, the client is not the only one in the room who is organized by motivational systems. The therapist has corresponding activation (and deactivation) of motivational systems in response to the client, and these can sometimes be maladaptive (Steele et al. 2001, 2017). For example, when therapists become defensive, their exploration, collaboration, and attachment systems are deactivated. The more these defenses can be recognized through meta-observation, the more the therapist can re-ground and re-engage therapeutically with the client. Consultation and/or personal therapy is helpful to the therapist in this regard.

One of the most pernicious difficulties in treating dependency is the fact that separation cry in the client naturally activates the caregiving system in the therapist who is witnessing the client in distress. Thus, caregiving feels natural to the therapist, but is not therapeutic. This counter-intuitive dilemma is essential to understand. The therapist must consciously help the client first feel safe, and then engage in collaborative behaviors, being curious with the client about what is happening. The more the client and therapist are in a collaborative state of mind, the more mentalizing functions will be available; they are often not available at all, or only very little with many of the other motivational systems (Liotti and Gilbert 2011). The goal of therapy with dependency is not caretaking, but collaborative work to help the client develop a more harmonious shift between motivational systems, to deactivate separation cry and other maladaptively employed systems, and to activate more prosocial systems.

References

Boon S, Steele K, Van der Hart O (2011). *Coping with trauma-related dissociation: Skills training for patients and therapists*. Norton, New York.

Bowlby J (1979). *The making and breaking of affectional bonds*. Tavistock, London.

Brown DP, Elliott DS (2016). *Attachment disturbances in adults: Treatment for comprehensive repair*. Norton, New York.

Cortina M, Liotti G (2010). Attachment is about safety and protection, intersubjectivity is about sharing and social understanding: The relationships between attachment and intersubjectivity. *Psychoanalytic Psychology* 27, 410-441.

Hill EL, Gold SN, Bornstein RF (2000). Interpersonal dependency among adult survivors of childhood

sexual abuse in therapy. *Journal of Child Sexual Abuse* 9, 71-86.

Liotti G (1992). Disorganized/disoriented attachment in the etiology of dissociative disorders. *Dissociation* 5, 196-204.

Liotti G (1999). Disorganization of attachment as a model for understanding dissociative psychopathology. In J Solomon, C George (eds) *Attachment disorganization*, pp. 297-317. Guilford, New York.

Liotti G (2006). A model of dissociation based on attachment theory and research. *Journal of Trauma and Dissociation* 7, 55-73.

Liotti G (2009). Attachment and dissociation. In PF Dell, JA O'Neil (eds) *Dissociation and the dissociative disorders: DSM-V and beyond*, pp. 53-65. Routledge, New York.

Liotti G (2011). Attachment disorganization and the controlling strategies: An illustration of the contributions of attachment theory to developmental psychopathology and to psychotherapy integration. *Journal of Psychotherapy Integration* 21, 232-252.

Liotti G (2014). Overcoming powerlessness in the clinical exchange with traumatized patients. *Psychoanalytic Inquiry* 34, 322-336.

Liotti G (2017). Conflicts between motivational systems related to attachment trauma: Key to understanding the intra-family relationship between abused children and their abusers. *Journal of Trauma and Dissociation* 18, 304-318.

Liotti G, Gilbert P (2011), Mentalizing, motivation, and social mentalities: Theoretical considerations and implications for psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice* 84, 9-25.

Nathanson D (1992). *Shame and pride: Affect, sex, and the birth of the self.* Norton, New York.

Panksepp J (1998). *Affective neuroscience: The foundations of human and animal emotions*. Oxford University Press, London.

Steele K, Boon S, Van der Hart O (2017). *Treating trauma-related dissociation: A practical integrative approach.* Norton, New York.

Steele K, Van der Hart O, Nijenhuis ERS (2001). Dependency in the treatment of complex posttraumatic stress disorder and dissociative disorders. *Journal of Trauma and Dissociation* 2, 79-116.

Steele K, Van der Hart O, Nijenhuis ERS (2005). Phase-oriented treatment of structural dissociation in complex traumatization: Overcoming trauma-related phobias. *Journal of Trauma and Dissociation* 6, 11-53.

Van der Hart O, Nijenhuis ERS, Steele K (2006). *The haunted self: Structural dissociation of the personality and treatment of chronic traumatization*. Norton, New York.