Edited by Elizabeth F. Howell ▪ Sheldon Itzkowitz

The Dissociative Mind in Psychoanalysis

Understanding and Working with Trauma

The Dissociative Mind in Psychoanalysis

The Dissociative Mind in Psychoanalysis: Understanding and Working with Trauma is an invaluable and cutting-edge resource providing the current theory, practice, and research on trauma and dissociation within psychoanalysis. Elizabeth F. Howell and Sheldon Itzkowitz bring together experts in the field of dissociation and psychoanalysis, providing a comprehensive and forward-looking overview of the current thinking on trauma and dissociation.

The volume contains articles on the history of concepts of trauma and dissociation, the linkage of complex trauma and dissociative problems in living, different modalities of treatment and theoretical approaches based on a new understanding of this linkage, as well as reviews of important new research. Overarching all of these is a clear explanation of how pathological dissociation is caused by trauma, and how this affects psychological organization—concepts which have often been largely misunderstood. This book will be essential reading for psychoanalysts, psychoanalytically oriented psychotherapists, trauma therapists, and students.

Elizabeth F. Howell, Ph.D., is the author of the award-winning books, *The Dissociative Mind* and *Understanding and Treating Dissociative Identity Disorder: A Relational Approach*. She is on the Editorial Board of the *Journal of Trauma and Dissociation*; Adjunct Clinical Associate Professor of Psychology, New York University Postdoctoral Program in Psychotherapy and Psychoanalysis; faculty, supervisor, Trauma Treatment Center, Manhattan Institute for Psychoanalysis; faculty, National Institute for the Psychotherapies; faculty, Psychotherapy Training Program: International Society for the Study of Trauma and Dissociation; and an Honorary Member of the William Alanson White Psychoanalytic Society. She has written extensively and lectured nationally and internationally on various aspects of trauma and dissociation, as well as on gender and trauma/dissociation. She is in private practice in Manhattan.

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The Dissociative Mind in Psychoanalysis: Understanding and Working with Trauma
Elizabeth F. Howell & Sheldon Itzkowitz (eds.)

"Drs. Howell and Itzkowitz have fashioned a resource for those who are interested in learning more about psychoanalytic treatment and how psychoanalysts work with and help victims of trauma, traumatic dissociation, and dissociative disorders. Psychoanalysis, cognitive science, cognitive neuroscience, and trauma research all have a say in this outstanding volume which explores trauma and dissociation within a broad psychoanalytic context. The editors should be commended for their written contributions, for gathering chapters from leading experts in the area, and for the scope and depth of the issues addressed."

— **Judith Alpert**, Ph.D., Professor, Department of Applied Psychology, New York University and Professor and Clinical Consultant at New York University Postdoctoral Program in Psychotherapy and Psychoanalysis.

"In this outstanding volume, Howell and Itzkowitz have collected a comprehensive set of scholarly contributions covering the depth and breadth of dissociative phenomena, as well as the clinical concerns in working with the sequelae of complex trauma. They include the full range of psychoanalytic orientations and provide extensive surveys of cultural, historical, diagnostic, and developmental considerations along with research findings. On top of this considerable achievement, the editors have situated all of these contributions within the context provided by their own introductory chapters. This book will be used as a basic teaching text for years to come."

— **Lewis Aron**, Ph.D., Director, New York University Postdoctoral Program in Psychotherapy and Psychoanalysis.

"Psychoanalysts both, Itzkowitz and Howell are well-known for their work with the naturally occurring dissociative aspects of mind and for their wise, humanistic, and compassionate work with patients suffering with trauma-generated dissociation, patients many might be afraid to treat in private practice. Now they bring their accumulated wisdom, together with the thinking of many distinguished colleagues, to bear, placing dissociation and the dissociative mind firmly in the psychoanalytic tradition, reading it in various theoretical and cultural contexts, explaining how it became hidden from view, showing how to understand and treat its sufferers now. This book will teach, encourage, and support all therapists who look for the human being underneath the 'pathology.' A great gift to us all."

— **Donna Orange**, Ph.D., Psy.D. author, *The Suffering Stranger* (Routledge, 2011).

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Understanding and Working with Trauma

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Our authors' contributions will afford the reader—as they did for us—the opportunity to explore, discuss, and deepen their understanding of the impact of trauma and dissociation from different theoretical and clinical perspectives. We want to acknowledge and thank our authors for their excellent, and often cutting-edge contributions to this volume: In the first Part, on the history of complex trauma and dissociative problems in living, we thank: Onno van der Hart, for his chapter on Pierre Janet's brilliant but generally underappreciated understanding of dissociation of the personality; and Margaret L. Hainer, for her chapter not only addressing Ferenczi's highly significant contributions, but also discussing the psychoanalytic field's stunning dissociation of him and his work. In the second Part, on psychoanalytic orientations, we thank: Elizabeth F. Howell, for her contribution on models of dissociation in Freud's work; Donald E. Kalsched, for his on Jung, including complexes, personifications and dreams; Dodi Goldman, for his on Winnicott and the uses of dissociation; Joseph Newirth, for his on Kleinian theory and miscarriages of dissociation; Philip M. Bromberg, for his on the relational/interpersonal approach; Jennifer Leighton, for hers on intersubjectivity and dissociation from the perspective of self psychology; and Elizabeth Hegeman, for hers on ethnic syndromes. In Part 3, on treatment, we thank: Richard P. Kluft, for his chapter on working with the dreams of dissociative patients; Jean Petrucelli, for hers on eating disorders and the uses of dissociation; Karen Hopenwasser, for her chapter on her concept of dissociative attunement; Wilma S. Bucci, for her chapter on dissociation and her multiple code theory; Richard A. Chefetz, for his on the importance of acknowledging self-states in the treatment of dissociative patients; Ira Brenner, for his on a multiphasic model of treatment; and

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We would like to extend our deepest gratitude to our patients, many of whose lives were altered by unthinkable, and unspeakable violence and pain. Their willingness to face each day anew and struggle to heal themselves despite deep emotional pain continues to be inspiring. We continue to learn and grow, both as psychoanalytic clinicians and as human beings, because of their courage and willingness to engage with us as we search to find what has been missing, mourn what has been lost, and rejoice in a fuller sense of our common humanity.

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Introduction

Elizabeth F. Howell
and Sheldon Itzkowitz

Trauma and dissociation

The face of psychoanalysis is changing. More and more it shows the effects of traumatic and dissociative experiences. It is as if psychoanalysis as a collective is looking at itself in the mirror and now seeing a different visage—not necessarily one that was not there before, but one that is more "seeable" now. Trauma as an interpersonal-relational event is now a topic that has come full circle (Herman, 1992) and is once again front and center among psychoanalytic concerns.

More than at any time in the last century, many psychoanalysts recognize trauma in their patients and in themselves. In this current "age of trauma" people increasingly resonate with the impact of such events as the World Trade Center disaster, the sexual abuse of young boys by priests and the Church's efforts at covering it up, the Boston marathon bombing, the shootings at Columbine, the movie theater massacre in Aurora, Colorado, and at Sandy Hook Elementary School, among the growing list of domestic catastrophes. Along with these, war casualties and domestic trauma, such as spousal abuse and child abuse, are undeniable and now for the most part accepted as horrific but true aspects of our society. Because certain traumas, such as the sexual abuse of children, are so painful and difficult to "know," they are particularly difficult to acknowledge.

The range of dissociative experiences is very broad. The more common and everyday form of dissociative experiences that we all know often involves a mild level of detachment or withdrawal from what we are doing at a given moment: We become absorbed with some internal experience such as day dreaming, or if we are driving, highway hypnosis. Other common experiences are for example becoming very absorbed in a book or a movie. However, dissociative disorders include severe disconnection and much suffering.

For the past several years each of us has been presenting our ideas about dissociation, dissociative processes, and our clinical work with people struggling with various levels of dissociation to classes, supervision,

colloquia and at national and international professional conferences. Sometimes our audiences are well versed in the treatment of trauma, PTSD, and dissociative disorders such as dissociative identity disorder (DID) and other specified dissociative disorders (OSDD). But just as often our audiences are highly trained and skilled psychotherapists and psychoanalysts who are less schooled in the theory and treatment of dissociative disorders (DDs). These fall into two categories. The first is a group of psychotherapists who do not have formal psychoanalytic training but are often hungry for more knowledge about the mainstays of psychoanalytic thinking, such as the importance of the analytic frame, the power and importance of transference and countertransference, enactments, how to make use of countertransference, dreamwork, and how to best use self disclosure clinically. The second group includes candidates, as well as graduates, of psychoanalytic institutes wanting to be better informed about how psychoanalysts can work with and help victims of trauma, traumatic dissociation, and the dissociative disorders (DDs). It is our experience that both groups of skilled clinicians are very eager, hungry even, to learn about the history of dissociation in psychoanalysis, the etiology of dissociation as a disorder, how to understand it from a psychoanalytic perspective, and how to work with it psychoanalytically. And both groups are eager to learn more about integrating trauma work within a psychoanalytic perspective.

It was to this end that we believed a book exploring trauma and dissociation within a broad psychoanalytic context was long overdue.

Using this book

The book is divided into four parts. In Part 1 we present a brief overview of the "History of complex trauma and dissociative problems in living." Chapter 1 begins with the question of whether working with trauma and victims of trauma is part of psychoanalysis. Perhaps a more central question is whether trauma or the symptoms that the traumatized person brings into our offices can be analyzed? Does the psychoanalytic clinician work only with repressed drives, wishes, and fantasy material or is real experience, or experience of everyday life, regardless of whose life it is, the stuff of psychoanalysis?

In Chapter 2, we explore, in brief, the history of psychoanalysis, which has its roots in hypnosis, hysteria, trauma and dissociation, all of which leads to the pioneering work of Pierre Janet, conducted in Paris at the Salpêtrière. Breuer and Freud originally agreed with Janet's ideas that hysteria was caused by a traumatic event, which because it overwhelmed the mind of its victim, caused dissociation. Freud, after rejecting both Janet and Breuer, abandoned the notion that real events caused hysteria. Rather it was the re-emergence of childhood wishes and fantasies due to the failure of repression that caused hysteria and was the foundation of all neurosis.

As psychoanalysts began working with more and more disturbed and traumatized individuals, they needed a way to account for what they were seeing while keeping it in the language and ideology of Freudian thought; splitting of the ego was the term that emerged.

In Chapter 3 we define what is trauma. Can there be objective criteria for what is traumatic? Or must we recognize that we each have different capacities to react and cope with life's situations? If two people experience the same event and one is overwhelmed and develops complex PTSD, or complex trauma disorder, and the other does not, can we consider this a traumatic event? We explore the idea that dissociation is caused by trauma or a series of traumatic events as well as something that develops within the attachment bond between infant and her caretaker known as "disorganized attachment." We end our discussion with a brief consideration of repression and dissociation and the dissociative nature of the human mind.

Chapter 4, authored by Onno van der Hart, presents the development of the concept of complex trauma and dissociation as first introduced by Janet and later followed by Freud and Breuer. Most psychoanalysts are not aware of Janet's seminal work and the originality of his contributions to working with complex trauma and dissociation and are likely to find van der Hart's chapter very informative.

Chapter 5, written by Margaret L. Hainer, follows with an analysis of the courageous and innovative contributions of Sándor Ferenczi. At a time when mainstream psychoanalysis had buried the causes of neurotic disturbance deep within the fantasy-driven mind of the child, Ferenczi was (re)discovering the profound impact of early childhood sexual abuse on the developing mind of the child. Because of Ferenczi's effort to highlight the overwhelming impact of reality on the child's mind, and because he acknowledged the impact that the members of the dyad had on each other, Interpersonal and Relational schools of psychoanalysis claim him as a key psychoanalytic progenitor.

In Part 2, "Psychoanalytic orientations and the treatment of complex trauma, dissociation, and dissociative disorders," we present the reader with a discussion of the concept of dissociation from the perspective of the major schools of psychoanalytic thought. Elizabeth F. Howell writes about Freud's contribution to and understanding of dissociation; Donald E. Kalsched represents a Jungian perspective; Dodi Goldman writes from the perspective of Winnicott's work; Joseph Newirth writes from a Kleinian perspective; Philip M. Bromberg provides an interpersonal-relational perspective; Jennifer Leighton looks at dissociation from the perspective of self psychology; and Elizabeth Hegeman offers a view of dissociation from a cross-cultural perspective. It may seem unusual that we have included in this Part a chapter on cross-cultural perspectives of dissociation. The history of complex trauma and dissociation (and its most pathological/dramatic presentation in the form of DID) has long been conceptualized in Western thinking and medicine as an illness. As a result we felt it imperative to

present our readers with the opportunity to explore how the psychic phenomena of dissociation are experienced and understood by other cultures, often being perceived as adaptive and normative.

In Part 3, "Aspects of psychoanalytic treatment of complex trauma and dissociation," we explore how dissociation is embedded in a variety of different clinical situations. We believe that an understanding of how to work with the impact of complex trauma and dissociation can be invaluable in helping to deepen the psychoanalytic process. Authors for this Part include: Richard P. Kluft, writing on dreams; Jean Petrucelli, writing about dissociative aspects of disordered eating; Karen Hopenwasser informs us about dissociative attunement, i.e. the conscious and unconscious manner in which information is shared within the analytic dyad; Wilma S. Bucci writes about multiple code theory and affective neuroscience as it pertains to dissociation; Richard A. Chefetz gives the reader an emotional view of what it is like for someone when she realizes that "the story of her life was not what she thought it was"; Ira Brenner presents his five-phase psychoactive model of working with DID; and Valerie Sinason grapples with the irony of the under-diagnosing of DID in children, a disorder that begins during childhood.

Psychoanalysts have only relatively recently begun to study the often confusing and complicated problems that patients suffering with complex trauma, dissociation, and DID experience and report. Therefore, in Part 4, "Current research trends in complex trauma, dissociation, and dissociative disorders," we have included a chapter on dissociation and DID in the prison system, written by Abby Stein, a chapter on contemporary research on complex trauma, dissociation, and DID, written by Bethany L. Brand and Daniel J. Brown and a chapter on neuropsychological aspects of dissociation written by Brian Koehler. We believe that it is important to provide our readers with research data showing the efficacy of talk therapy for those suffering with this disorder.

The clinical presentation of complex trauma and dissociation, particularly in its most extreme form (DID), confronts the psychoanalytic clinician with the difficult task of making sense out of a variety of confusing and often bizarre symptoms. Many of these symptoms overlap with those that fall under a variety of diagnostic labels, ranging from anxiety and depressive disorders, to personality disorders, to psychosis. We have included these chapters with the hope that it will assist the psychoanalytic clinician in developing a deeper understanding of the clinical presentation of this disorder and how it differs from psychosis.

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Part I

History of complex trauma and dissociative problems in living

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Chapter 1

Is trauma-analysis psycho-analysis?

Elizabeth F. Howell
and Sheldon Itzkowitz

> Among the immigrant psychoanalysts, many who had fled from the terrors of the Holocaust, "Orthodoxy became an armor, the theory became their armor, to leave no opening for some memory, some recognition of what had happened to creep in."
>
> Dori Laub (quoted in Kuriloff, 2013, p. 43)

The obscuration of trauma in psychoanalysis

A most remarkable thing about psychoanalysis is its checkered response to trauma-generated dissociation. Now one "sees" it, and now one doesn't. Why can it not be recognized? Why does it disappear from "sight" or thought? Even though psychoanalysis began in the study of dissociation, not long after its inception, Freud redefined the data of psychoanalysis, moving the topic of inquiry away from an explicit exploration of trauma and of dissociated experiences and dissociated mental structure. And for the most part psychoanalysts followed suit, like their forefather, all too often ignoring the importance of exogamous traumatic reality.

A theoretical model of mind acts as a scheme that structures our experience of reality and our understanding of our patients and ourselves. Barnett (1966) explains, "It is a commonplace observation that the psychoanalytic theory one uses influences one's perception of clinical reality" (p. 88).

Psychoanalysts who privilege repression and the drive-defense-fantasy model of Freud and who think along classical Freudian lines are more likely to attribute symptomatology to conflict between the drive and the defense than the emergence of dissociated material. This is not to gainsay the importance of the drive-defense model or of Freud's inestimable contribution to understanding the human mind.

The implications of overlooking the impact of trauma are serious because the classical Freudian model filters out, or minimizes, the contributing factor of reality in general and the reality of early childhood trauma causing dissociation and the dissociative structuring of the mind. For the traumatized and dissociative patient then, her reality is likely to be overlooked,

misunderstood, misinterpreted as fantasy, or wishes, and/or not to be considered as valid data for analytic inquiry (of course the modern Freudians, among them Ross, Druck, Blum, Bach, Hurvich, Thaler, Vorus, and others, are more and more bringing dissociation into the picture).

Yet, like so many suppressed realities of the experiences of the oppressed, trauma and dissociation went underground. The unconsciously coded language for trauma-generated dissociation became "splitting." Now dissociation could be talked about without being talked about.

Even Freud's most influential theories—for example, the Oedipus Complex—can readily and easily be deconstructed in terms of the underlying motifs of the most heinous type of child abuse: infanticide; murder (Ross, 1982). So, the topics of abuse, murder, and dissociation never really went away, they simply became dissociated as an "unseeable" aspect of reality. Especially among the ranks of the intellectual elite, where the classical model of Freudian psychoanalysis, including adherence to the fantasy model, and of the Oedipal complex often prevailed, there has also been inadequate recognition of the power of overwhelming trauma-generated dissociation. Why? Nobody likes to think about it. To talk about this is unpopular, even stigmatizing. To think about it brings up emotional and cognitive conflicts about attachment, not only to abusive attachment figures, but also to power relationships, that is, prevailing powers espousing non-recognition vs. the recognition of abuse of children and others who are less powerful. To openly recognize these reality-based conflicts requires exposing oneself to powerful interests that can destroy one's credibility, trust in the world, and one's livelihood (see Chapter 5—this is what happened to Ferenczi). Thus, the denial of exogamous trauma becomes itself a real source of exogamous trauma. To say the least, this is complicated: For many reasons, mainstream psychoanalysis has, both knowingly and unknowingly, obscured the impact of trauma.

Is trauma work psychoanalysis?

The question of whether trauma work is officially, or is "really," psychoanalysis often comes up for the two of us in our work with colleagues, supervisees, and students, including psychoanalytic candidates. This question concerns several issues, including:

1 the nature of psychoanalytic data;
2 the issue of proper technique;
3 the question of who can be successfully treated using psychoanalytic technique;
4 the principle behind the technique, and finally, and perhaps most importantly,
5 the purpose and expected outcome of the enterprise of psychoanalysis.

The nature of psychoanalytic data

What are the legitimate sources of data for the psychoanalyst? Does trauma as a real interpersonal/relational event in the patient's life qualify? This question strikes at the heart of the key issue of disagreement not only between and among current schools of psychoanalysis, but also deriving from current media streams, appearing to be from much of mainstream psychology, that disavows trauma and dissociation. This conflict mirrors and repeats a very powerful earlier one: that between two great thinkers, Pierre Janet in France and the "psychoanalytic," or post-"prepsychoanalytic" Sigmund Freud in Vienna, in their views of the treatment of the disorder of the mind known at the end of the nineteenth century as hysteria. Between 1893 and 1896 both men endorsed the importance of dissociation in hysteria. Janet wrote of the subconscious centers of trauma-related dissociated psychic life as "fixed ideas." And the early Freud heartily endorsed the premise of dissociation, in his and Breuer's description of "double consciousness" as intrinsic to hysteria. As is well known and will be further examined in Chapter 3, after 1897 Freud re-oriented the premise that hysteria was a disorder stemming from trauma occurring in the real interpersonal/relational world, shifting his focus to the internal drive- and fantasy-driven "psychic" life of the hysterical patient. In this way "hysterics" were understood to be victims of their own repressed infantile, sexual, and aggressive impulses. In contrast, Janet continued to work with dissociation throughout his life.

In a general sense, "the unconscious" has typically been considered the *sine qua non* of psychoanalytic data to be unearthed. Then, where do we look for these data of the unconscious? Is it in derivatives of drives and in unconscious fantasy? Or do we encounter it in the dissociated knowledge of trauma, or both?

Once drives and fantasy are privileged as causative, events in the patient's real life are meaningful primarily as a medium within which fantasy material grows (Levenson, 1981). With this revision the patient's internal psychic life became the object of inquiry as well as the presumed breeding ground for psychological ills. As Boulanger (2007) notes, "The Freudian subject, by bringing drives under control achieves agency . . . The battles waged against oneself carry far more weight than indifferent reality" (p. 57).

The repudiation of real experience as relevant data in the classical model of psychoanalysis

Unfortunately, examples of how far the exclusion of real events from the data of psychoanalytic inquiry went include an odd form of Holocaust denial, especially among the survivors who emigrated to the United States. As Prince (2009) notes, "A central theoretical obstacle in attending to

survivor dynamics has been the antinomy in psychoanalysis between psychic and external realities . . . Confronted with overpowering reality, it seems that psychoanalysts retreated to the primacy of infantile phantasy. The connection between Holocaust trauma and the patient is minimized or avoided" (p. 182). The reasons for this were multiple, deeply painful, and sometimes tragic. Kuriloff (2013) describes how "Many European analysts found refuge in America. Their published memoirs chronicle the details of escape and adjustment to their new homes. Most of these accounts, however, do not mention the impact of such ordeals on how they conceived and practiced psychoanalysis itself" (p. 1). Kuriloff, referring to part of an interview with Dori Laub, explains that Laub's analyst had knowledge about the atrocities visited upon the inmates of the Nazi concentration camps from liberated survivors, "who gave impossibly petrified depositions regarding their experiences during the Holocaust as they recovered in Sweden" (p. 42). Laub continues discussing his own experience in analysis and recollecting the past:

> It was then that he [Laub's analyst] stopped me . . . He interrupted my descriptions of my idyllic childhood on the banks of the river Bug [in the Ukraine]. Because I was not able to know about it . . . There were sounds of the Nazi death squads killing Jews on the other side of the river, instead I said I was playing in the green fields with another child and debating whether or not you could eat grass . . . Soon we figured out this had something to do with hunger . . . because I was starving.
>
> (Kuriloff, 2013, p. 42)

Kuriloff underscores the point that reality, even when it is traumatogenic, even when humankind is forced to come face-to-face with and endure unrelenting, pernicious, and dispassionate evil in the other, does not qualify as appropriate data for the psychoanalyst, and includes the following:

> But Laub says that *his analyst was the exception*. "Most clinicians didn't explore these things. It was all about infantile neurosis." When he began to write about trauma, and co-founded what are now the Fortunoff Archives of Holocaust Testimony at Yale University, *Laub told me, "I was non-existent to mainstream psychoanalysts."*
>
> (p. 42, italics added)

During a moving roundtable discussion titled "Last Witnesses: Child Survivors of the Holocaust," four psychotherapists discuss how their experiences as children during the Holocaust affected their lives (see Brown *et al.*, 2007). In describing one of his analytic experiences, Clem Loew explains:

> Yes I understand it was a rough time for you during the Holocaust, but what about actions of your father and what about your mother, and what about the oedipal or what about the pre-oedipal? And it was more about that than acknowledging the trauma of the event of the Holocaust. *For many of us, the event of the Holocaust was not really important* [to our early analysts].
>
> (Brown *et al*., 2007, p. 32, italics added)

Sophia Richman, a co-panelist in the discussion, describes herself as an analysand during her first analysis. The dissociation of a traumatized self can clearly be heard by how she described her childhood experiences during and after the Holocaust:

> what he [her analyst] wanted to focus on was Oedipal issues. And I talked about my [Holocaust] experience but I talked about it in a very detached way. *I was really in a very dissociated state, without realizing that that's what it was*. I would talk about it very mechanically, like these were the facts, this is what happened, this is my childhood. But there was no feeling. I was like a robot . . . And he . . . wasn't able to do anything with that.
>
> (p. 33, italics added)

Richman also raises another important issue about psychoanalytic data and technique. She offers her analyst's culture and possible shared experience(s) as possible explanations for his disinterest in her Holocaust history and his lack of recognition of her dissociation:

> He didn't seem interested. I guess he wanted to talk about what he knew about or what he was comfortable with, I don't know, maybe the fact that he was a Jewish analyst . . . but maybe he was influenced by it and didn't want to bring the Holocaust into the consulting room.
>
> (p. 33)

Loew was considered a "hidden child." His mother found a convent that was willing to accept and hide him from the Nazis who were hunting Jews for deportation to concentration camps for extermination. We quote him here because he explains clearly how his analyst's interest in his real (*trauma*) experience (during the Holocaust) helped undo the impact of trauma and dissociation.

> the analyst that had the most profound effect on me asked me things like, so Clem, what did you do all day in the convent. What did you do all day? You were there two years; what did you do? And I can't tell you how emotional I am just talking about it, because *it's the question that*

> *really attaches me to myself, that I think most Holocaust survivors, especially child survivors have the issue of being separated from themselves*. I was separated from myself for a long time. And questions like . . . what was it like for you? You wonder—you were in Lwó, your mother worked—she was away working, and you were five and a half, six years old, what did you do by yourself all day? *What an incredible and simple, beautiful, eloquent question that very few analysts really ask. And so,* [it gave me] *the ability to get me to get in touch with myself and to release the separateness from myself . . .*
>
> (p. 33, italics added)

Despite the stream of denial coming from those who had suffered extreme terrors, as indicated above, by the early middle part of the 1900s, an early group of analysts who were interpersonally oriented, including Sullivan, Fromm, Thompson, Horney and Fromm-Reichmann, relocated the source of problems in living in the center of the human crucible, the nuclear family and its embeddedness in the larger society and culture in which it resides. The interpersonal perspective introduced a radical shift in what was considered to be relevant data of, as well as what represented proper technique for, the practice of psychoanalysis. Although they rejected Freud's exclusive focus on instinct, fantasy, drive and defense, they retained the analysis of transference, the use of countertransference, and dream interpretation as defining principles of the work of psychoanalysis.

While a movement towards integration of these schools is occurring now (see Druck *et al.*, 2011), a schism between these schools had been longstanding.

The issue of proper technique

The issue of proper psychoanalytic technique is inextricably tied to that of proper psychoanalytic data. Just as "the unconscious" has generally been considered the *sine qua non* of psychoanalytic data, one might similarly say that how one works with the unconscious is a major aspect of technique.

For much of the last century or so proper technique according to the classical model of psychoanalysis followed certain rules and guidelines. Good analytic technique included multiple sessions per week (often four to five times), the exclusive use of the couch, the development of a transference neurosis, transference interpretation, analytic abstinence, dream interpretation and the analyst's careful perusal of her/his own countertransference lest it interfere with the treatment. Real events in the patient's life might prove to be of serious concern, but were not the essence of the psychoanalyst's object of study. The primary focus was the patient's unconscious fantasy life, and the goal was the development of and eventual resolution of a transference neurosis.

When the interpersonalists redefined the data of psychoanalysis as what goes on between people in real interpersonal relations, that what happens and how one creates meaning out of experience matters, the door opened to allow trauma and traumatic experience to once again become a legitimate focus of psychoanalytic inquiry and treatment. (The new theories, however, did not avail themselves of the richness of the old "pre-analytic" theories of Breuer and Freud.) The participant observer model stressed the importance of historical data, a detailed inquiry into the nature of the patient's experience, and a direct exploration of patient analyst interactions (transference) as an aid in understanding meaning and clarifying distortions. The interpersonalists believed that the counterbalance to the destructive and distorting impact of interpersonal–relational trauma was the healing potential of a real, meaningful, human relationship with the analyst. Because from this perspective meaning emerges from interpersonal–relational experience and not from intrapsychic drives and fantasies, the use of the couch and the frequency of sessions take a back seat to the centrality of the analytic relationship.

Who can be successfully treated using psychoanalytic technique? Only "neurotics"? Who weighed in?

There were important developments in the use of theory and technique over time. In the late 1920s and early 1930s Ferenczi was writing of new methods that he found for working with difficult patients. Ferenczi's creativity was expressed in his adapting Freud's theories and techniques to accommodate the needs of his patients; patients who were often found untreatable by others practicing within Freud's model. Even though this was not considered proper technique, Ferenczi used active methods and interactive methods to help his patients get better. He was highly aware of the mutual influence that analyst and patient had on each other, and although he did not coin the term, he was one of the first, if not the first, to advocate a "two-person" psychology. But, as will be addressed in Chapter 5, Ferenczi's discoveries and incorporation of his active techniques ran counter to Freud's theoretical model and definition of what constituted psychoanalytic praxis, and it cost Ferenczi dearly.

From the late 1930s through the mid-1950s Fairbairn was writing of work with traumatized, schizoid people. Fairbairn also contributed to the two-person model and the relational turn in his emphasis on the importance of real and then internalized "objects." Winnicott as well wrote of his work with difficult, and certainly not exclusively "neurotic" patients. And, following Fairbairn and Winnicott, many others wrote, in the same spirit, of work with internal object relations. Greenson (1967) wrote of the importance of the real relationship as well as the transference and countertransference. Broadening the scope of the types of patients considered treatable by psychoanalysis, "parameters of technique" were developed to

accommodate the needs of patients who might not otherwise be considered suitable for psychoanalytic methods.

Kernberg (1975) addressed the treatment of people with personality disorders, formerly considered inappropriate for psychoanalytic methods. Kohut (1968, 1971) developed both theory and methods that restored narcissistic problems to the realm of the treatable. Importantly, he recognized the importance of understanding and working with deficits.

The innovations in theory and technique introduced by Harry Stack Sullivan and the interpersonal school of psychoanalysis meant that psychoanalytic treatment became available to patients who were once thought to be untreatable. With the pioneering work of Sullivan, Frieda Fromm Riechman, and Harold Searles, patients suffering from serious forms of illness such as schizophrenia were able to benefit from psychoanalysis.

The principle behind the technique

What is the principle behind the technique? An implicit principle, though often not stated, is the restoration and creation of meaning, and enhancing the capacity for self-reflection. However, in a general sense, the stated principle has generally been the integration of "the unconscious" with "the conscious." The key question, though, is, "What is unconscious, and why?" Are we referring to a repressed unconscious, a dissociated unconscious, or both? Are we talking about unconscious fantasy, drive derivatives, and defenses against these? Or do we find the "unconscious" in the dissociated knowledge of trauma, or both? This makes a difference in terms of what we listen for and what we validate, consciously or unconsciously. If we understand the impact and importance of trauma and dissociation in people's lives, our technique includes not only acknowledgment, but also an effort to remediate the suffering entailed.

In work with trauma victims and those suffering from the different forms of complex PTSD, the psychoanalytic clinician is called upon, even required at times, to assume a more active approach. To understand and clarify: "What are the relevant data of this patient's experience in real life?" (Levenson, 1989, p. 537) often requires the clinician to deviate from the classical approach to treatment. This may include the use of relaxation techniques, hypnotic techniques, and an active inquiry into the nature of the patient's past history, involving the corroboration, when and if possible, of claims of extreme forms of early childhood abuse, the freedom to actively and creatively engage with dissociated self-states, grounding techniques to reorient patients before they leave sessions to help guarantee safety, and allowances for between-session contact to help insure the safety of the patient. These are just some of the things that clinicians working with trauma victims use frequently (which in traditional psychoanalytic technique would be considered breaking the frame). However, following the

psychoanalytic principle of exploration of meaning, the psychoanalyst is careful to explore with the analysand the feelings and meanings arising from what some might consider extra-analytic technique. This exploration of meaning and the analysis of shared experience by the dyad is what makes this work interpersonal-relational and intersubjective psychoanalysis. (For an interesting discussion of these issues see Itzkowitz *et al.*, 2015.)

There remain many aspects of standard psychoanalytic theory and technique, such as the setting and maintenance of clear boundaries, that can be and should be used—in fact are essential—in the treatment of complex trauma, DDNOS, and DID. In addition these may include multiple sessions per week, the development and analysis of transference, the use of countertransference data, and dream interpretation.

In addition, one might ask about the experience of analysands who are not "official" trauma victims. Many have "completed" analyses that did not meet—or ignored—some of their most important needs. Designated trauma victims are not the only people who need help at times with stabilization, with containment, and with affect regulation.

With so much that is the same and so much that is different, how would we understand trauma work as psychoanalytic?

The purpose and expected outcome of psychoanalysis: What is the essence of psychoanalysis?

Do we retain the emphasis on working with the unconscious? If so, how do we understand the meaning, the method and the expected outcome of this enterprise? Mann (1995) explains that Fromm's definition of psychoanalysis was "a method of uncovering the unconscious reality of a person . . . which assumes that in the process of uncovering the person has a chance to get well" (p. 565). For Fromm (1973) the essence of psychoanalysis is "essentially a theory of unconscious strivings, of resistance, of falsification of reality according to one's subjective needs and expectations (Transference), of character, and of conflicts between passionate strivings . . . and the demands for self-preservation" (p. 109). Fromm credited Harry Stack Sullivan and Frieda Fromm Reichmann, among others, for paving the way for making what goes on between people in their interpersonal relations and in the analytic setting the central focus of psychoanalysis. He also held Fairbairn, Winnicott, Balint and Guntrip in high regard for their contributions and for helping to transform psychoanalysis "into a theory and therapy that encouraged the rebirth and growth of an authentic self within an authentic relationship" (p. 110).

In an inspiring article entitled "The essence of psycho-analysis as opposed to what is secondary," Neville Symington (2012) profoundly and succinctly addresses our question of "What is psychoanalysis?" He believes that

"psychoanalysis is an inspiration, capable of revolutionizing our world" (p. 396). The essence of psychoanalysis for him is the realization and process of becoming "who I am." He views the standard tools, techniques and requirements of psychoanalysis to be "historical cultural-bound" phenomena (p. 402). In creating this distinction between the *tools* of psychoanalysis and the *essence* of psychoanalysis, Symington turns to the philosophical distinction between the noumenon and the phenomenon. The noumenon can be defined as "a posited object or event as it appears in itself independent of perception by the senses" (Merriam-Webster) or, as Symington describes, "the substance of the thing itself" (p. 395). And for Symington the noumenon of psychoanalysis, the essence of psychoanalysis, is "who I am." While phenomenon refers to "something . . . that can be observed and studied" (Merriam-Webster), and for Symington the phenomena of psychoanalysis are the tools of the psychoanalyst, e.g., use of the couch, frequency and length of sessions, interpretations, transference, etc.

For Symington the noumenon of psychoanalysis has become confused with and obscured by the phenomenon of psychoanalysis. This has occurred as the essence of psychoanalysis has sometimes been inverted by the tools and techniques through which psychoanalysis seeks to accomplish its goal. The use of the couch, the 50-minute hour, the frequency of weekly sessions, transference, interpretations, etc. have become emblematic of psychoanalysis. According to Symington, psychoanalysis is the act of self-creation and self-realization. The capacity to be self-reflective and afford oneself the opportunity to know oneself, to free oneself to become who one is and who one is capable of being, by transforming oneself through self-knowledge into an alive and vital human being; this is the essence of psychoanalysis, as Symington sees it.

The purpose and expected outcome of the enterprise of psychoanalysis

For the traumatized and dissociated patient, to become who one is, to fully realize "who I am," to be alive and vital and to know and feel "who I am" is an arduous task. It requires the loosening of the grip of dissociation whose very purpose has been to keep the person living in a world of partial truths, confusion caused by gaps in experience, and shifting dissociated self-states. Dissociative processes function to prevent the person from knowing the past, i.e., to obstruct knowledge of the past and to prevent it from breaking into consciousness and threatening to overwhelm the damaged, fragmented self and its tenuous hold on reality. The overwhelming and devastating impact of trauma or other events of the environment that directly affect a person's capacity to continue functioning in the world contributes to the dissociative structuring of the mind. The development of dissociative symptoms is the result and expression of the mind's adaptive potential

and proclivity towards self-protection in the face of ongoing emotional hyperarousal, and psychic trauma.

For highly dissociative patients, as well as those with DID, the purpose and outcome of the psychoanalytic enterprise is the loosening of dissociative barriers to fully knowing oneself and one's traumatic history. Coming to terms with the overwhelming pain of one's past enables formerly dissociated self-states the opportunity to become consciously dedicated partners in the enterprise of self-experience, self-knowledge, and personal growth.

Trauma-analysis, which we consider an intrinsic part of psychoanalysis, then, returns us to Freud's early observations, theories, and methods of treatment

To fully know "who I am" requires that both patient and analyst embark on a courageous journey into the patient's internal world. In the case of the dissociative mind the internal world is a world filled with traps set to protect the fragmented self and maintain the dissociative structure of the patient's mind. One of the goals of psychoanalysis, then, is to sift through, differentiate, clarify and liberate frozen, dissociated affect so the patient can begin to feel her way into herself and know her mind; to be able to know who she is. This process can only be successful within the context of a safe dyadic relationship capable of holding and containing the intense emotional upheavals, the shifting states of consciousness, and enactments that go hand-in-hand with treating the traumatized person. Only in this way can the dissociated patient begin to come alive and truly begin to know and feel her formerly dissociated self-states and come to know herself in the larger sense.

When dissociative barriers begin to break down and the need to not know diminishes, there is likely to be an initial period of emotional uncertainty, anxiety and disorientation, as the person begins to get a new and clearer sense of herself in the world. But ultimately a sense of inner expansiveness develops as previously dissociated parts of the self are located or relocated. The patient becomes capable of formulating and knowing her experience (Stern, 2003, 2010) in a new way. It is only then that the patient can truly stand in the spaces (Bromberg, 2001, 2009) and allow for the possibility of living with a multiplicity of truths.

For Levenson (1981), "Psychoanalysis begins when what is talked about between the two participants is also *experienced* between them. This, coming full circle, was, of course, Freud's great discovery: the transference" (p. 495). Both Symington and Levenson view psychoanalysis as a means by which two people come together, encounter and interact with each other with the goal of the transformation of the patient's life. In this dynamic process both participants become, to use Levenson's metaphor, fellow travelers in an

effort to help expand the patient's self-understanding and develop a clearer picture of the world within which she has been embedded. If the work goes well, it is not only the patient's life that is transformed but the analyst's as well.

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Chapter 2

From trauma-analysis to psycho-analysis and back again

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Confronting trauma face to face, in ourselves and in others, requires an ability to accept that there exists the kind of profound and searing emotional pain that knocks people off their axis of feeling centered and oriented in the world. This is the kind of disorientation that makes people feel they are losing their minds until or unless they find a way to make it stop. This is what dissociation does: it arrests the unutterable horrible feeling of going insane, the feeling that the world makes no sense and that one's mind has no continuity or expectable form.

The ubiquity and importance of dissociative experience

The capacity for dissociation is an inherent aspect of the human mind, and dissociative phenomena have played an important part in the human life since the earliest times. Throughout the history of humankind, dissociative trances have been intrinsic to communal religious ceremonies, e.g., shamanism; and, on an individual basis, a person's entry into dissociative trance has been recognized and understood as a response to life's problems (Cardena, 2001). Even today dissociative altered states, for example, *ataques de nervos* in Puerto Rico (Lewis-Fernandez, 1994), provide socially acceptable ways of expressing extremely intense feeling. As Kluft noted, "DID is the contemporary and demystified form of an anthropological commonplace" (1984, p. 21).

Historical itinerary of the classification of dissociative experiences: From spirit possession to hysteria

Dissociative trances have in many cultures been understood as benign spirit possession (Hilgard, 1977; Levine, 1997; Cardena, 2001), whether to receive messages from the gods or the departed (Ellenberger, 1970; Ross, 1989, 1996). Somer (2004) has described how dissociative trances, via possession

by a dybbuk, provided a way for people to express the experience of violation. Although dissociative trances were often likely manifestations of dissociation of the personality (Ellenberger, 1970), in the Middle Ages, as the Catholic Church gained more prominence in Western culture, such trances were most frequently viewed as demon possession, to which the solution was exorcism.

The study of dissociation begins in hypnosis

It was not until the late 1700s that the scientific study of dissociative phenomena began. Using his "magnetic" approach (what today we understand as hypnotic phenomena), Anton Mesmer began a curative process that revealed dual states of consciousness. These discoveries of dualism went hand-in-hand with the development of the use of hypnosis for the relief of suffering. His magnetic approach elicited altered states of consciousness, demonstrating dissociation. The "animal magnetizers," as they were known, would, by making passes with their hands, create a kind of hysterical crisis in the symptomatic person which, when resolved, would result in symptom relief. One of the mesmerizers, the Marquis de Puységur, discovered a manifestation of dual consciousness in what he called artificial somnambulism: a patient appeared to go into a deep sleep, in which he spoke, but about which he had amnesia upon awakening (Dell, 2009a, p. 714; Van der Hart and Dorahy, 2009).

Although the theory of animal magnetism was soon scientifically discarded, the question of how it worked remained a topic of scientific investigation largely because Mesmer himself insisted that an explanation be found (Fromm, 1987). According to Middleton, Dorahy, and Moskowitz (2008), "accounts of individuals switching between identity states and demonstrating amnesia between states or switching into fugue states, had always been part of the literature associated with mesmerism" (p. 10).

Hysteria and dissociation

By the mid-1800s the concept of double consciousness, or the splitting of consciousness, was discussed by such writers as Jules Janet, Pierre Janet's brother, among others (Van der Hart and Dorahy, 2009). Soon hysteria became linked with double or split consciousness, a linkage that placed dissociation as a central factor in hysteria. The term "hysteria" (in the Greek *hystera* meant uterus) derived from the belief in ancient Greece that hysterical symptoms were caused by a uterus that was wandering about the body). Even though the medical beliefs were revised, the term "hysteria" was used as a diagnostic medical term from the 1700s until the late 1900s when it was eliminated from the DSM. (In Freud's and Janet's time "hysteria" was a diagnostic category that included what we would now

call dissociative identity disorder (DID), other specified dissociative disorders (OSDD), borderline personality disorder, and somatic disorders—essentially complex trauma disorder as formulated by Herman (1992).)

Hysteria, trauma, and "hypnoid" states

The late 1800s were a ripe time for the emergence of a study of the mind rooted in trauma and dissociation. The French physician and neurologist, Jean-Martin Charcot, began the linkage of the ideas of dissociation, hysteria, and trauma, with a focus on hypnotism and hysteria, demonstrating how hysterical symptoms and paralysis could be caused by psychological events. Even though he believed that the cause of hysteria was constitutional weakness, he enabled hysteria to become understood as psychological in origin.

His colleague, Pierre Janet, made the explicit link between hysteria and trauma (Van der Hart and Dorahy, 2009). Beginning in the mid-1880s, Janet used the concepts of trauma and dissociation to explain the many symptoms of hysteria (see Chapter 4). Janet came to understand that powerfully strong emotions created by traumatic events would cause a disruption of memory, such that experiences of and around the trauma would become unavailable to consciousness. He used the term "fixed ideas" to refer to the memories of traumatic events that became unavailable to ordinary consciousness but remained present in a subconscious state, belonging to a dissociated mental system that made them unavailable to conscious thought, but that nonetheless had a powerful influence on behavior and experience. Because these fixed ideas had become isolated from ordinary consciousness and ordinary will, they operated subconsciously and autonomously and could be "triggered," as we currently say, by external or internal emotional events. Because the dissociated material could exert itself and intrude into their consciousness, people who suffered from hysteria had no conscious control of the dissociated contents in their minds. (Janet worked within the French tradition of careful observation rather than grand theory building (Dell, 2009b).)

The birth of psychoanalysis

Both Janet and Freud were separately, but deeply, influenced by Charcot's theories. Given the climate of the late 1800s, it is not surprising that psychoanalysis drew its initial inspiration from the study of trauma and dissociation. In the late 1800s, only slightly after Janet began publishing on hysteria as dissociative (1885, 1886, 1889), Freud and his mentor and friend Josef Breuer also articulated the dissociative basis of hysteria. In "The Preliminary Communication," the first chapter of *Studies on Hyster*ia (1893–1895), they described hysteria and its symptoms, as involving

dissociation, i.e., hypnoid states: "The basis and the *sine qua non* of hysteria is the existence of hypnoid states" (Breuer and Freud, 1893, p. 12). "Hypnoid" was a term that Breuer adopted from Charcot (Breger, 2000). As in hypnosis, "hypnoid states" are characterized by intense ideation, which is cut off from association with the rest of consciousness. Stressing the importance of dissociation in hysteria, they wrote:

> The longer we have been occupied with these phenomena, the more we have become convinced that *the splitting of consciousness which is so striking in the well-known classical cases under the form of* "double conscience" [footnote: the French term "dual consciousness"] *is present to a rudimentary degree in every hysteria, and that a tendency to such a dissociation, and with it the emergence of abnormal states of consciousness* (*which we shall bring together under the term "hypnoid"*) *is the basic phenomenon of this neurosis*. In these views we concur with Binet and the two Janets.
>
> (Breuer and Freud, 1893, p. 12)

Breuer and Freud observed that the memories of hysterical attacks corresponded to the precipitating causes of the illness, which had become sequestered from associational contact with the rest of consciousness. They articulated how trauma caused a splitting of consciousness and that traumatic memories were stored in hypnoid states remaining unavailable to the rest of consciousness. These ideas, traumatic memories, however, remain associated among themselves and form a "more or less highly organized rudiment of a second consciousness, *a condition seconde*" (p. 15).

They stated that even though they did not yet know the cause of hysteria, they had found a cure: abreaction. Observing that the memories of hysterical attacks corresponded to the precipitating causes of the illness and had been cut off from associational contact with the rest of consciousness, Breuer and Freud (1893–1895) stressed that the traumatic memories which have not been abreacted or associatively linked with other thoughts, are "found to belong to the ideational content of hypnoid states of consciousness with restricted association" (p. 15). They offered that when the "strangulated affect" (p. 17) of the idea that could not be abreacted "can find its way out through speech" (p. 17), it can become linked with normal consciousness, resulting in symptom reduction. Breuer's famous patient, Bertha Pappenheim, known in their writings as Anna O., developed in her work with Breuer a method that she called "chimney sweeping" of her mind, that is, abreaction. She also called this "the talking cure." (From today's standpoint, it is most likely that Pappenheim had DID (Ross, 1989). Ironically, this early period of such compelling and fertile theory later became known as the "pre-analytic" period.)

Although formally eclipsed, dissociation lives on as "splitting"

Despite what might seem such a grand opening, Freud soon dismissed hypnoid hysteria in favor of what he called defense hysteria.[1] Although dissociation continued to be implicit or explicit in many of his formulations (see Howell, 2005), his later emphasis was on repression and defense. Nonetheless, Freud used the terms "splitting" and "split off," referring to a kind of dissociation, as did Melanie Klein, Ferenczi, and Fairbairn, among many others. Thus, many of Freud's contemporaries, colleagues and some of his former protégés continued to write of trauma and dissociation, sometimes using different terms. Sandor Ferenczi, Freud's last discarded disciple and protégé, wrote eloquently of trauma-induced dissociation, and specifically of the impact of child sexual abuse (see Chapter 5). He wrote of how the traumatic shock resulting from sexual abuse causes the child to become "numb and robbed of his senses" (Ferenczi, 1949).

Splitting: Klein, Ferenczi, Fairbairn, Winnicott, and Guntrip

A few years following Ferenczi's last publication, Ronald Fairbairn, who was influenced by the theories of Janet, Klein, and Freud, based his theories of endopsychic organization on the process of splitting. As Arnold Modell noted, "Klein described splitting of the object; Freud, the splitting of the ego, and Fairbairn, the splitting of the self" (Modell, 2000, p. 202). He had worked with abused children and he wrote eloquently of the psychodynamics derivative of childhoods of abuse, neglect and spurned or inadequately reciprocated attachment longings. He described at length what he considered the schizoid, i.e., split, psyche, and he felt that because at least some traumatic impingement is unavoidable for humans, everyone is to varying degrees schizoid. Fairbairn was also notable in his theoretical emphasis on relationality. He considered real object relationships, relationships with real people, the basis of internal object relations.

In sum, many psychoanalytic writers, including Sigmund Freud, Sandor Ferenczi, Melanie Klein, Ronald Fairbairn, Donald Winnicott, and Harold Guntrip, have all used the term "splitting" or "splitting off." Of course, if the mind is split or a part is split off it is dissociated. Thus, psychoanalysts have been discussing dissociation for a very long time, without using the word. The manifestations and labeling of dissociative processes have taken various twists and turns throughout time and place, but whether they are called possession or splitting or something else, they have always been present in the human psyche.

Carl Jung and "complexes"

Carl Jung, who was Freud's first chosen protégé, also kept the linkage of trauma and dissociation alive in the form of what he called "complexes." Jung was also heavily influenced by Janet's thinking (Ellenberger, 1970; Moskowitz, 2008) and his understanding of complexes is remarkably similar to Janet's concept of fixed ideas and the contemporary notion of dissociated self-states. Jung also learned much from Morton Prince in America. When developing his own theory about dissociation he credited both men for their contributions.

> Jung, of course, studied with Pierre Janet in Paris in the winter semester of 1902–1903 and was influenced by him. "I owe a great deal of mental stimulation and knowledge to Janet," he writes in a letter to American neurologist Smith Ely Jelliffe on 24 February 1936. "I also got a great deal from his books. I certainly owe a very important psychological point of view to his psychology."
>
> (Noll, 1989, p. 355)

Jung thought that the capacity for dissociation was a normal part of mental life but most easily seen in psychopathology. As did Janet, he felt that parts of the psyche detach from consciousness with the potential for leading an independent life and feeling alien to the person. He termed these dissociated parts "complexes." In normal mental functioning Jung believed that these dissociated parts could facilitate "the expansion of the personality through greater differentiation of function" (Noll, 1989, p. 356). In psychopathological conditions, such as multiple personality disorder (now dissociative identity disorder), Jung believed that the complexes became stronger and had a greater severity of dissociation. He referred to these dissociated parts as "splinter psyches." "These splinter psyches may then potentially develop into alternate personalities, each with consciousness, memories, and specific adaptive functions that promote the survival of the individual as a whole" (Noll, 1989, p. 358).

Splitting and dissociation: From hysteria to schizophrenia

For Jung as well as Janet, Prince, and the "pre-psychoanalytic" Freud, early trauma was the culprit for the development of dissociation. The more severe the trauma in childhood the more obstreperous and resistant would these splinter psyches become.

Complexes form in reaction to trauma and are split-off aspects of the person's experience, containing thoughts, feelings, and emotional and cognitive patterns of behavior, all of which are held together by a similar

feeling tone or affective valence. Meier (1992) states: "One of the most mysterious properties of complexes is their ability to live a life of their own by automatically assimilating new experiences of the subject which are consonant with their own feeling tone" (p. 204). He explains that when complexes are, in contemporary terms, "triggered," they can overtake the ego of the person and assume control of consciousness: "For example, if we are overwhelmed by a complex—something, incidentally, which can perfectly well happen to a 'normal' person—a completely different personality will speak through us that [*sic*] the one which we commonly show to the world" (p. 206).

Jung was a close associate of Eugen Bleuler at the Burgholzi Hospital (Moskowitz, 2008), and Bleuler adopted his use of the term "complex." Bleuler went on to change the name of Dementia Praecox to "schizophrenia" which, drawn from the Greek, means, "split mind." Emphasizing that schizophrenia is dissociation-based, Bleuler (1911/1950) wrote, "the splitting of psychic functions is one of the most important characteristics" (p. 8). Notably, Freud also incorporated the term "complex" in his writing, but there the term lost the assumption of autonomy (see Moskowitz, 2008).

Back to Freud, child abuse and the one-person psychology

Replacement of the seduction theory with the theory of infantile sexuality

As we know, Freud proposed his seduction theory, in his 1896 paper, "The Aetiology of Hysteria." In contrast to his and Breuer's earlier statement in "The Preliminary Communication" that they had not found the cause of hysteria—only the cure—in this paper Freud stated that he had found the source of hysteria in early traumatic seductions (abuse). For a number of reasons, Freud revised the position he had taken in this paper. By 1897, only a year and a half later, his new theoretical formulations regarding psychosexual development included the Oedipus complex, which primarily emphasized the child's sexual fantasies, rather than real events (seductions/child abuse), as the root cause of neurosis. (Nonetheless, he did not deny that child sexual abuse did sometimes occur.)

Rejection of the seduction theory: A dissociative gap in theory

As this new theory took root, it became the cornerstone of the psychoanalytic understanding of mind, and exogamous trauma took a back seat to fantasy. For nearly a century this thesis became a schema through which most psychoanalysts as well as other mental health professionals would

understand claims of childhood abuse and sexual molestation. This constituted a dissociative gap in theory.

Many reasons, both Freud's own, and the speculations given by others, have been given for Freud's sudden shift in focus. One of the reasons Freud gave was that his former theory must be wrong because, considering the one-to-one correspondence between hysteric and "seducer" that he had found, there simply could not be that many perpetrators. (Freud was probably not aware, then, that many pedophiles have multiple victims, sometimes in the thousands (Salter, 2003), with the result that there is not a one-to-one correspondence. Another reason was that once one is relying on mentation that could be unconscious there is no way of knowing what really happened. Another was that his patients all fled from treatment once he told them the news of his discovery. Kupersmid (1993) observed that personal reasons as well as those given by Freud might have influenced his rejection of his earlier seduction theory. More specifically, Masson (1984) has suggested that Freud felt threatened by the cool reception to his paper, and changed his theory to fit social acceptability. In addition he noted that Freud's letters to Fleiss indicated that he recognized that his own father might have molested his siblings.

In discussing Freud's de-emphasis of the seduction theory, Levenson (1983) cites Krull's use of the following dream of Freud's that occurred in 1896, one year before his shift in thinking, "In the dream he reads on a board the following message: It is requested to close the eyes". Krull believes, and Levenson concurs, that Freud had to close his eyes to avoid knowing about his own father's transgressions and many inconsistencies and mysteries in Freud's own past history. By adopting the new theory of infantile sexuality, Freud in essence relocated the etiology of neurosis from the impact of real interpersonal-relational traumatic events in the child's life into the mind of the child, which now contained fantasies of sexuality resulting from innate biological drives. Unfortunately, this revised thinking gave pedophiles a defense—that children's claims of abuse were based on their own fantasies rather than on reality. The reality of the sexual abuse of children is so abhorrent that most people would prefer not to believe it possible. It would take almost a hundred years before the news media would present the reality of this unthinkable crime in a manner in which society could no longer turn a blind eye (and psychoanalysts a deaf ear).

Thus the dissociative gap in theory was mirrored by a dissociative gap in cultural mores and "knowledge."

One-person psychology and the denial of a perpetrator

With the advent of his new theory of infantile sexuality, the role and impact of reality on the mind took a back seat to the construct of powerful desires,

impulses, and fantasies in the minds of children. This one-person psychology involving erotogenic stages, in which the child is the sole guilty one with respect to unsocialized impulses, does not leave room for the existence of a perpetrator. In contrast, accepting relational trauma requires accepting the possibility of an aggressor, abuser, or perpetrator. In this context, it is both astounding and not surprising that Ernest Jones, Freud's disciple and biographer, was acquitted in his 1906 trial for sexual assaults on and abuse of children in his charge. Jones had been dismissed from several positions because of allegations of sexual abuse, and in this trial, the evidence, which included semen stains, as well as several children's testimony regarding Jones's behavior, involving exposure and assault toward them, seemed irrefutable (Kuhn, 2002). But, according to Kuhn, this was a time in which children's words were not taken seriously, and besides, Jones had an expensive, high-class lawyer. The intermeshing of Freud's new theory with Jones's legal exculpation is interesting.

Object relations theory and relational psychoanalysis

Ronald Fairbairn retained Freud's use of the term "object" (which for Freud meant object of the instinctual drives), but gave it a new meaning. Now the "object" is a real other human being whom the child needs and loves; but the object also becomes internalized as part of the inevitably schizoid psyche. This makes for a two-person psychology as well as a relational turn. Winnicott, Guntrip and others soon followed in the same tradition of a basically two-person, relational psychology. Meanwhile, in the United States, Harry Stack Sullivan was in the mid-1900s developing his interpersonal theory of psychiatry and of human development. Notable among his many contributions was his concept of "participant observation," referring to the role of the therapist. While object relations theorists were talking about the internalization of important figures in the child's early life, Sullivan was describing an even larger realm of influence from the culture, essentially the "field." In addition, Sullivan was aware of the potential impact of overwhelming anxiety on the mind of the developing child. His inclusion of the concept of the "not me" was his version of a container (or place holder) of dissociated self-experience.

In the closing decades of the twentieth century, a group of psychoanalysts, many of whom, but not all, were trained in the Interpersonal tradition, began seeing the need to include the impact of reality on the structuralization of the mind. This shift in thinking was in no small way impacted by the social-cultural and political tectonic shifts that defined the milieu in which these psychoanalytic thinkers came into their own. By combining the Interpersonal school of Psychoanalysis and British Object Relations Theory, and calling it the "Relational Structure Model" (Greenberg and

Mitchell, 1983), a new school of psychoanalytic thinking came into being. This turn of events made it possible to think of the mind as being directly and profoundly affected by the impact of reality. And the psychoanalytic endeavor that was once characterized by the idea that the analyst was capable of interacting from outside of her field of observation, a one-person model of experience, shifted with the idea that all dyadic relationships are co-created. In the new two-person model of experience, the analyst was now both observer and participant. Mind was now considered to be structured by both endogenous and exogenous factors, and anatomy was no longer destiny. Nowhere else is the impact of real, interpersonal-relational events more powerfully felt than in the devastating impact of relational trauma.

The devaluation of women, children, and the less powerful

Another factor in the lack of recognition of child sexual abuse may be the devaluation of women (to which Freud's writings contributed). Women were more vulnerable and were viewed as lesser beings, even without Freud's contribution (see Freud, 1925). (And even today, the term "mankind," as opposed to "humankind," is unfortunately used way too often.) All of the eighteen cases on which Freud based his 1896 essay, "The Aetiology of Hysteria," in which he claimed that every one of them had been sexually abused, were women. Nonetheless, four of his long case histories were of men, with whom he appears to have identified more. Social stratification contributes to the assumption that the less well-off are inferior, which makes them more vulnerable. For example, during and after the First World War, British officers liked to think that only enlisted men stuttered, that officers were immune to this humiliating impediment to attempts at self-expression. Yet, as some began to notice, officers also sometimes stuttered, even though they weren't supposed to, exposing the idea that trauma only disrupts the endurance and integrity of lesser beings. To acknowledge the dissociative mind is to acknowledge that it characterizes all of us, to varying degrees.

Guilty man, tragic man, and hysterical woman

Freud's initial formulation of psychodynamics included dissociated experiences and states. In *Studies on Hysteria,* Freud, along with Breuer (Breuer and Freud, 1893–1895), was interested in the problems of hysterical women, that is, women who suffered memory losses, somatic disturbances, and who had terrible attachment difficulties as well as difficult life circumstances. This "pre-analytic" Freud, like his predecessor and contemporary, Janet, was writing about hysterical, dissociative women. As Kohut astutely noted, Freud's theory, with its inevitability of guilt following repressed

sexual and aggressive impulses, was one of "guilty man." Kohut counterposed and added a model of "tragic man," one that emphasized deficit psychology as well as narcissistic needs and shame.

The model that Freud started to work on but did not finish in terms of dissociative psychodynamics was a model of hysterical woman. Not that hysteria applied only to women (Barnett, 1971). As is well known, hysterical symptoms of amnesia, somatoform dissociation, and state-specific expression of traumatic memories were common among war casualties (Van der Hart *et al.*, 2000). "Hysterical" symptoms were symptoms of unresolved trauma. In this way, the "gender" (in the sense of "type") of "hysterical woman" is "traumatized and dissociative." However, for about the next century "hysterical woman" (understood as Janet and the early Freud did, in terms of the dissociative psychodynamics) occupied a dissociative gap in psychoanalytic consciousness and memory. Today we may more productively speak of guilty, tragic, and hysterical people. That is, guilt, tragedy, and hysteria are genderless.

Healing complex trauma and dissociative problems

If we return to the question that we raised in the introduction of how psychoanalysis sees its subject, perhaps once again "hysterical woman," that is, vulnerable, devalued, dissociative human beings who suffer from various forms of a complex trauma disorder, comes into focus. Dissociation protects the mind from the unthinkable, the unimaginable, and the unbearable helplessness to stop events that trigger feelings of terror, annihilation and non-being. The encapsulation of self-states into varieties of dissociated ways of being containing affect and experience forestalls the total collapse and dissolution of the mind. This allows the person to preserve a semblance of self-continuity and capacity, albeit changed and somewhat limited, of engaging with the interpersonal-relational world.

Once the traumatic experience has been dissociated from the sense of "who one is," it is no longer thinkable as a self-narrative or so-called "rational" process. The emotional set of living experiences has now been encapsulated as a part of past living time, and remains contained in that self-state as present and ongoing. When the experience has become dissociated, what the trauma is and was is not known to the self-state of "me" that is usually presented to the world. This dissociative mental structure remains—until the traumatic experience reappears, often in raw form as a flashback or memory, whether verbal or somatic; hopefully in the presence of someone who can listen and help the person assimilate the experience, such as in intense moments in psychotherapy. Then the person *does* begin to know. In this way a psychotherapy or psychoanalysis that is informed about the psychodynamics of dissociated self-states offers an anamnesis and the prospect of genuine healing.

Note

1 Although Freud's official dissociation period was short-lived, his later work did describe dissociative phenomena without naming them as such (see Howell, 2005, pp. 62–76; and Howell, 2011, pp. 47–48).

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Chapter 3

The everywhereness of trauma and the dissociative structuring of the mind

Elizabeth F. Howell
and Sheldon Itzkowitz

What is trauma?

The word "trauma" is used in multifarious ways to refer to many different kinds of experiences. We speak of massive trauma as well as everyday trauma (which may or may not be massive). We speak of "big T" trauma and "little t" trauma (Shapiro, 2001), early trauma and later trauma, cumulative trauma, psychological trauma, relational trauma, and developmental trauma. Trauma has been considered to be both rare and frequent—perhaps until recently, it was more often thought of as rare. Yet, clearly, on the basis of current observable events, trauma is not rare. It has become an undeniable, albeit unwelcome fact of our lives. Furthermore, for many, such as war combatants, or battered women and abused children, such trauma can be ordinary, an experience of everyday life (Brown, 1991).

In an endeavor to achieve clarity and objectivity, the current *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5, 2013) provides:

> Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition.
>
> Two specifications are noted including delayed expression and a dissociative subtype of PTSD, the latter of which is new to DSM-5. In both specifications, the full diagnostic criteria for PTSD must be met for application to be warranted.
>
> (DSM-5 Criteria for PTSD, 2014)

(For a detailed review of the complete diagnostic criteria see the Appendix to this chapter, pages 39–41.)

The assumption is of an objectively heinous event or series of events, such as violent death, murder, serious injury, or threat of experience of these. In this vein, massive trauma, such as the devastations caused by earthquakes, tsunamis, floods, and so on, became practically synonymous to many with "objective" trauma.

"Objective" massive trauma vs. subjective trauma

However, the problem with the concept of "objective" trauma is that not everyone who has been subjected to massive trauma develops posttraumatic stress. Why, after experiencing the same stressful event, do some people break down, while others do not? Why is the same experience traumatic for one person, but not for another? We speak of resilience, a seemingly personal attribute that has a protective impact against the effect of trauma. But what accounts for resilience? (For an interesting discussion of this topic, see Itzkowitz *et al.*, 2015.) Because various kinds and severity of "traumatic" events affect people differently, some speak of trauma as an experience that is overwhelming to the individual. Does trauma then refer to a quantifiable event or to an individual's subjective experience?

In a way that encompasses both, David Spiegel has described trauma in the following way:

> Trauma can be understood as the experience of being made into an object; the victim of someone else's rage, of nature's indifference, or of one's own physical and psychological limitations. Along with the pain and fear associated with rape, combat trauma, or natural disaster comes a marginally bearable sense of helplessness, a realization that one's own will and wishes become irrelevant to the course of events, leaving either a view of the self that is damaged; contaminated by the humiliation, pain, and fear that the event imposed; or a fragmented sense of self.
>
> (Spiegel, 1990, p. 251)

Bessel Van der Kolk defined trauma more subjectively as "an inescapably stressful event that overwhelms people's existing coping mechanisms" (1996, p. 279). Judith Herman (1992) observed that "at the moment of trauma the victim is rendered helpless by overwhelming force" (p. 33). From the overwhelmed person's perspective, trauma disrupts reflective functioning; indeed, it powerfully curtails the mere ability to think.

Dissociation as the result of trauma

How then do we categorize these different types of trauma? Is it extraordinary and massive, ordinary and massive, ordinary and cumulative? Does it apply to events of adulthood or childhood, or both? How do we categorize and

understand the effects of trauma on the human mind? Although the idea of trauma encompasses many kinds of events and experiences, above all, it affects us profoundly. One way to look at this is in terms of dissociative processes. If, as Van der Kolk described, trauma is an inescapably stressful event that overwhelms people's existing coping mechanisms, then it refers to events that were too overwhelming to be assimilated. If the overwhelming traumatic event could not be taken in and integrated with the rest of experience, it is dissociated. There is a split in experience. Experience that is too overwhelming to be assimilated will cause a division of experiencing and knowledge. Parts of self-experience will be separated or split off from one another, and one part of ourselves will not know of other parts of ourselves. "Trauma refers to events that could not be assimilated . . . if the traumatic event could not be taken in, it cannot be linked with other experience," and perforce, "the result of trauma is dissociation" (Howell, 2005, p. vii). Trauma then connotes divisions or fissures in experience.

When a part of experience cannot be absorbed into the rest of the experiencing self, it becomes, as Pierre Janet (1907, 1925) so well described, a "fixed idea," living on its own, disconnected from the rest of the self. It is a dissociated part of experience. When the traumatic event cannot be linked with other experience, a structural dissociation of experience, whether small or large, results (Van der Hart *et al*., 2004). In short, the result of trauma is dissociation. Reasoning backwards, something is traumatic if it was overwhelming enough to cause a fissure in experience. Thus, all of these kinds of trauma, seemingly massive, or ordinary, large, small, occurring in childhood or adulthood, while different and having different effects, cause some degree of dissociation.

The dissociation model also helps us to understand how mitigating circumstances contribute to resilience. These often have to do with the availability of another person with whom to communicate about one's experiences, such as a grandparent, another trusted attachment figure, or close friend who may offer comfort and understanding, helping the traumatized person to link the earlier overwhelming experience with current safety, so that it is not so overwhelming. Such interpersonal-relational forms of relatedness make it easier to tolerate and assimilate frightening experience, thus lessening the need for dissociation.

Developmental trauma and disorganized attachment

What of developmental trauma (Van der Kolk, 2005; Bromberg, 2011)? Philip Bromberg persuasively tells us that developmental trauma, the kind of trauma that affects the developing child, is ubiquitous:

> Developmental trauma is a core relational phenomenon and invariably shapes personality in every human being. It contributes to every human

> being's potential for affect dysregulation, which is always a matter of degree even in those for whom secure attachment has led to relative stability and resilience. We all are vulnerable to the unanticipated experience of coming face to face with our own "otherness," which sometimes, albeit temporarily, feels more "not-me" than our minds can deal with. This is part of the human condition. The big difference between people is the extent to which the sudden affective hyperarousal touches an area of unprocessed developmental trauma and is not only unpleasant, but mentally unbearable and thus unavailable to cognition. (2011, pp. 32–33)

Disorganized attachment includes the effects of a very early kind of developmental trauma (Liotti, 1992, 2004, 2006) and has been robustly linked to dissociation (Lyons-Ruth, 2003, 2006). When attachment styles were first studied, three were identified: secure attachment, which accounts for about half of the infants studied; anxious avoidant attachment, the next most frequent; and anxious ambivalent or resistant attachment. Disorganized attachment (DA), a fourth pattern of attachment, has more recently been recognized and labeled (Main and Solomon, 1986; Main and Hesse, 1990; Main and Soloman, 1990). DA refers to markedly disconnected or dissociated models of attachment. Something in the infant's experience of the attachment figure has been too overwhelming to be assimilated into a consistent working model of attachment. DA has been found to occur in about 80 percent (Carlson, Cicchetti, Barnett, and Braunwald, 1989) of maltreated infants. Yet, there appear to be other routes to DA other than maltreatment or abuse. About 15 percent of the infants of "low-risk" families also had DA (Liotti, 1999; Lyons-Ruth, 2003). This suggests that there may have been less overt or visible, perhaps "hidden" or "hidden in plain sight," but in many ways, "unseeable," events involving such things as severe misattunement or overly aggressive play, or neglect. Some adult behaviors and interpersonal events that would not be considered overwhelming to an adult or older child may be so to an infant or younger child. As a result, in DA, part of the infant wishes to approach, connect with and be attached to the parent, and a part wants to flee. DA may develop even in the absence of overt, recorded abuse, and may occur when the parent is sufficiently out of tune with the infant's cues and needs. This dilemma, with which such children must deal, often results in the child's difficulty in achieving a sense of coherence of self.

According to the view just advanced, traumatic experiences lead to dissociative experiences. We are in agreement with Philip Bromberg (1993, 1998, 2006, 2011) and Ronald Fairbairn (1952), most notably, that the mind is structured dissociatively. This is in many ways a paradigm shift, from the earlier one-person concept of the tripartite structural model of id, ego, and superego. From this new perspective, the mind is understood to be multiply and dissociatively structured; in the sense that the mind is

characterized by a multiple self-structure, and in which trauma, which is, to a lesser or greater degree, endemic to everyone, leaves its mark in dissociative structure. In the ideal, multiple parts are connected and available to each other, but in more troubling and painful developmental outcomes, these parts are less available to each other, and there are more severe and disabling dissociative problems, such as dissociative identity disorder (DID). What makes a difference in kinds and severity of problems in living is not only the severity of dissociative fissures but also the way the dissociative parts are structured in internal relationships. For example, what is known as borderline personality appears to have a particular kind of dissociative structure, in which two main parts oscillate, as opposed to DID, in which there are usually more parts that take over executive function at different times (Howell, 2002). A better term that encompasses both is "complex trauma," or "complex PTSD" (Herman, 1992), also known as "disorders of extreme stress" (DESNOS). Complex PTSD is described as involving alternations in views of the self and other.

The dissociative structure of mind and the dissociative unconscious

Since Freud's initial explication of "the unconscious" as part of the topographical model and his later incorporation of the structural theory, much has changed. In the late twentieth century Erich Fromm, regarding Freud's immeasurable contributions with respect to the workings of the unconscious, observed that:

> This theory was radical because it attacked the last fortress of man's belief in his omnipotence and omniscience, the belief in his conscious thought as an ultimate datum of human experience. Galileo had deprived man of the illusion that the earth was the center of the world, Darwin of the illusion that he was created by God, but nobody had questioned that his conscious thinking was the last datum on which he could rely. Freud deprived man of his pride in his rationality . . . and discovered that . . . most of conscious thought is . . . a mere rationalization of thoughts and desires, which we prefer not to be aware of.
>
> (Fromm, 1980, p. 134)

We are still on the crest of the wave, riding the thrill of discovery with regard to "knowing" about "the unconscious." Recently, perspectives on the unconscious have expanded and become more differentiated. New terms, such as "the relational unconscious" (Bromberg 2006; Schore, 2009; Zeddies, 2000), "the cultural unconscious" (Kimbles, 2003), and the "ontological unconscious" (Stolorow, 2007), among others, have been offered. Inquiry into the nature of dissociation also opens up another vista: Not only

is conscious thought often unreliable—"a mere rationalization of thoughts and desires which we prefer not to be aware of"—as would be understood from the perspective of repression and repression-related defenses; but also real traumatic events have occurred resulting in dissociative processes and dissociative structure.

Repression and dissociation

Freud's most relied-upon defense was repression. Although the repressed unconscious did diminish humankind's claim to unassailable reason, the theory suggests that we mostly know the basic content of the unconscious mind. Much of the unconscious content involved sexual and aggressive impulses, impulses that connote agency and power. In contrast, a construct of the dissociative unconscious includes past experiences that were so emotionally and cognitively overwhelming that they could not be assimilated. When these dissociated experiences intrude into consciousness unbidden, they are often testimony to our utter helplessness and lack of agency at times of trauma.

Repression is an active defense that connotes mastery. As Boulanger (2007) notes, "The Freudian subject, by bringing drives under control, achieves agency" (p. 57). Repression banishes known (Davies and Frawley, 1994) and formulated (Stern, 1997) experience from consciousness making it unconscious—even though the precise mechanism by which this occurs may be in dispute (see Erdelyi, 1990, 1992, 1994; Stern, 1997; Howell, 2005). Repression enables a person to live with less interference from unacceptable impulses and desires as well as from extremely upsetting and unpleasant memories (Bromberg, 2006). In contrast, dissociation occurs when the experience was so overwhelming that it could not be emotionally borne or consciously formulated. Dissociation refers to those gaps in memory, knowledge, and emotions that we don't know that we don't know—experience that was too overwhelming to be assimilated.

The dissociative nature of the human mind

Bromberg (1998), who is foremost in the current writing about the "dissociative nature of the human mind" (p. 8), conceptualized the unconscious in terms of dissociated self-states:

> What we call the unconscious might usefully include the suspension or deterioration of linkages between self-states, preventing certain aspects of self—along with their respective constellations of affects, memories, values, and cognitive capacities—from achieving access to the personality within the same state of consciousness.
>
> (Bromberg, 1993, p. 182)

The dissociative unconsciousness then is characterized by gaps in our conscious experience. Yet the "unconscious" experiences in these gaps continue to exist as living experience in that self-state. This offers a reconceptualization of the mind as characterized by many different strands of experience existing on different levels of consciousness.

An enlightened psychoanalysis (or psychoanalytic perspective) recognizes and ***embraces*** the pervasiveness of trauma and its potential for structuring the mind dissociatively. Psychoanalysis as a theory of mind, and psychoanalysts as practitioners of a healing art, must adopt the project of ameliorating trauma and dissociation as a significant, if not major, part of the work (a topic addressed in detail in Chapter 1).

DSM-5 Criteria for PTSD diagnosis

Source: Friedman, M. J. (2015) PTSD History and overview. In National Center for PTSD: PTSD History and overview. Retrieved from www.ptsd.va.gov/professional/PTSD-overview/ptsd-overview.asp

(T)he **"A" stressor criterion** specifies that a person has been exposed to a catastrophic event involving actual or threatened death or injury, or a threat to the physical integrity of him/herself or others (such as sexual violence). Indirect exposure includes learning about the violent or accidental death or perpetration of sexual violence to a loved one. Exposure through electronic media (e.g. televised images the 9/11 attacks on the World Trade Center) is not considered a traumatic event. On the other hand, repeated, indirect exposure (usually as part of one's professional responsibilities) to the gruesome and horrific consequences of a traumatic event (e.g. police personnel, body handlers, etc.) is considered traumatic.

Before describing the B-E symptom clusters, it is important to understand that one new feature of DSM-5 is that all of these symptoms must have had their onset or been significantly exacerbated after exposure to the traumatic event.

The **"B" or intrusive recollection criterion** includes symptoms that are perhaps the most distinctive and readily identifiable symptoms of PTSD. For individuals with PTSD, the traumatic event remains, sometimes for decades or a lifetime, a dominating psychological experience that retains its power to evoke panic, terror, dread, grief, or despair. These emotions manifest during intrusive daytime images of the event, traumatic nightmares, and vivid reenactments known as PTSD flashbacks (which are dissociative episodes). Furthermore, trauma-related stimuli that trigger recollections of the original event have the power to evoke mental images, emotional responses, and physiological reactions associated with the trauma.

Researchers can use this phenomenon to reproduce PTSD symptoms in the laboratory by exposing affected individuals to auditory or visual trauma-related stimuli (10).

The **"C" or avoidance criterion** consists of behavioral strategies PTSD patients use in an attempt to reduce the likelihood that they will expose themselves to trauma-related stimuli. PTSD patients also use these strategies in an attempt to minimize the intensity of their psychological response if they are exposed to such stimuli. Behavioral strategies include avoiding any thought or situation which is likely to elicit distressing traumatic memories. In its extreme manifestation, avoidance behavior may superficially resemble agoraphobia because the PTSD individual is afraid to leave the house for fear of confronting reminders of the traumatic event(s).

Symptoms included in the **"D" or negative cognitions and mood criterion** reflect persistent alterations in beliefs or mood that have developed after exposure to the traumatic event. People with PTSD often have erroneous cognitions about the causes or consequences of the traumatic event which leads them to blame themselves or others. A related erroneous appraisal is the common belief that one is inadequate, weak, or permanently changed for the worse since exposure to the traumatic event or that one's expectations about the future have been permanently altered because of the event (e.g., "nothing good can happen to me," "nobody can be trusted," "the world is entirely dangerous," "people will always try to control me"). In addition to negative appraisals about past, present and future, people with PTSD have a wide variety of negative emotional states such as anger, guilt, or shame. Dissociative psychogenic amnesia is included in this symptom cluster and involves cutting off the conscious experience of trauma-based memories and feelings. Other symptoms include diminished interest in significant activities and feeling detached or estranged from others. Finally, although individuals with PTSD suffer from persistent negative emotions, they are unable to experience positive feelings such as love, pleasure or enjoyment. Such constricted affect makes it extremely difficult to sustain a close marital or otherwise meaningful interpersonal relationship.

Symptoms included in the **"E" or alterations in arousal or reactivity criterion** most closely resemble those seen in panic and generalized anxiety disorders. While symptoms such as insomnia and cognitive impairment are generic anxiety symptoms, hypervigilance and startle are more characteristic of PTSD. The hypervigilance in PTSD may sometimes become so intense as to appear like frank paranoia. The startle response has a unique neurobiological substrate and may actually be the most pathognomonic PTSD symptom. DSM-IV's Criterion D2, irritability or outbursts of anger, has been separated into emotional (e.g., D4) and behavioral (e.g., E1) components in DSM-5.

Irritable and angry outbursts may sometimes be expressed as aggressive behavior. Finally reckless and self-destructive behavior such as impulsive acts, unsafe sex, reckless driving and suicidal behavior are newly included in DSM-5, as Criterion E2.

The **"F" or duration criterion** specifies that symptoms must persist for at least one month before PTSD may be diagnosed.

The **"G" or functional significance criterion** specifies that the survivor must experience significant social, occupational, or other distress as a result of these symptoms.

The **"H" or exclusion criterion** specifies that the symptoms are not due to medication, substance use, or other illness.

Please refer to the PTSD website for further recommended reading and reference material. www.ptsd.va.gov/professional/PTSD-overview/ptsd-overview.asp

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Chapter 4

Pierre Janet, Sigmund Freud, and dissociation of the personality

The first codification of a psychodynamic depth psychology

Onno van der Hart

In 1892, Sigmund Freud wrote to his mentor and collaborator Joseph Breuer, "we consider it essential for the explanation of hysterical phenomena to assume the presence of a dissociation—a splitting of the consciousness" (p. 30). With this formulation, which they later elaborated, Breuer and Freud joined their French predecessors and contemporaries, notably, Jean-Marie Charcot, Alfred Binet, and the brothers Jules and Pierre Janet (Ellenberger, 1970). Freud and Breuer attributed the development of this dissociation in all cases to psychological trauma. A few years later, Freud specified this trauma euphemistically in terms of "a memory of a premature sexual experience," a proposition which he regarded as the "source of the Nile" of neuropathology (Freud, 1896, p. 187). Shortly thereafter, however, Freud abandoned dissociation theory.[1]

In contrast, Freud's French counterpart and source of inspiration, Pierre Janet (1859–1947), remained interested in dissociative phenomena all his life. Although Freud's work has been the major chapter in psychoanalytic theory, especially in North America, Janet's theory of how the mind becomes structured by trauma has been a hidden gem of psychodynamic theory.

Treasures lost and rediscovered

Pierre Janet was a founding father of the field of posttraumatic stress, in particular the master of trauma-related dissociation (e.g., Brown *et al.*, 1996; Putnam, 1989; Van der Kolk and Van der Hart, 1989). During the centennial and bicentennial of the French Revolution, he was honored for his 1889 famous philosophical thesis on trauma-related dissociation, *L'automatisme psychologique: Essay de psychologie expérimentale sur les formes inférieures de l'activité humaine* (*Psychological automatism: Experimental-psychological essay on the inferior forms of human activity*). John Nemiah (1989), then Editor of the *American Journal of Psychiatry*, called this publication "an occurrence in French history that, from a scientific point of view at least, is perhaps of equal magnitude" (p. 1527), and praised Janet's psychological contributions to psychopathology, which have stood

the test of time. In recent times, Janet has been recognized worldwide as the most important French psychologist (Carroy and Plas, 2000). However, his work was rather eclipsed by mainstream psychoanalysis and psychological theory for most of the twentieth century.

Only in 1970, when Henri Ellenberger devoted a brilliant chapter to him, did psychologists and psychiatrists begin to discover the treasures hidden in Janet's vast oeuvre—estimated to span more than 20,000 printed pages—and recognize the stature of this giant in psychology and psychiatry (Ellenberger, 1970). In 1977, Ernest Hilgard put Janet's dissociation theory center stage by applying his insights in the domain of experimental psychology, notably hypnosis. The psychodynamically oriented psychiatrist Nemiah subsequently drew attention to the clinical relevance of Janet's dissociation studies (e.g., Nemiah, 1979).

Pierre Janet: Philosopher, psychologist, psychiatrist

Janet started his career as a philosophy professor at Le Havre in 1882. That year, a publication by Charcot re-establishing the scientific status of hypnosis made a deep impression on him. At the psychiatric hospital in Le Havre that now bears his name, Janet conducted experimental research and treatment of psychiatric patients, about which he published a series of scientific articles (e.g., Janet, 1886, 1887). These studies formed the basis of his doctoral dissertation in philosophy (Janet, 1889).

Recognizing his merits, Charcot invited Janet in 1889 to set up the first psychological laboratory in the Salpêtrière. There, Janet obtained his medical degree in 1893 with a study on the mental state of hysterics. In 1895, he replaced Théodule Ribot as professor of experimental and comparative psychology at the Collège de France, a famous institute for advanced learning—a chair he held until 1935. Several of Janet's courses subsequently appeared in book form, winning both national and international recognition. This resulted in frequent invitations to lecture internationally—of which the lectures at Harvard University are among the most well known (Janet, 1907).

Janet's studies of dissociation in patients suffering from hysteria

In his early studies of hysteria patients at Le Havre, Janet systematically explored the two fundamental characteristics these patients manifested: (1) a retraction of their personal field of consciousness—that is, a reduction of the number of psychological phenomena that could simultaneously be perceived; and (2) the dissociation of psychological phenomena, also described in terms of the doubling of the personality (*dédoublement de la*

personnalité) (Janet, 1886). Thus, certain mental and physical functions (e.g., amnesia, anesthesia, contractures, blindness) absent in the (daily-life) "personality" (Janet, 1887), or "existence" (Janet, 1889), could be found in another "existence," or the other way around. His prime subject was Lucie, a nineteen-year-old patient who experienced a complete anesthesia of various parts of her body, failing to sense pain, contact, temperature or pressure. When she was not watching her hands, for example, she would be unaware that an object was placed in them. Janet contacted another "personality," Adrienne, placed a pencil in her right hand and paper on her lap, and subsequently pinched her left hand (which Lucie couldn't see). He then asked, "Adrienne, tell me what I did with the left hand?" The right hand wrote curtly while the patient's body remained motionless, "You are pinching me." "Which finger am I touching?" "The little one . . . the second." And so on.

Lucie also suffered from so-called hysterical crises, beginning with convulsions and followed by terrifying hallucinations in which hidden men played a major role (Janet, 1886). While unresponsive in the midst of such a crisis, she—probably as Adrienne—could still hear Janet speaking to her. When eventually Adrienne could write, she repeatedly wrote: "I am afraid," nothing more. It became clear that Lucie had no memories of these crises. Janet hypothesized that it was Adrienne who experienced them, and eventually was able to question her about their contents. She wrote that, while staying with her grandmother during a vacation, she saw a curtain in the garden behind which two men were hiding. This had frightened her horribly. "Since then I am always afraid." Lucie herself only vaguely remembered that she had been seriously ill at the age of seven following a terrible fright.

Integration and creativity versus dissociation

Janet distinguished two types of actions in which the human mind engages: actions that preserve and reproduce the past (as during reactivated traumatic memories) and actions directed toward integration and creation. Most mental and behavioral actions consist of combinations of these two functions, which are interdependent and regulate each other. Integrative activity "reunites more or less numerous given phenomena into a new phenomenon different from its elements" (Janet, 1889, p. 483). He posed that this activity functions to organize the present as it effectuates new combinations that are necessary to maintain equilibrium with the changing surroundings at any given moment.

Janet believed he could study psychological automatism (automatic actions performed apparently subconsciously) in individuals who exhibit it in extreme degrees, i.e., psychiatric patients suffering from hysteria. He aimed to explore human activity in its simplest and most rudimentary

forms: automatic because it is regular and pre-determined, and psychological because it is accompanied by sensibility and some degree of consciousness. (It was Janet who coined the construct of *subconscious* actions in order to differentiate them from unconscious processes linked to some physiological functions and not amenable to consciousness (Perry and Laurence, 1984).)

Janet observed that psychological automatism could be total as well as partial (Janet, 1889). The former implies that consciousness is completely dominated by a reproduction of past experience. The latter occurs when the automatism occupies only a part of consciousness, but is found in a second "existence," as illustrated in the example of Lucie and "Adrienne." Some secondary "existences" exist in rudimentary form with hardly a sense of self, as in catalepsy where only a single thought and single automatic action appear to occupy consciousness. Less primitive is the hysterical crisis, a dissociative episode complete with amnesia, in which the patient may re-enact a traumatizing event, such as Lucie's fright of the two hidden men. Janet also observed that certain, more or less subconscious, fixed ideas or dreams could become centers around which a larger number of psychological phenomena arrange themselves to become distinct "personalities," complete with their own life history, often continuing to develop as they interact with the surroundings.

Janet found that certain "elementary forms of action" found in dissociative "existences" were highly developed, including the ability to reason and make judgments. Contrary to what he expected, he found integrative and creative actions in some secondary "existences" that remained outside the patient's usual consciousness. In fact, a secondary "existence" could be healthier than the apparent primary "existence" in some patients. Furthermore, some secondary or tertiary "existences" could be aware of what the other "existences" were experiencing, while these were amnesic for the actions of such a non-amnestic "existence."

Fixed ideas

In his earlier works, Janet used the existing concept of subconscious fixed ideas (*idées fixes*) to refer to dissociative phenomena, such as thoughts, mental images, intense emotions, and related behavioral actions, that play a major role in hysterical crises, i.e., traumatic re-enactments (Janet, 1889, 1898). Major fixed ideas are the core of traumatizing experiences and their re-enactments, which tend to intrude into ordinary consciousness or even dominate it. Janet distinguished between primary and secondary fixed ideas. A primary fixed idea is the total complex of images (visual, auditory, kinesthetic, tactile, etc.) of a particular traumatizing event plus the corresponding vehement emotions and behavioral actions. Secondary fixed ideas have the same characteristics as primary ones, but present after the

main one. An example of a primary fixed idea is the traumatizing experience of the sudden death of a beloved in which survivor guilt is a major component. For some highly religious bereaved the secondary fixed idea consists of terrifying hallucinations of being tortured by devils in hell. (For more detailed analyses of secondary fixed ideas, see Janet, 1898; Van der Hart and Friedman, 1989.) For treatment to be completely helpful, it is necessary to resolve both primary and secondary fixed ideas.

Careful reading of Janet's studies on this matter clearly indicates that he understood that "personalities" or "existences" have their own sense of self, with some consisting only of one fixed idea and others being able to interact with the outside world and attain more autonomy. Janet later adopted the concept of (reactivated) traumatic memories to label the reactivated fixed ideas during hysterical crises (e.g., Janet, 1919/1925, 1928).

Positive and negative dissociative symptoms

Janet observed that the lack of integration in patients suffering from hysteria manifested in essentially two ways: through symptoms of "too little," i.e., negative symptoms, or symptoms of "too much," i.e., positive symptoms (Janet, 1889, 1904). He labeled the former as *mental stigmata* and the latter as *mental accidents*, in accordance with the already well-established classification system. The stigmata are the essential constitutive symptoms, and since patients do not always report them, clinicians should take initiative in assessing them. Janet distinguished, among others, anesthesias, amnesias, restrictions in movements and character modifications, and he carefully described the different forms of each negative symptom. He referred to the shared mental aspects of accidents: suggestion, subconscious acts and the fixed ideas that are the core of hysterical crises—dissociative intrusions, in modern language.

Defining hysteria

In 1889, Janet postulated that *psychological misery*, i.e., a reduction of the individual's integrative capacity, constituted the essence of hysteria. He contrasted this deficiency to mental health, characterized by "a high capacity for integration, which unites a broad range of psychological phenomena within one personality" (Janet, 1889, p. 460). He recognized the possible role of constitutional factors, along with trauma, in the development of this deficiency. In 1907, Janet expanded on these ideas, explaining hysteria as "a malady of the *personal synthesis*" (p. 332); dissociation of the personality thus results from an integrative failure. Janet further defined hysteria as: "a form of mental depression [i.e., lowering of the integrative capacity] characterized by the retraction of the field of consciousness and a tendency to the dissociation and emancipation of the systems of ideas and functions

that [through their synthesis (Janet, 1909, p. 345)] constitute personality" (p. 332).

Janet's psychology of action

Janet's psychology of action, integrated in the theory of structural dissociation of the personality (Van der Hart *et al*., 2006), clarifies that all psychological facts can be understood in terms of behavioral and mental *actions*. Thoughts, fantasies, images, and memories are mental actions, with affect and emotional sensations being regulators of actions (Janet, 1932). About narrative memory he remarked, "memory is an action: essentially it is the action of telling a story" (Janet, 1919/1925, p. 661). He regarded (vehement) emotions as lower-order substitute actions, having a disintegrative effect and replacing adaptive actions that a situation demands but which the person is unable to perform. In traumatizing events, simple actions usually are easily performed, but other, more complicated actions, such as the integration of traumatic memories, require a high integrative capacity (cf. Van der Hart *et al*., 2006). In short, while feelings or normal affect were regulators of behavioral actions, he regarded (vehement) emotions as disruptive, lowering integrative capacity.

Janet used action language to explain the existence of traumatic memories: "Such patients are continuing the action, or rather the attempt at action, which began when the [trauma] happened; and they exhaust themselves in these everlasting recommencements" (Janet, 1919/1925, p. 663). In other words, the hallucination of a traumatizing event involves the patient continuing the actions belonging to an event from the past. Janet saw the persistence of the hallucinations invariably as a consequence of inadequacy of the action during the actual traumatizing event. Thus, instead of an autobiographical narrative memory, the patient

> remains confronted by a difficult situation in which he was not able to play a satisfactory part, one to which his adaptation had been imperfect, so that he continues to make efforts at adaptation. The repetition of this situation, these continual efforts, give rise to fatigue, produce an exhaustion which is a considerable factor in his emotions.
>
> (1919/1925, p. 663)

Janet saw the need to help patients resolve their traumatic memories and integrate them as one of the chapters in their "autobiography" (Janet, 1928). Van der Hart *et al*. (2006) established that Janet basically distinguished two levels of integration: *synthesis* and *realization*. Synthesis pertains to those basic integrative mental and behavioral actions through which experience and a sense of self are both bound together and differentiated. Realization consists of higher order integrative actions that are based on the lower order

ones and in turn consist of two components: *personification* (Janet, 1935) or ownership ("this happened to *me*," "these are *my* feelings and *my* actions") and *presentification* (performing the actions of being firmly rooted in the present while connected with one's past history and one's anticipated future). Janet concluded that traumatized individuals suffer from syndromes of non-realization (Janet, 1935). It should be mentioned that "derealization," as currently understood, does not cover the whole range of manifestations of non-realization.

Janet's psychotherapy

Janet was known for his sharp observational skills. Nicknamed "Dr. Pencil," he meticulously wrote down everything his patients at the Salpêtrière said and everything he observed. When studying dreams, for example, he would contact his patients *while* they were asleep to directly hear their dreams, rather than relying on reports written by them on the morning following these dreams. Janet was also an exceptionally good psychotherapist who developed an "almost unlimited variety of psychotherapeutic devices" (Ellenberger, 1970, p. 351; see also Bühler and Heim, 2001, 2011). He used a wide range of approaches and techniques (1919/1925), including psychological analysis (a construct that preceded Freud's "psychoanalysis"), hypnosis, a transference approach (Haule, 1986), psycho-education, cognitive-behavior therapy *avant la lettre*, cognitive interventions, relational approaches, and body-oriented therapy (Ogden *et al.*, 2006).

Janet's dynamic constructs of *mental force* and *mental tension* stand out. Mental force (or energy) refers to the total amount of psychic energy available, mental tension (or integrative capacity), to the level of organization of this energy and the capacity for competent, creative and reflective action. Trauma-related dissociative disorders (hysteria) involve a deficiency of mental tension. Eventually, they are also characterized by low mental force, due to the exhaustion caused by the reactivated traumatic memories. Thus, both mental force and mental tension must be carefully attended to in therapy. Janet found that completing one's well-performed actions to resolution brings about either triumph or acceptance (in particular, of loss). This heightens mental tension or the integrative capacity—a major principle in sensorimotor psychotherapy (Ogden *et al.*, 2006).

Janet observed that patients suffering from trauma-related dissociative disorders tend to initially be hindered in the integration of their traumatic memories by a host of other "unfinished business" (Ellenberger, 1970). Thus, his therapy, presaging most current approaches to complex trauma, was characterized by a phase-oriented approach, consisting of (1) stabilization, symptom reduction, and preparation of the resolution of traumatic memories; (2) treatment of traumatic memories; and (3) personality

(re)integration, rehabilitation, and relapse prevention (Van der Hart, Brown, and Van der Kolk, 1989).

However, Janet found that the mental and physical state of severely traumatized patients who were continuously re-experiencing their trauma was often so bad that even phase-1 work would not result in raising their mental tension to a level that would be sufficient to integrate traumatic memories. In these cases he would use a substitution method (comparable with modern rescripting techniques used in the treatment of traumatic nightmares) in which he helped the patient to change the contents of the traumatic memory into more positive ones.

The tension between Janet and Freud

Freud and Janet were initially complimentary of each other. In his 1892 communication to Breuer, Freud stated, much in line with Janet's view, that "The memory which forms the content of an hysterical attack is an *unconscious* one, or, more correctly, it is part of the second state of consciousness which is present in a more or less highly organized shape in every hysteria" (p. 31). Indeed, Breuer and Freud (1893) recognized Janet as a predecessor in the study of patients suffering from hysteria, and their early views were quite similar to his. Janet, in turn, expressed happiness about Breuer and Freud's verification of his own interpretation regarding subconscious fixed ideas in these patients (Janet, 1894/1901). However, Freud soon made it clear that Breuer and he "recede[d] from Janet who assigns too great importance to the splitting of consciousness as a characteristic of hysteria" (Freud, 1894, p. 72). Subsequently, Janet expressed the belief that Freud adopted some of his key concepts and gave them different names, without proper acknowledgement, e.g., psychological analysis and psychoanalysis.

An extremely cautious researcher, Janet criticized Freud's tendency toward overgeneralization. Freud, from his side, expressed his disdain for Janet. His students, of course, followed his lead and ostracized Janet and his dissociation theory. When Ferenczi (1933) (see Chapter 5) later returned to a dissociation perspective on childhood traumatization, he suffered a similar predicament within the psychoanalytic movement. (For elaborations of the conflict between Janet and Freud, see Dell, 2009; Ellenberger, 1970; Perry and Laurence, 1984.)

Breuer and Freud attacked a simplified version of Janet's view regarding his inclusion of possible constitutional factors in the etiology of hysteria, and differentiated their own conclusion: that trauma was the origin of hysteria in all cases. Incidentally, they themselves eventually included disposition or constitution as a possible factor (Freud and Breuer, 1895/1974). In addition, Freud viewed dissociation primarily as a defense, rather than an integrative failure. Criticizing Janet's view, Freud (1894/1963) stated:

"I repeatedly succeeded in demonstrating that the splitting of consciousness is the consequence of a voluntary act on the part of the patient; that is to say, it is instituted by an effort of will, the motive of which is discernable" (p. 69).

Freud's abandonment of the dissociation theory

In hindsight it should be concluded that Breuer and Freud were on target when they stated, in 1893, that "[We] have become convinced that *the splitting of consciousness* which is so striking in the well-known classical cases under the form of *double conscience* is present to a rudimentary degree in every hysteria, and with it the emergence of abnormal states of consciousness . . . is the basic phenomenon of this neurosis" (pp. 61–62). Soon thereafter dissociation became an objectionable topic for Freud, and subsequently for mainstream psychoanalysis (O'Neil, 2009). Thus, first, Freud emphasized the existence of conscious (dissociative) states, and then he and Breuer introduced the concept of the unconscious mental state instead. Of course, Freud presented arguments for this shift in his understanding, but they remain open to severe criticism (e.g., Zemach, 1986). Zemach concluded that "one cannot but wonder how Freud could have neglected the phenomenon so completely, and how little thought he gave to cases of dissociation, which are certainly striking and which seemed to him, at the beginning of his career, to hold the key to the mysteries of the mind" (p. 132).

Discussion

A note on terminology

With the exception of his 1889 thesis, in which he spoke of "psychological disaggregation," Janet consistently used "dissociation." In nineteenth-century France many related concepts were used, such as "double conscience," "doubling of the ego" (*dédoublement du moi*), "doubling of consciousness," "double personality," "division of the personality," and "multiple personality" (see Van der Hart and Dorahy, 2009, for an overview). Cases of double consciousness (the construct that Breuer and Freud adopted) or double personality were probably more the exception than the rule.

Breuer and Freud's translation of "dissociation" into "splitting of consciousness" was not entirely correct. Such a conceptualization denies the possibility of experiential or functional overlap between the "existences" or dissociative subsystems of the personality. O'Neil (2009) found not only "splitting" but also dissociation in terms of division inaccurate; he argues for the use of "dissociative multiplicity."

There was, and still is, a confusion of tongues with regard to the concepts used to denote the subsystems of the personality that are dissociated from each other. Breuer and Freud (1893) originally used "abnormal states of conscious," which they brought together under the term "hypnoid." The language chosen in this chapter reflects the view that dissociation pertains to a division of the personality among different subsystems, all with their own sense of self, or first-person perspective (cf. Nijenhuis and Van der Hart, 2011). In modern parlance, authors use concepts such as "(alter) personalities," "ego states," "identity or personality states," "dissociative parts of the personality"; with psychoanalytically-oriented therapists preferring dissociated "self-states." It is unclear to what degree these concepts refer to self-aware dissociative subsystems.

Another problem is that dissociative patients in their daily functioning are understood as being normal in the sense of not being dissociative, and that only their hypnoid states are abnormal. Janet (1889) observed that this is not always true: He found that some hysterical patients functioned much better in these somnambulistic states than in their daily-life functioning. A helpful basic distinction that the theory of structural dissociation of the personality makes is that between dissociative parts of the personality functioning in daily life and dissociative parts involved in the re-enactment of traumatic experiences (Van der Hart *et al*., 2006), the former parts being phobic of the latter parts and their traumatic memories.

Finally, there is an important but often overlooked corollary to the notion of the dissociation of the personality as formulated by Janet and current students of dissociation: When one's personality is divided in different subsystems, then all these subsystems are dissociated from each other, that is, all of them are dissociative in nature. Thus, the notion of the person having certain dissociated self-states split off from the remainder of the self might incorrectly imply that the main part of the dissociative person, as he or she ordinarily functions in daily life, is *not* dissociative.

Conclusion

Although the scope of Janet's studies had become increasingly wide over the years, one of his last publications testifies that all his life he valued the phenomenon of the dissociation of the personality:

> These divisions of the personality offer us a good example of dissociation which can be formed in the mind when the laboriously constructed syntheses are destroyed. The personal unity, identity, and initiative are not primitive characteristics of psychological life. They are incomplete results acquired with difficulty after long work, and they remain very fragile.
>
> (Janet, 1946, p. 146)

Note

1 It is commonly understood today that not all cases of hysteria (the modern diagnostic categories that all involve a dissociation of the patient's personality) are caused by early sexual trauma. However, there is increasing regret among psychoanalysts that Freud abandoned his dissociation theory (e.g., Bromberg, 1998; Howell, 2005, 2011; O'Neil, 2009).

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Chapter 5

The Ferenczi paradox

His importance in understanding dissociation and the dissociation of his importance in psychoanalysis[1]

Margaret L. Hainer

> BEING ALONE leads to splitting. The presence of someone with whom one can share and communicate joy and sorrow (love and understanding) can HEAL the trauma. Personality is reassembled *"healed"* (like glue).
> (Ferenczi, 1988, pp. 200–201, emphasis original)

There is a paradox at the center of the story of Sándor Ferenczi, revolving around the importance of his contribution to psychoanalysis and trauma studies and his disappearance as a credited influence in these fields. For many years, Ferenczi, a Hungarian psychoanalyst, clinician and theoretician, was Freud's heir apparent, well known and well respected, both in Europe and the United States. And yet, he was virtually eliminated from the history of psychoanalysis and trauma studies.

The key to Ferenczi's disappearance is his understanding of dissociation. Although mentioned by many, dissociation does not become the focus of attention or the organizing principle it deserves to be. It is the phenomenon of dissociation as a response to trauma that is so vividly described and so passionately grappled with in the *Clinical Diary* (CD; Ferenczi, 1988). The psychoanalytic literature focuses on Ferenczi's experiments in *technique* to deal with the problem of dissociation, or on one aspect of his contribution, such as the importance of the mother and the early years, but somehow the issue of *dissociation itself* gets lost or minimized. Few discussions of Ferenczi's work highlight the fact that his later writings are eloquently and obviously about the far end of the dissociation spectrum: about dissociative identity disorder (DID) and depersonalization/derealization. Instead there is an emphasis on methodology/technique and the process of therapy as well as the *reality*—not fantasy—of childhood trauma (Aron, 1996; Haynal, 2002; Rachman, 1997; Rudnytsky *et al*., 1996). This misses how he revealed a dissociative model of the mind, a description of the mental processes of response to violence and trauma. What is discussed is relevant and crucial, but what is not examined is fundamental.

It is no accident that Ferenczi's seminal contribution in his later years focused on dissociation. The paradigm of dissociation, and its appreciation in psychoanalytic theory, contains a similar paradox to that of the legacy of Ferenczi. Dissociation is at its essence about both forgetting and remembering. It has the feeling of: "I can't remember and I can't *not* remember."

This centrality of dissociation explains why Ferenczi was disappeared and continues to be undervalued and under-read, despite the fact that he has been "rediscovered" for over twenty-five years. Although he is acclaimed in certain circles for being a forerunner in a two-person-system psychology with an emphasis on mutuality (Aron, 1996; Aron and Harris, 1993), it is his emphasis on the *pervasiveness* of childhood abuse, with resultant dissociative disorders including what we now call DID, which still seems dangerous to discuss. Psychoanalysts remain afraid of being sidelined, ridiculed, or disappeared like Ferenczi, when we hold in focus extreme human reactions to an extremely violent world. This is especially true when it is stories of interpersonal or intrafamilial violence we are being asked to listen to.

The paradox of knowing and not knowing is inherent in the difficulty of the actual material that is dissociated. Because it is so hard to look at, it becomes easier to look away. Although currently in the United States there is a greater acknowledgment of sexual abuse (after more than a decade of scandals in various social, religious, academic, athletic, military, political, and corporate organizations) and trauma in general (especially post 9/11 in psychoanalytic circles), it is possible that this knowledge will once again be forgotten, as the cycle described by Judith Herman (1992) of remembering and forgetting revolves again.

In a beautiful fragment from Ferenczi:

> Traumatogenesis being *known*; the doubt, whether reality or fantasy, remains or can return (even though everything points at reality). Fantasy theory = an escape of *realization* (amongst resisting analysts too). They rather accept their . . . mind (memory) as unreliable than believe that such things with *those* kind of persons can *really* have happened. (Self-sacrifice of one's own mind's *integrity* in order to save the parents!)
>
> (1955/2002, p. 268, emphasis original)

Thus, to solve the paradox of the legacy of Ferenczi, we must understand the paradox of the dissociative experience and the compulsion to repeat. We must remember his unique contribution in order to re-associate Ferenczi into the history of psychoanalysis. And, thus, in turn help us to heal the splits caused by trauma.

Remembering Ferenczi's legacy

The first step in solving this paradox is to remember Ferenczi's importance in the history of psychoanalysis. At the time of his death, Clara Thompson said

Sándor Ferenczi was "the greatest of Freud's pupils . . . not only because of his remarkable intellect, imagination, and unquenchable scientific curiosity, but also because of his profound simplicity, humility, and gentle human kindliness" (1964a, p. 65). Freud himself appeared to go one better, saying in his 1933 obituary of Ferenczi: "His works have made all analysts into his pupils," and ironically went on to say: "It is impossible to believe that the history of our science will ever forget him" (1933, p. 299). (Freud, however, was referring only to Ferenczi's work before 1927, having repudiated his later work (Freud, 1933, p. 299; Masson, 1992, pp. 180–184).) In fact, it was said that if Freud was the father of psychoanalysis, Ferenczi was the mother (Hoffer, 1991, p. 466; Rentoul, 2010, pp. 55ff.).

This frequently cited comment suggests a variety of things: that Ferenczi was a co-parent with Freud, developing work collaboratively, at least until the early 1920s; that Ferenczi shifted from the paternal stance of classical analysis when he introduced the "relaxation" method, which he described as maternal, kind, patient, supportive, loving; Ferenczi was emphasizing the importance of the first five years of life when the mother is crucial, as opposed to Freud's emphasis on the later Oedipal period, which stresses conflict with the father; Ferenczi's belief that the infant is in a "primary object love" relationship with the mother, as opposed to Freud's concept of primary narcissism; and Ferenczi's emphasis on the emotional, the collaborative, the relationship, the "anti-rational" is in some sense "feminine" (as opposed to the "science" of Freud), which is connected to the dangers inherent in speaking about sexual abuse and a willingness to explore dissociative experience.

Over a period of twenty-five years, Ferenczi became Freud's companion, confidant, co-theorist, analysand, and voluminous correspondent. He had an enormous influence on his generation of analysts and those who followed,[2] including Michael Balint, Melanie Klein, Clara Thompson, Margaret Mahler, Harry Stack Sullivan, John Bowlby, and Erich Fromm; his impact was particularly transferred through a clinical, oral tradition whether as analyst, teacher, or supervisor (Thompson, 1964b, pp. 74–75). He founded the Budapest school of psychoanalysis and was its president for life. He was elected the first president of the IPA, was the first university professor of psychoanalysis, and offered the first training analysis (Aron and Harris, 1993, p. 1). He introduced many theoretical concepts that were later elaborated by or credited to others (Dupont's "Introduction" in Falzeder *et al.*, 2000, p. xxxix; Rachman, 1997), e.g., Winnicott's "transitional object" (Gedo, cited in Aron and Harris, 1993, p. 131; Ferenczi, 1955/2002, p. 67) and Anna Freud's "internalization of the aggressor"[3] (for fuller exposition, see Frankel, 2002; Howell, 2014), and anticipated many developments that are truly contemporary or still controversial, as will be discussed below.

Freud encouraged Ferenczi to collaborate with Otto Rank on a book entitled *The Development of Psychoanalysis* (Ferenczi and Rank, 1923/2012). Here he introduced his "active" method, which was his first

attempt to modify the passive and withholding stance of the analyst by actively intervening when free associations dry up "to help over dead points in the work of the analysis" (Grubrich-Simitis, 1986, p. 261). The book was also critical of the overemphasis on the *intellectual* reconstruction of childhood and the lack of the *emotional* experience of the transference. In general it highlighted the critical importance of the *interpersonal* nature of the clinical exchange, in itself a radical departure from the classical position.

Crucial later writings

From 1927 on, Ferenczi slowly elaborated his divergence from Freud and classical theory. Five papers, plus the *Clinical Diary* and *Notes and Fragments*, comprise the most original and controversial contributions of Ferenczi (Dupont, 1988, p. 250), which are briefly summarized below (all page references are from *Final Contributions to the Problems and Methods of Psycho-analysi*s, see Ferenczi, 1955/2002). Ferenczi wrote in the language of his day, while at the same time struggling to describe clinical phenomena that had not yet been articulated. He descriptively captured the clinical experience, sometimes using the term "splitting" to be synonymous with dissociation. However, he had a wider net for dissociation, sometimes describing knowing something cognitively, but without emotions; sometimes describing feeling something intensely physically, but without thoughts. When he spoke of regression he was describing dissociative states: switches in self-states, trances, and the feeling like he was actually *with* a young child, as opposed to regression suggesting an indulgence or slipping back into younger behavior or childlike thinking. He was observing his patients to see what really goes on, without imposing a theoretical construct upon them. He painted a very vivid and broad picture of dissociative experience, without always invoking the term.

The Elasticity of Psycho-Analytic Technique (1928)

Ferenczi adopted the concept of elasticity from a patient's idea: "The analyst, like an elastic band, must yield to the patient's pull, but without ceasing to pull in his own direction, so long as one position or the other has not been conclusively demonstrated to be untenable" (p. 95). Technique depends on the analyst's "tact," explained as the analyst's capacity for "empathy, self-observation, and making judgements" (p. 96), combined with respectful suggestions, willingness to admit mistakes, frankness and honesty, and patience.

The Unwelcome Child and His Death Instinct (1929)

Ferenczi emphasizes the long-term effects of neonatal experience, the reality of traumatic injury over the role of fantasy, and the mind/body connection.

As he said: "The child has to be induced, by means of an immense expenditure of love, tenderness, and care, to forgive his parents for having brought him into the world without any intention on his part" (p. 105), but if children instead come as "unwelcome guests of the family" (p. 104) they will manifest unconscious, self-destructive physical and psychic symptoms, including suicidality; they need to be treated indulgently by the analyst—at least at the beginning of therapy—so they can "for the first time, enjoy the irresponsibility of childhood" (p. 106).

The Principles of Relaxation and Neocatharsis (1930)

Here Ferenczi was taking an audacious step that challenged Freud and the orthodoxy. Grounding himself in his clinical work with severe cases, he argued for the analyst's technique to combine *the principle of indulgence* side by side with that of *frustration* (p. 118). Relaxation in the patient produced an "astonishing" newly minted form of catharsis:

> hysterical symptoms would suddenly make their appearance . . . often with subsequent amnesia . . . the reconstructed past had much more of a feeling of *reality and concreteness* about it than heretofore, approximated much more closely to an actual *recollection* . . . I was able to . . . receive important information about dissociated parts of the personality.
>
> (pp. 118–119, emphasis original)

He prefigured later exposition in "The Confusion of Tongues" of the "long neglected traumatogenesis" of adult suffering (p. 122):

> *The first reaction to a shock seems to be always a transitory psychosis*, i.e. . . . *a psychotic splitting off* of a part of the personality. The dissociated part, however, lives on hidden, ceaselessly endeavoring to make itself felt, without finding any outlet except in neurotic symptoms.
>
> (p. 121, emphasis original)

Starting from this period, much of what he wrote about was multiple self-states, DID, depersonalization, derealization, or what he later referred to as "*extreme fragmentation*, which could be called *dematerialization*" (p. 220, emphasis mine).

Child Analysis in the Analysis of Adults (1931)

Ferenczi talked about true "relaxation," when enough trust is established with the analyst, so that the child self-state can safely emerge and reenact the conflicts of the past.

Ferenczi described a "kind of hysterical 'twilight' state" (p. 130), which took

> a quasi-hallucinatory form . . . a trance state . . . we might say that in analysis it is not legitimate to suggest or hypnotize things *into* the patient, but it is not only right, but advisable, to suggest them *out*.
>
> (p. 134, emphasis original)

He described the splitting of

> the self into a suffering, brutally destroyed part, and a part which . . . knows everything but feels nothing . . . [This is] the genesis of the narcissistic split of the self . . . under the stress of imminent danger, part of the self splits off and becomes a psychic instance self-observing and desiring to help the self, and that possibly this happens in early—even the earliest—childhood.
>
> (pp. 135–136)

This dissociation forced Ferenczi to articulate a new way of working: "Tactful and calming words, reinforced perhaps by an encouraging pressure of the hand, or . . . a friendly stroking of the patient's head," helped to bring the patient back to his adult state, where the experience of repetition of childhood states can be understood with tenderness and sincerity, using the analyst's position of power "in a means of educating them to greater independence and courage" (p. 134).

The Confusion of Tongues Between Adults and the Child: The Language of Tenderness and Passion (1933)

This magnificent, historic paper contains compelling ideas about the failure of classical technique with the most dissociated patients, asserting that it actually re-traumatized them. He argued for a newly formulated stance for the analyst as patient, authentic, maternal. He made bold assertions about the prevalence of childhood sexual and physical abuse, while he detailed the emotional and psychological process poignantly drawn from the child's vantage point. He described the reasons children react the way they do to sexual abuse, which included what he was the first to name as the "identification with the aggressor." He explained how the child's playful need for "passive object love"—otherwise, he says, known as "tenderness"—is confused by the adult to be understood as passionate, mature sexuality that violently overwhelms and fragments the child:

> When the child recovers from such an attack, he feels enormously confused, in fact, split—innocent and culpable at the same time—and

> his confidence in the testimony of his own senses is broken . . . If the shocks increase in number during the development of the child, the *number* and the *various kinds of splits in the personality increase too,* and soon it becomes *extremely difficult to maintain contact without confusion with all the fragments each of which behaves as a separate personality* and yet *does not know of even the existence of the others.*
>
> (pp. 162–165, emphasis mine)

This is a clear and concise description of the etiology and experience of being multiple.

Essentially it was Ferenczi's argument that childhood sexual and physical abuse is widespread and real that led both Freud and Jones to declare Ferenczi to be suffering from "*pseudologia phantastica*" (defined as the invention of experiences that are just fairy tales) or "paranoia" (Masson, 1992, pp. 180–181, quoting correspondence between Freud and Jones). Ferenczi's paper was the culmination of the split between himself and Freud.

The Clinical Diary (1931) and Notes and Fragments (1932), both published posthumously

Ferenczi, in the last year of his life, kept a clinical diary, a form of self-analysis, which documented his clinical experiments with severely wounded and difficult clients. His most famous experiment was "mutual analysis," that he tried with only several patients and after several months decided was not viable in its most radical version, although he continued to believe that to some extent every analysis must be mutual (CD, p. 213). The diary and notes were not meant for publication; although the details are fascinating, as are his ruminations about himself and Freud, they are fragmented, incomplete, and open to interpretation (Frankel, 1998).[4]

But it is Ferenczi's struggle to articulate the clinically astute and experience-near quality of his understanding of dissociation—with the implications for both sides of the analytic dyad—that animates the clinical dialogue. From every angle, he is deconstructing the analytic exchange: the "hypocrisy" of the analyst's remoteness; the positive use of countertransference; the need for gentle, non-erotic touch, patience and kindness, but also honesty; and the expression of negative feelings from both the analysand and the analyst. Ferenczi was driven by an intense desire to alleviate his patient's suffering (what Freud critically called his *furor sanandi,* "rage to cure," (Rudnytsky *et al.*, 1996, p. 174), without colleagues to share his formulations and/or to challenge his excesses.

Because of the nature of the material, it is difficult to summarize, but I offer a few examples to illustrate my argument.

Ferenczi stayed in silence for more than ten minutes, as an experiment, with a patient who had occasionally told him to shut up and who was

having alarming physical symptoms, in tremendous confusion, and immeasurable rage, but didn't know why. Finally Ferenczi commented:

> we can only assume that impressions of the *external world* are being retained and reproduced in the unconscious . . . *one must assume that whatever you do not want to feel, know of, or remember is far worse than the symptoms you escape into.*
>
> (CD, p. 30, emphasis mine)

He describes what happens when a child is mistreated:

> "the child comes to *be beside itself"* . . . this "being gone" is not necessarily a state of "not-being," but rather one of "not-being-here." . . . [b]eing outside time and space, of "omniscience," of being able to see and act at a great distance, and all this in a shifting and incoherent succession of images, hallucinations.
>
> (CD, p. 32, emphasis original)

Another example:

> a child is the victim of overwhelming aggression, someone who has "given up the ghost" [i.e., died] . . . survives this "death" physically and with a part of his energy begins to live again; he even succeeds in reestablishing unity with the pretraumatic personality . . . But this amnesic piece is actually a part of the person, who still is "dead" or exists permanently in the agony of anxiety. The task of the analysis is to remove this split.
>
> (CD, p. 39)

Ferenczi compassionately, but cautiously and not overly optimistically, persuaded the split-off fragment that it is not dead and must begin to live again and that the patient must gradually mobilize his own will to reunify the self.

Ferenczi's final years

From the late 1920s to early 1930s, Ferenczi was developing, with his patients as collaborators, theories about dissociation and the centrality of the interpersonal relationship to recovery and healing, which became his legacy (e.g., Aron, 1996, p. 170; Haynal, 2002).

As the "analyst of last resort," working with "unanalyzable" patients, he intellectually understood the importance of traumatic reality in the etiology of psychological dysfunction, but he also clinically experienced the extent of his patients' dissociation as both their protection and liability. And he was

treading on that dangerous terrain of advocating for survivors of childhood sexual, physical, and emotional abuse.

In 1932, Ferenczi traveled to Vienna, on his way to Germany, to share with Freud "The Confusion of Tongues," which Ferenczi was to present at the IPA. Freud asked Ferenczi to withhold the paper, which he strongly disapproved of. Ferenczi felt badly rejected, but he delivered it anyway and continued to develop his ideas in his *Clinical Diary*.

Ferenczi was fully coming into his own, while his body was giving way and the world was collapsing. The perfect storm was developing, which drastically and tragically culminated in his long-term disappearance. He simultaneously was alienated from and rejected by Freud; he was debilitated with what was too late diagnosed as pernicious anemia; he was exhausted by his clinical experiments; and Europe was being overrun by fascism, which was disastrous for the psychoanalytic movement made up of intellectuals, Jews, leftists, and dissidents. Despite their rift, Ferenczi urgently appealed to Freud to get out of Vienna after the Reichstag Fire in 1933, which Jones cited as further evidence of Ferenczi's panicky, pathological state (Jones, 1957, p. 177). Ironically, it was Jones who, barely in time, went to rescue Freud from Vienna in 1938 (Rachman, 1997, p. 115).

The contradictions between Ferenczi and Freud exploded in "an appalling familial and institutional tragedy, riven with Oedipal disappointments . . . and fratricidal battles" (Aron and Harris, 2010, p. 6), while psychoanalysis itself was under attack and analysts were worrying about their livelihoods or trying to arrange for safe passage out of danger. Only a few were left to defend Ferenczi.

It was largely on the basis of "The Confusion of Tongues"—now considered his most famous, acclaimed paper—that Ernest Jones (1933) in his obituary called Ferenczi "psychotic" and that Michael Balint (1949), his literary executor, either protectively or defensively, feared that conditions weren't ripe for publication of Ferenczi's last works (Aron and Harris, 2010, pp. 13–14; Balint, 1958). Jones created a mythology of Ferenczi's deranged mind—despite reliable eyewitness reports of Ferenczi's mental stability until the end—which was not sufficiently challenged by his supporters (Balint, 1949; Thompson, 1964a; Dupont, 1988). Jones perpetuated the fabrication of Ferenczi's mental decline in his widely influential biography of Freud (Jones, 1957). But, as Dupont accurately argued, the best defense of Ferenczi's mental acuity in his last years was his writings from that period (Dupont's "Introduction" in Ferenczi, 1988).

Multi-determined reasons why Ferenczi was disappeared

Why was Ferenczi so abruptly disparaged and discarded? Why was Ferenczi the target of a destructive acrimony of major psychoanalysts and ultimately

essentially abandonment by Freud? Why had he been written out of the historical memory?

The answer is, in part, that Ferenczi was from the beginning a "dissident analyst." Before Ferenczi had met Freud, he primarily worked with the poor, prostitutes, homosexuals, transvestites, and the "unanalyzable." As early as 1902, he said that homosexuality was not a disease, but a "psychic disposition." By the 1920s he was overtly characterized as "the *enfant terrible* of psychoanalysis" (Dupont in Ferenczi, 1988, p. xix).

Ferenczi himself in some ways clouded his contribution with constant deference to Freud and equally constant need of approval from him, minimizing his own originality (Thompson, 1964b, ch. 9). Add to that the dislocations and decimations of war-torn Europe, and the dramatic dispersal of the psychoanalytic community through emigration—which occurred in a period of reaction, particularly in the United States (Jacoby, 1983). Together, these are some of the causes of Ferenczi's disappearance.

Nonetheless, the overriding reason for Ferenczi's disappearance was the controversial nature of his last writings: the development of a dissociated model of the mind and a different clinical approach that were far in advance of his time—so much so that the works that were held as evidence of his craziness are the very ones that are now seen as prescient, contemporary, and powerful.

Many of his later writings were actively suppressed, not translated, not disseminated, not published, or they were sheltered from view for so long that later generations were unaware of his existence or his prominence. Some of the many influenced by Ferenczi claimed his ideas as their own, further elaborating them without crediting Ferenczi, or disassociated themselves from him so as not to be stigmatized by the mythology of his pathology.

And as a consequence, not only was the messenger killed, but so was the message: trauma was split off from psychoanalysis and buried for many years. The trauma field started to emerge again, at least in the United States, in part as a result of PTSD among Vietnam veterans and the women's movement struggle against rape and domestic violence; yet an articulation of trauma and dissociation was largely alienated and separate from psychoanalysis.

Ferenczi's partial rediscovery

Beginning with the French (1985) then English (1988) translation of Ferenczi's *Clinical Diary* was a revival of interest in Ferenczi's impact on the development of psychoanalysis. There are eloquent and sophisticated discussions of Ferenczi's legacy, which both credit and critique his concepts and his practice (Aron and Harris, 2010; Frankel, 1998; Haynal, 2002; Rachman, 1997; Rentoul, 2010). Aron and Harris (1993), among others,

focus on the experiments Ferenczi made with "mutual analysis," passed down to us in contemporary interpersonal, relational, and intersubjective theories. His radical approach—his openness to his patient's symptoms as communication of their early experience, his ability to hear patients' criticisms of him, his willingness to acknowledge mistakes and the limits of therapeutic action—all are now appreciated by many contemporary psychoanalysts. They are the hallmarks of the Ferenczi revival.

However, Ferenczi's developing understanding of dissociation and his formulation of how to work with the far end of the continuum are not adequately discussed. Extreme dissociation scares people because it reveals the extent of violence in our world—on the social and political levels and on the personal and interpersonal as well—and requires a great deal from the therapist willing to face that violence with a dissociated client. The coherence of his emerging formulations about the mechanisms of dissociation has been dissociated from the question of mutuality, a two-person psychology, or other important areas of exploration, while in some circles Ferenczi continued to be maligned as crazy or extreme or injudicious or problematic, or he was simply ignored.

The need for a re-association of Ferenczi's insights on dissociation

Why Ferenczi remains marginalized is a result of dissociation being underappreciated because it forces us to acknowledge the consequences of the worldwide epidemic of violence and abuse. Thus we have not integrated an understanding of dissociation as the basic organization of the mind and as a creative response to overwhelming and chronic terror. Ferenczi's powerful clinical descriptions lead to a recognition of the reality of DID, which is much more common than most clinicians are willing to believe (ISSTD, 2011, p. 117).

There are still political risks involved. There remains a legacy of fear from the False Memory Syndrome Foundation's attacks—especially severe and effective in the United States in the 1990s—on therapists who spoke out about parental abuse, modern-day equivalents of the attacks on Ferenczi. There has been a chilling effect on therapists who recognize and work with dissociative disorders, especially DID, and who are also stigmatized, like Ferenczi, as being crazy or naive or dangerous.

As psychoanalysts, we have to heal the split in our own theory and history. It is important to reclaim, reiterate, reassure because knowing what Ferenczi was advocating is still hard to hold onto in face of a culture and a historical legacy that both wants and doesn't want to know. Our failure to understand the dissociative paradox of simultaneously remembering and not remembering, is reflected in our inability to remember and integrate Ferenczi's legacy and contribution. The splitting off of Ferenczi from the

psychoanalytic canon is emblematic of the splitting off of psychoanalysis from the field of trauma and from the prevalence and effects of unspeakable acts of violence and abuse.

Notes

1 I was not alone in formulating the thoughts and sentences for this chapter. My heartfelt thanks go to the editors, Elizabeth F. Howell and Sheldon Itzkowitz, as well as Gabriel Hainer Evansohn, Alex Tarnopolsky, Susan Gutwill, Tina Weishaus, and Karen Hopenwasser, without whom none of this would have come together.

2 Additional analysts that Ferenczi influenced: Judith Dupont, Margaret Little, D.W. Winnicott, Harry Guntrip, Paula Heimann, John Rickman, Wilfred Bion, Ronald Fairbairn, Therese Benedek, Franz Alexander, Sandor Lorand, Sandor Rado, Jacques Lacan, Georg Groddeck, Heinz Kohut, Heinrich Racker, and the Budapest school, including Imre Hermann and Vilna Kovacs.

3 Anna Freud adopted and then narrowed Ferenczi's original concept to simply mean becoming like the aggressor, while Ferenczi explained that part of the child—because of enormous anxiety—automatically identifies acutely with the aggressor, so that the aggressor becomes intra-psychic, accompanied by the feelings of guilt and shame.

4 Jay Frankel has pulled together Ferenczi's thoughts about trauma and dissociation from his writings and correspondence, in effect articulating a trauma theory that Ferenczi never had the chance to write. But he limits Ferenczi's view to the trauma victim's inner object world, while I would extend it to a vivid articulation of DID and depersonalization.

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Part 2

Psychoanalytic orientations and the treatment of complex trauma, dissociation, and dissociative disorders

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Chapter 6

Models of dissociation in Freud's work

Outcomes of dissociation of trauma in theory and practice

Elizabeth F. Howell

Even after he stopped using the word "dissociation," Freud did not stop writing about it.

Freud's formulations opened up huge new vistas of understanding of human motivations and defenses; even his own, for example, sexist conclusions about the inferiority of women's morality and ego development can be understood as projection (Howell, 1981; Lewis, 1981; Stolorow and Atwood, 1979). However, his eventual prioritization of incestuous fantasies over incestuous realities caused harm to many patients who were sexually abused and then had to deal with the double trauma of first being abused and, second, of not being believed.

Freud's oeuvre on diverse topics has sometimes resulted in contextomy by authors in an effort to support their own views. The positions he took about various matters often changed, and a quote from one part of his life may be contradicted by a different citation from a different period—or, if taken out of context, even in the same paragraph. In addition, the varying slants produced by his various biographers and other commentators on his life and work present astoundingly different pictures of the man and what he meant by what he wrote at different times.

Yet, a thorough examination of his trauma/dissociation theories has been hindered by a postmortem polarization between doctrines retained by many of his followers and his detractors. After his death, the need of his followers to preserve his work in the face of possible fragmentation of the movement was intensified (Fliegel, 1973). Equally important was the effect of the Holocaust on the surviving analysts, especially those who had immigrated to the USA and had a special need to preserve their identification with Freud (Kuriloff, 2013; Prince, 2009; see Chapter 1 for a more thorough discussion of this matter). "For almost thirty years after his death little was published that was not in agreement with his formulations" (Howell, 1981, p. 7). One of the things this meant was that the "pre-analytic" period of his work was largely overlooked, if not *verboten*, for a long time.

The birth of psychoanalysis in Freud's "pre-analytic" period: Dissociation models 1 and 2

In the following few pages I describe an updated and shortened version of the four models of dissociation present in Freud's work that I identified in my book, *The Dissociative Mind*. It is credible to say that the birth of psychoanalysis sprang from Breuer and Freud's brilliant 1893–1895 work in *Studies on Hysteria*. Despite having been written almost a century and a quarter ago, "The Preliminary Communication" (1893), which is the first part of the volume, reads like the best of modern trauma/dissociation theories. Linking psychological trauma, dissociation, and hysteria, the authors compared the memory of the trauma to a "foreign body which long after its entry must continue to be regarded as an agent still at work" (p. 6). They noted that symptoms disappeared when the memory and its affect could be discharged (abreacted) and/or expressed in words—the cures of abreaction and remembrance. The hysterical symptoms corresponded to traumatic memories that had remained unhealed either by subsequent benign experiences or by sufficient discharge (abreaction). "It may therefore be said that the ideas which have become pathological have persisted with such freshness and affective strength because they have been denied the normal wearing-away processes by means of abreaction and reproduction in states of uninhibited association" (Breuer and Freud, 1893–1895, p. 11). When the "strangulated affect" (p. 17) of the idea that could not be abreacted "can find its way out through speech" (ibid.), it can be associated with normal consciousness, and the symptom recedes.

Breuer and Freud stated, "The basis and the *sine qua non* of hysteria is the existence of hypnoid states" (p. 12). These "hypnoid states" have in common with hypnosis an intense ideation that is cut off from association with the rest of consciousness. They comprise a "more or less highly organized rudiment of a second consciousness, *a condition seconde*" (p. 15). Thus, hypnoid states and second consciousness represent the first Freudian model of dissociation. Here Breuer and Freud, in a way that is strikingly similar to Janet's (1889) thinking, are describing what I understand as the Dissociation 1: how one *becomes* more than one, or many.

The most illustrative patient in this volume is the famous Anna O. who most likely had dissociative identity disorder (DID). The study of her symptoms influenced Breuer and Freud's thinking. In his theoretical section of *Studies on Hysteria,* Breuer notes the frequent amnesias and alternation between the hypnoid and the normal states, and how restriction of the hysterical symptoms to the hypnoid state strengthens it by repetition and protects it from correction by the waking state.

Dissociation 2: One makes two

However, Breuer and Freud described *two* groups of conditions in which associative working-over fails to occur. One depended on the psychological

state in which the patient had the experiences in question—for example, fright or autohypnotic reverie and daydreaming. The other group had to do with

> the kind of memories, such as loss, unrelieved shame, or other situations the patient wished to forget or because social circumstances made a reaction impossible or because it was a question of things which the patient wished to forget, *and therefore intentionally repressed from his conscious thought and inhibited and suppressed.*
>
> (p. 10, emphasis mine)

This is repression or the second model of dissociation

While in both groups there is a "splitting of consciousness," the dissociative processes in them are distinct. In the first group (Dissociation 1) the associative working-over fails to occur "because there is no extensive associative connection between the normal state of consciousness and the pathological ones in which the ideas made their appearance" (p. 11). In the other group it fails to occur because the patients are "determined to forget the distressing experiences" (Breuer and Freud, 1893–1895, p. 11). I conceptualize this as how "one makes two." Despite his earlier endorsement, in the "Preliminary Communication," in his own theoretical section *of Studies on Hysteria,* Freud states that he has never seen a case of hypnoid hysteria: They have all turned into defense hysteria. By this Freud means that the division of consciousness has been brought about by active resistance to some upsetting idea, not by hypnoid states. Here the divide between Dissociation 1 and Dissociation 2 first occurs. Even though Dissociation 1 predominates in the "Preliminary Communication," Dissociation 2, or repression, is there also. It is described in such phrases as "the patient wished to forget," "intentionally repressed from his conscious thought and inhibited and suppressed." It should be noted here that repression is a subcategory of dissociation. Both serve to divide conscious from unconscious—i.e., dissociation, but repression refers to a particular kind of dissociation (Erdelyi, 1990, 1994; Putnam, 1997). While Dissociation 1 is differentiated in terms of psychological state, and its mechanism is non-agentic, Dissociation 2 is defensive, highly active, and refers to contents, not mental states.

The seduction theory

One year after *Studies on Hysteria* (1893–1895) came Freud's passionate exposition of what has been called "The Seduction Theory," most notably described in "Aetiology of Hysteria" which detailed the pathogenic effects of child sexual abuse, and how these led to the symptoms of hysteria. This essay had in common with *Studies* the assumption that real events in the child's life are the primary source of the traumas. In "Aetiology of

Hysteria," Freud stated that he had found the cause of hysteria: It was childhood sexual abuse.

He felt so strongly about this discovery that he called it *the caput Nili* (source of the Nile) of neuropathology. He had discovered that in all of eighteen cases of hysteria, two of them corroborated, that there were "one or more occurrences of premature sexual experience" (1896, p. 203), which had been pushed out of awareness as incompatible ideas. Symptoms emerged as a result of current reminders of the earlier sexual experiences—for example, hearing an off-color remark. "Sexual experiences in childhood consisting in stimulation of the genitals, coitus-like acts, and so on must therefore be recognized, in the last analysis, as being the traumas which lead to a hysterical reaction to events at puberty and the development of hysterical symptoms" (pp. 206–207). The hysterical symptoms "can be traced to a *psychical conflict* arising through an incompatible idea setting in action a defense on the part of the ego and calling up a demand for repression" (pp. 210–211).

This thrusts the incompatible idea into the unconscious and the hysterical symptom takes its place. Freud underscores that stimulation of the genitals and coitus-like acts in childhood must be understood as traumas. He also notes that behaviors springing from these initial causes might seem odd when one does not understand their source, but they cease seeming so, once one does understand. Freud was passionate in his expression of the horror of what happens to little children who are abused:

> For the idea of these infantile sexual scenes is very repellent to the feelings of a sexually normal individual; they include all the abuses known to debauched and impotent persons, among whom the buccal cavity and the rectum are misused for sexual purposes . . . on the one hand, the adult who is armed with complete authority and the right to punish, and can exchange one role for the other to the uninhibited satisfaction of his moods, and on the other hand, the child, who in his helplessness is at the mercy of this arbitrary will, who is prematurely aroused to every kind of sensibility . . . all these grotesque and yet tragic consequences reveal themselves as stamped upon the later development of the individual and of his neurosis, in countless permanent effects which deserve to be traced in the greatest detail.
>
> (1896, pp. 214–225)

Freud's changes of heart and mind

So what happened? How did we get from the exogamous trauma of sexual abuse or other traumatic occurrences to the emphasis on Oedipal phantasy? Freud's early expositions (1893–1895/1896) of the powerful effect of real interpersonal trauma and the ensuing dissociation changed; soon, fantasy

replaced reality for him as the primary route of pathogenesis. *I must emphasize here that the substitution of fantasy for memory does not change the type of dissociation, i.e., repression or Dissociation 2, in operation.* In both cases part of experience, whether it is a memory or a wish, is no longer accessible. Conscious and unconscious are separated, dissociated, albeit via repression.

Despite his 1896 certainty, Freud's views of the child's predominant dilemma appeared to have changed significantly in a brief period of time (Masson, 1984; Gay, 1988; Kupersmid, 1993; Tabin, 1993; Davies and Frawley, 1994; Brothers, 1995; Breger, 2000). Within about 17 months he proposed a new theory, one of infantile sexuality, in which sexual and Oedipal wishes were repressed and accounted for the symptoms of hysteria. In the intervening time his father died (an event that he reported "tore him up by the roots" (Mahl, 1985) and his self-analysis led him to his Oedipal theory. By October 1897, he reported to his friend Fliess that the Oedipal relationship of the child to its parents was a "general event in early childhood" (Gay, 1988, p. 100).

Much has been made over the issue of *the extent* to which Freud continued to acknowledge that child sexual abuse does occur and is pathogenic. The pronouncement in Jeffrey Masson's (1984) book, *The Assault on Truth*—that Freud abandoned the Seduction Theory out of cowardice owing to his feeling that he had been abandoned by his peers as a consequence of confronting them with the "truth" of the frequency of sexual abuse and betrayal—became a popular refrain. But this treatise had its faults, and led to vigorous objections on the part of some Freudian theorists (e.g. Blum, 2008; Hanly, 1986). These writers have noted that Masson's message conveyed the false impression that Freud *completely* renounced his earlier observation that seduction (or sexual abuse) of young children occurs and that its results are pathogenic. For example, in "Three essays on the theory of sexuality," Freud wrote, regarding the sexual activity of young children,

> great and lasting importance attaches at this period to the accidental *external* [Freud's emphasis] contingencies. In the foreground we find the effects of seduction, which treats a child as a sexual object . . .
>
> An influence of this kind may originate either from adults or from other children. I cannot admit that in my paper on 'The Aetiology of Hysteria' (1896c) I exaggerated the frequency or importance of that influence, though I did not then know that persons who remain normal may have had the same experiences in their childhood, and though I consequently overrated the importance of seduction in comparison with the factors of sexual constitution and development. Obviously seduction is not required in order to arouse a child's sexual life.
>
> (1905, pp. 190–191)

Again in "Further remarks on the neuro-psychoses of defense" (1894), a footnote added by Freud in 1924 speaks to his recognition that real seductions do occur: Even though he believed at that time that he had been mistaken earlier to conclude that all neuroses are caused by sexual seductions, that does not mean that none are:

> This section is dominated by an error which I have since repeatedly acknowledged and corrected. At that time [1896] I was not yet able to distinguish between my patients' phantasies about their childhood years and their real recollections. As a result, I attributed to the aetiological factor of seduction a significance and universality which it does not possess . . . Nevertheless, we need not reject everything written in the text above. Seduction retains a certain aetiological importance, and even today I think some of these psychological comments are to the point.
> (1894, p. 168)

Tracing the trajectory of Freud's arguments about this is quite a maze. In "Aetiology" in 1896, he said that he had reconstructed his patients' memories by tracing associations backward according to Breuer's method. In later papers, the perpetrator changed from adults to older siblings, and later he stated that his patients had told him that they were abused, and that he had foolishly believed them (Ahbel-Rappe, 2006).

Finally, regarding his claim that Freud fled his seduction theory out of social fear, Masson does correctly quote Freud's feeling that his theory had been rejected, for he wrote to Fliess saying, "the donkeys gave it an icy reception." The aforesaid feeling may have been contradicted by the evidence. According to Ellenberger (1970), "This theory was seen by some, such as Krafft-Ebing, with benevolent skepticism, by others such as Lowenfeld with interest, but in the literature of that time no expression of hostility is to be found" (p. 490). Sulloway (1979) agrees, and also notes that *Studies on Hysteria* was greeted with "the highest praise and respect" (p. 81): "Bleuler, for instance, judged the Studies to be one of the more significant publications of the last few years; while Janet wrote, 'I am happy to see that the results of my already old findings have been recently confirmed by two German authors, Breuer and Freud'"(ibid.).

Freud gave four reasons for his change of mind about the seduction theory. Additional reasons concerning Freud's personal conflicts have been suggested by a number of other writers (Ahbel-Rappe, 2006; Blum, 2008; Breger, 2000; Brothers, 1995; Kupersmid, 1993; Peskin, 2012; Tabin, 1993). However, the main theoretical issue that concerns how we think and how we practice is that of the distinction between fantasy and reality, as well as their interaction. I will return to this topic below, but will note again now, the importance of avoiding polarization. It does not have to be "either/or" and most likely is not.

Dissociation model 3: Split between the ego and the superego

A third model of dissociation concerns the separation of the superego from the ego. In a series of publications, Freud gradually develops his construct of the superego. In *Mourning and Melancholia* (1917) Freud describes the separation of parts of the ego, which then war against each other. In contrast to normal mourning, the melancholic castigates himself mercilessly—not for himself, but on account of an ambivalently loved other. In identification with the abandoned object,

> the shadow of the object fell upon the ego, so that the latter could henceforth be criticized . . . like the forsaken object. In this way . . . the conflict between the ego and the loved person is transformed into a *cleavage between* the criticizing faculty of the ego and the ego as altered by the identification.
>
> (1917, p. 249, italics added)

As a result, "in spite of the conflict with the loved person, the love-relationship need not be given up" (1917, p. 249). A few years later, in *Group Psychology and the Analysis of the Ego* (1921), he develops these ideas further:

> these melancholias . . . *show us the ego divided, fallen apart into two pieces,* one of which rages against the second. This second piece . . . has been altered by introjection and . . . contains the lost object. But the piece, which behaves so cruelly . . . comprises the conscience, a critical agency within the ego, which even in normal times takes up a critical attitude toward the ego, though never so relentlessly and so unjustifiably . . . some such agency develops in our ego which may cut itself off from the rest of the ego and come into conflict with it. We have called it the "ego ideal."
>
> (1921, p. 52, italics added)

In order to preserve the "love relationship," the ego has divided against itself. In *Ego and the Id* (1923) Freud adds that the child replaces Oedipally related incestuous and parenticidal feelings with identification:

> The broad general outcome of the sexual phase dominated by the Oedipus complex may, therefore, be taken to be the forming of a precipitate in the ego, consisting of these two [the parents] identifications in some way united with each other. This modification of the ego retains its special position; it confronts the other contents of the ego as an ego ideal or super-ego.
>
> (1923, p. 34)

Thus, "The ego ideal is therefore the heir to the Oedipus complex" (p. 54).

Cameron and Rychlak's (1985) observation that "ego" and "superego" are dissociated is especially evident in the case of harsh, or archaic superego, which may often describe more a relationship of dissociated parts of the personality (the "sadistic" superego and the "masochistic" ego), than mature ego-development or mature morality. Castration threat, which Freud (1925) felt made the boy's superego superior to the girl's, is potentially traumatic. Taken literally, castration threat brings up the terror of dismemberment and deprivation of masculinity and can be understood as potentiating of dissociation. In my view, the harsh archaic superego is best understood as a dissociated structure.

Dissociation model 4: Splitting of the ego

In this model, a part of the ego itself is split off, rather than divided and raging against itself. The two parts exist side by side, without contradiction. In his 1927 paper, "Fetishism," Freud describes a process of disavowal involving fetishism, saying that "the fetish is a substitute for the woman's (the mother's) penis that the little boy once believed in and—for reasons familiar to us—does not want to give up" (pp. 152–153). The piece of reality that the boy did not want to give up has been disavowed by the ego in a way that is similar to the disavowal of castration by fetishists.

In "Splitting of the Ego in the Process of Defense," Freud (1938) observes that the boy's belief that the female has a penis, exists side by side with his knowledge that she does not.

There is no resolution or integration of these two sets of contradictory views (which may have developed in response to frightening thoughts) of reality. In this unfinished paper, while using the word "splitting," Freud is talking about structural dissociation.

Dissociative and traumatic roots in Freud's reconstruction of the myth of Oedipus

Ironically, Freud's most famous myth is itself framed in themes of child abuse and infanticide. Freud's Oedipus story left out the horrifying beginning, which had to do with infanticide and pederasty (Devereux, 1953; Fromm, 1980; Ross, 1982). Freud focused on the part of the story about the tragic hero who marries his mother. Prior to his ascension to the throne, Oedipus's biological father, King Laius, had received a curse for the crime of abducting and raping the teenage son of a neighboring king. The curse was that Laius's own son would murder him and marry Laius's wife, his mother. To avoid the curse, Laius instructed that his infant son be abandoned to die with a stake pierced through his ankles (hence the name "Oedipus" meaning "swollen foot"). Despite his father's efforts to have him

murdered, Oedipus was rescued and brought up as the son of a neighboring king. He left home to avoid the curse (Ross, 1982), but met his fate anyway when he quarreled with and slew another traveler, who, unbeknownst to him, was Laius, his real father. Interestingly, Freud only focused on the tragic adult struggles as if their meanings could be segregated from earlier history. But in ignoring the beginning of the myth he was dissociating infanticide and pederasty!

Trauma, dissociation, reality and fantasy

I have shown how, even without using the word "dissociation" very much after 1895, Freud used the concept in different ways throughout his work. The consequences of his departure from explicit dissociation theory as well as the seduction theory are enormous. If Freud had been able to see how dissociation is also used defensively, (O'Neill, 2009) and in conjunction with repression (Dell, 2009), who knows what other kind of magnificent structure he might have built?

Freud chose to build his edifice on the cornerstone of repression (Dissociation model 2), which is an agentic defense. Dissociation, which connotes greater helplessness, was largely left by the wayside.

Likewise, what has been lost by Freud's departure from the seduction theory? It is not just that too many people who were abused as children have been disbelieved and perhaps regarded as "crazy," which is bad enough. The polarized controversy and blame regarding the seduction theory may have made it harder to think about it, to appreciate the tragic effects of traumatic abuse on Oedipal longings and wishes (Ahbel-Rappe, 2006; Boulanger, 2012): "When the terrible is true, not only are we not safe, but we can no longer imagine" (Howell, 2005, p. 248). Freud's *Dora* (1905) is a case in point. The backstory of Freud's analysis of Dora was that Dora's father was having an affair with Frau K, and the expectation was that Dora, a 13–15 year old child, was to be pimped to Herr K to keep his complicity. Dora was very upset when Herr K propositioned her, and her report of the incident to her parents resulted not only in disbelief, but their view that she was unstable (Decker, 1998). Freud's interpretations to her that she felt sexually aroused may have been correct, but that was beside the point: The child needs to be protected. And as Peskin (2012) notes, she needed a witness, something that Freud was unable to provide. Feeling doubly betrayed, Dora left treatment. (I have heard the story repeated more than once by teachers, teaching analysts, or students or friends of those analysts, with no regard for confidentiality, that Dora was "bitter" and "disagreeable." If true, no wonder.)

The case of Dora set a model for ignoring reality. The very important question of the differentiation of what is real from what is fantasy becomes obscured by the inability to notice or know what has been dissociated. Like slips of the tongue (Hilgard, 1977), the traumatic memories of seduction are

just as likely, if not more likely, to be dissociated as repressed, since they are elicited or "triggered" by current reminders. For in those circumstances in which a child's fears and fantasies become reality, when the terrible is true, when fears and fantasies are made real they are not fantasies anymore. As a result of traumatic abuse, terrified, rageful, sexual, and longing/loving self-states become dissociated from a person's consciousness. What is left is, to varying degrees, an outside shell of a person who manages life's tasks in a fairly depersonalized way. Oedipal longings and wishes do not get a chance to develop and flower.

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Chapter 7

Jung and dissociation

Complexes, dreams, and the mythopoetic psyche

Donald E. Kalsched

Contemporary trauma and dissociation theory has issued in a whole new paradigm in psychotherapy—one that recognizes the exquisite sensitiveness of the human person to relational trauma across the life-span (Schore, 2012). This new paradigm is organized around one central and overriding realization/discovery, namely, that *as human beings we are simply not equipped, in many cases, to experience all of our experience consciously*. However, we *are* equipped to manage this unfortunate limitation with exquisitely sophisticated defenses that help us escape from the unbearable experience by dissociating it—then banishing it to an *unconscious* part of the psyche/soma where it is sequestered until such time as it can be accessed again and *returned* to us. C.G. Jung was at the forefront of these discoveries, although his contributions have rarely been recognized. This short chapter is an effort to access some of the Jungian ideas sequestered in the "unconscious" of our field and return them to the conversation unfolding in the pages of this book. I will be linking Jung's early writings on dissociation with affective neuroscience (Schore, 1994, 2003a, 2003b, 2012) and with relational understanding of trauma and dissociation so well described by Bromberg (1998, 2006, 2011).

The human psyche as an intermediate phenomenon

It is a fascinating historical fact that the discovery of severe dissociation was historically coincident with the discovery of the psyche-in-depth. At the end of the nineteenth century almost all mental illnesses were explained as either diseases of the brain or in "spiritualistic" terms as possession by demonic entities. Yet when these divided or possessed patients were hypnotized and told their secret stories, their symptoms sometimes disappeared (or could be reproduced) and their demons vanished (Ellenberger, 1970). It became clear that the "lesion" was not in the brain, nor was the "possession" a literal spiritual invasion. The lesion or invasion seemed to be happening, in another medium—i.e., neither in the spirit nor in the body—but in an *intermediate*

reality that came to be known as the human *psyche* or *soul*. Moreover, this new realm, intermediate between the worlds of spirit and matter, seemed to be both the location of consciousness (ego) and to have a mysterious depth dimension (now identified as a sub-conscious or un-conscious aspect).

The question then became "What was causing the lesion in the psyche (or the invasion of its integrity)" and "through what mechanisms were separate parts of the personality kept isolated from one another and from ego-consciousness?" Pierre Janet (1907) was the first to answer this question in a way that illuminates modern dissociation theory. Sigmund Freud, in collaboration with Breuer (1893), was the second, and Carl Jung (1902) was the third. They concluded it was unbearable affect caused by some *trauma* that was causing the lesion in the psyche (Freud later abandoned this idea in favor of sexual fantasy), and they described the mechanism that kept separate parts of the personality out of consciousness as *dissociation* (Freud later abandoned dissociation in favor of repression). They all prescribed a form of psychotherapy that had to do with the recovery of traumatic memories, the abreaction of split-off affect associated with these memories, and the gradual undoing of dissociation through the process of psychotherapy.

Jung, however, went further than his predecessors in two important respects: (1) he emphasized that it was only in the relationship with the doctor that dissociation could be fully healed; and (2) he discovered that dissociated parts of personal experience have a universal tendency to image themselves in dreams and other fantasy material as coherent animate presences that he called *complexes*. In other words, he discovered the mythopoetic basis of the psyche—its tendency to automatically personify its *affects* in the form of recognizable *images* and to link these images together with stories. Every complex for Jung constitutes an "affect-image" (Perry, 1976) or, alternatively, the "image of a personified affect" (Jung, 1926). Complexes constitute the "people" of our dreams, the "voices" in our heads, the imps and gremlins that abscond with our thoughts, the visionary figures that appear at times of stress, the alternative personalities of severe dissociation (DID), and finally the demons, ghosts and spirits that haunt or hallow the so-called primitive mind. The psyche, for Jung, is multiple, but *this multiplicity is more than multiple "self-states"* (Bromberg, 1998, 2006). It constitutes a symbolic *inner world* and its "part-personalities" have their basis in affect, image, and story. This emphasis on the inner world carries important implications for our work with dissociation in the clinical setting, as I will try to demonstrate with a clinical example below.

Jung and the discovery of the "complex"

In December 1900, when Jung took up his post as assistant psychiatrist at the Burgholzli Mental Hospital in Zurich, he was confronted by a psychiatry without the psyche (Jung, 1963). The field of scientific psychiatry was

obsessed with diagnosis and the prevailing etiological assumptions involved organic causes. Delusions, hallucinations, and other symptoms of mental disease were detailed, labeled, and classified, and then the rudimentary physical treatments of the day were applied. But Jung wanted to know the deeper personal story underneath the surface description of "hysteria" or "dementia praecox." He suspected that there must be an intelligible human drama behind the bizarre delusions and hallucinations of the insane, but he needed techniques to get at this material, which was no longer apparent in the incoherent babblings of his patients.

While Freud was experimenting with "free association" in Vienna, Jung seized upon another form of association—a simple test-procedure previously used by Wundt, called the Word Association Test. The test involved giving a series of emotionally valenced stimulus words to his subjects who responded immediately with an associated single word. Jung's goal was to differentiate typical patterns of association in normal vs. abnormal subjects (Jung, 1904). Surprisingly, he found that even in normal subjects, the expected pattern of association and behavior was disturbed by the intrusion of otherwise invisible *psychological* factors. Jung was excited by this surprising discovery. Like Janet and Charcot before him, he was discovering the reality of the psyche as an *intrusion* into his subjects' lives from a seemingly foreign territory where it was being sequestered somehow:

> It has long been recognized in experimental psychology . . . that a particular experimental procedure does not apprehend the psychic process directly, but that a certain psychic condition interpolates itself between it and the experiment . . . this psychic "situation" can sometimes jeopardize the whole experiment by *assimilating* not only the experimental procedure but the purpose underlying it . . . what the method was aiming at, namely to establish the average speed of the reactions and their qualities, was a relatively subsidiary result compared with the way in which the method was disturbed by the autonomous behaviour of the psyche, that is, by assimilation. It was then that I discovered the feeling-toned complexes, which had always been registered before as *failures to react.*
>
> (Jung, 1934)

Jung used the word "constellation" for the activation of a complex and found that subjects might be constellated many times during a particular experiment if certain stimulus words happened to "hit" an inner complex, leading to prolonged reaction time, gaps or failures of memory, clang associations and other "complex indicators." For several years, Jung pursued his research with the Word Association Test and, because complexes seemed to be constellated by strong dissociated *affect*, he added a galvanometer as

well as a pneumograph to study subjects' skin conductance and respiratory rates as they associated to stimulus words (Jung, 1907a).

The role of emotion and the body in complex-formation was central to Jung's understanding, and because contemporary dissociation theory and developmental neuroscience also emphasizes the constellating power of bodily based affect (Schore, 2012) or "vehement emotion" (Van der Hart, 2006; Howell, 2005) for trauma-related pathology, it is worth mentioning Jung's emphasis on emotion and the body.

"The essential basis of our personality," Jung insisted, "is affectivity" (Jung, 1907b). As the central organizing principle of psychic life, affects link together otherwise discrepant components of the mind (sensations, ideas, memories, judgments) by lending each of them a common "feeling-tone." Moreover, our ego-complex—the center of our consciousness and the richest in associations—is supported by the somatic innervations that *come from the feeling-tone of our own body* and its sensations.

If we undergo a traumatic experience, Jung suggested, the affect of fear floods the psyche/soma and this brings about bodily changes, including changes in the autonomic nervous system:

> Through the fright, countless body sensations become altered, and in turn alter most of the sensations on which the normal ego is based. Consequently the normal ego loses its attention-tone . . . It is compelled to give way to the other, stronger sensations connected with the new complex, yet normally it is not completely submerged but remains behind as an "affect ego" . . . strong affects always leave behind very large complexes.
>
> (1907b, paras 86–87)

Given this understanding, it is easy to see why Jung employed the galvanometer and pneumograph in order to measure emotional disturbances in the body and hence the constellating power of the complex. His work with these experimental procedures proved to be extremely effective in identifying what Janet had called *subconscious fixed ideas* in his subjects. In modern parlance, they tapped dissociated affects encoded in the right hemisphere as "implicit procedural memories" (Schore) or "somatoform symptoms" (Howell 2005; Van der Hart, 2006).

Complexes in the relational field

Jung was especially interested in how the association experiment reproduced the psychic situation of a dialogue between two people, while at the same time it opened up the unspoken background-affects that were not apparent on the surface. The implications of his analysis for a relational understanding of dissociation are interesting:

> What happens in the association test also happens in every discussion between two people. In both cases there is an experimental situation which constellates complexes that assimilate the topic discussed or the situation as a whole, including the parties concerned. The discussion loses its objective character and its real purpose, since the constellated complexes frustrate the intentions of the speakers.
>
> (Jung, 1934)

Jung's comment seems to me an early relational understanding of how dissociation works in the bi-personal field, and—although the emphasis is different—his ideas are reminiscent of Bromberg's description of how he attunes himself clinically:

> I imagine the mind as comprising relationally interlocking stage sets [on which different actors appear and then leave] . . . I pay special attention to the dissociative gaps in subjective reality that are created because of unannounced changes in cast . . . The very moment of change, the moment when the "switch" in cast takes place, is the moment when a dissociative gap is created. This is the moment when "reality blinks" and the moment of the blink is not available to reflective thought.
>
> (Bromberg, 2006)

The "blink," for Bromberg, is a dissociative gap—in Jung's language the intrusion of a complex into the "normal" flow of associative conversation.

If complexes are apparent in relational dialogue, then by implication, they can be integrated relationally also, and perhaps uniquely so. Here is one place where Jung is remarkably "modern" in his emphasis on how important the relationship with the doctor is in the healing of trauma-induced dissociation. In his 1921 paper *The Therapeutic Value of Abreaction* he discusses the treatment of war-trauma and suggests that abreaction of the traumatic memory is not enough:

> the mere rehearsal of the experience does not itself possess a curative effect: *the experience must be rehearsed in the presence of the doctor* . . . that is to say [in the presence of] his human interest and personal devotion . . .
>
> The healing effect comes from the doctor's efforts to enter into the psyche of his patient, thus establishing a psychologically adapted relationship. For the patient is suffering precisely from the absence of such a relationship . . . the transference is the patient's attempt to get into psychological rapport with the doctor. He needs this relationship if he is to overcome the dissociation. And the curative value of therapy does not depend solely on the discharge of affective tensions; it depends far more on whether or not the dissociation is successfully resolved.
>
> (Jung, 1921)

We cannot credit Jung here with the same relational understanding of dissociation and its treatment that Schore's (1994, 2007) understanding of "right brain-to-right brain" communication or Bromberg's (2006) "enactment and repair" process have brought into recent clinical focus. But throughout his work Jung showed a deep sympathy for the intersubjective emotional field between patient and analyst, which he compared to a chemical reaction between two substances in which both are changed (Jung, 1946). "The doctor," said Jung, "must go to the limits of his subjective possibilities, otherwise the patient will be unable to follow suit" (ibid., p. 400).

Complexes and the untold story

When Jung investigated the human events that seemed to lie behind the complexes, he was invariably led to traumatic circumstances in his patients' lives. But these traumas and their resulting complexes, were not all the same. Some appeared to result from psychological wounds suffered by a coherent ego—often in later childhood or adulthood. Jung called these *personal* complexes. Memories of the painful events causing personal complexes could be recovered, while other more severe complexes appeared to derive from earlier and deeper injuries-—possibly from early childhood or even infancy—injuries that could not be remembered and perhaps had never been conscious before. Personal complexes seemed to have a secret, yet coherent *personal* story, discernible in the Word Association Test and in dreams but kept out of consciousness by dissociation. But the more severe complexes, which Jung called *collective* complexes (Jung, 1928), were more extreme in their affective charge and in their autonomy, often resulting in possession by "demons" or legions of demons, and in the replacement of the ego with a separate personality or several separate personalities.

These complexes, Jung speculated, may have been formed in early infancy or young childhood—when there was not yet a coherent ego—and hence no coherent story that could be recovered. In a neglected or violent childhood, Jung surmised, there must be experiences that are so terrifying, and that so fragment the child's psyche, that nothing is recoverable as narrative memory. Jung felt that at such moments the nucleus of a complex can be laid down and that this nuclear element then grows by accretion around the armature of archaic and typical (archetypal) affects and images. The resulting "memories" are quasi-hallucinatory dramas which may appear as powerful stereotypical scenarios—mythopoetic narratives such as alien abductions, ritual abuse, satanic cults, persecutory delusions or false memories (Hedges, 2000). Such images and affects are *collective*, not personal. They have an alienating and disorganizing effect upon the conscious ego and can lead to serious forms of dissociative psychopathology. In contrast to personal complexes, their content has never been conscious before.

Complexes personified in dreams

As Jung began to investigate his own dreams and those of his patients, he realized that personal complexes have a natural tendency to personify themselves in the unconscious, thus becoming the "little people" of our dreams and fantasies (Jung, 1934), each with a fragment of consciousness, feeling, intention and perhaps even a "subtle body" capable of creating psychosomatic symptoms (Jung 1937). The idea that complexes represent splinter psyches—personified beings—each with their own rudimentary subjectivity (Jung, 1934) constitutes a unique contribution to our understanding of psychic dissociation in general and dreams in particular.

That the psyche should be capable of taking mental events, associations, affects and scraps of experience—then fashioning them into psychic "presences" (including animals and other beasts) so that our experience of the inner world is *personal*—this is perhaps more remarkable than we realize. It suggests that *personification* is a fundamental activity that is going on all the time in the unconscious and that our "inner objects" are not only internalized from the outer world (as some object-relations theorists suggest) but are equally *creations* of an inner dream-maker who writes the scripts of our dreams and peoples their stories with psychic presences representing the different parts of us in personified—sometimes *mythologized*—form. This discovery led to Jung's technique of working with dream and fantasy-products on the "subjective" level of interpretation:

> The whole dream-work is essentially subjective, and a dream is a theatre in which the dreamer is himself the scene, the player, the prompter, the producer, the author, the public, and the critic . . . This simple truth forms the basis of what I have called interpretation on the subjective level . . . all the figures in the dream are personified features of the dreamer's own personality.
>
> (1916, p. 509)

In the following example of an important clinical moment, we see how a classic "inferiority complex" gets personified in a dream and how this part-personality—now vividly evident to myself and the patient—helped in the negotiations around what Bromberg (2006, 2011) calls an "enactment" of mutual dissociation.

The case of "Barry"

Barry consulted me as a 22-year-old gay man, charming and talented in business but inwardly depressed and filled with anxiety in personal relationships. A surface story of entertaining bravado covered over painful inferiority feelings suffered as the effeminate brother of his very athletic

older brother—a high school football star and his father's favorite. A sensitive young boy, Barry had been profoundly hurt by his sarcastic and brutal father who kidded him mercilessly about his "klutsy" ways and his effeminate body, leaving him with deep feelings of inadequacy and shame. These painful feelings could not be entertained consciously. They were simply too painful and were dissociated. They formed the core of what might be called his "inferiority complex."

We had worked for over a year individually, and three months in group, when the following incident occurred. Individual work was going well, whereas in the group Barry adopted a charming persona, often distinguishing himself as "junior therapist," offering trenchant but annoying interpretations to the other members—risking nothing of his own vulnerability, and frequently glancing sideways in my direction, seeking approval. I grew increasingly uneasy with this collusive "alliance" with my therapeutic "son" in this group-family.

During one session, group members were sharing stories about their "difficult fathers." I noticed Barry's glazed-over eyes as he stared conspicuously around the room, apparently bored. Recalling stories about his father from individual therapy, I asked if there was anything he wanted to share. He went blank for a moment, then said something dismissive about my question and sarcastic about the group for wasting its time on such trivial matters. Members of the group challenged him and "forced" him to say something about his personal life—which he did with great resistance—and, to my surprise, with some breakthrough of genuine feeling. He left group clearly upset. That night he had the following dream, which he reported to me in his next individual session:

> I'm in a swimming pool and you are the lifeguard sitting on a tower. You suddenly yell "buddies" and I know this means I have to find my buddy and hold up our hands together. I'm horrified as I try to do this because my "buddy" is an emaciated boy—like a concentration camp victim, starved and disease-ridden—disgusting! Finally I touch the boy, then hold our hands up together. Then I jump out of the pool and rage at you for making me do this.

This is a classic example of an unconscious complex personified in a dream. The self-state of "inferiority feelings" was out-pictured in the dream as an emaciated, neglected boy who showed all the signs of having been judged "inferior," then locked up (dissociated) in a concentration camp and starved. This "boy" was not familiar to the dreamer consciously, i.e., was not a personal acquaintance of his. He was a symbol—a "construction"—of the psyche whose "meaning" emerged only in Barry's associations and reactions to him in the dream, and later in the *enactment* that followed.

Barry "knew" his dream was commenting on the prior night's group experience. He was no less angry with me when he presented the dream, than he had been at the lifeguard (myself) in his dream. In fact he was fuming with rage. For Barry, the dream constituted "proof" of what I had "done to him," betraying his confidence. He felt this was "unconscionable" and threatened to leave therapy, possibly pursuing ethics charges.

I was shaken by this explosion and Barry was shaking with anger—obviously a moment of great urgency between us. Fortunately we had a lot of "money in the bank," in the rapport we'd developed. He knew I was fond of him, and that I hadn't intended to hurt him. My emotional struggle, which I did not hide, was clear; I was honestly sorry for my blunder. He also sensed my genuine curiosity about his dream and how it might help us understand what we had just played out together. Here was a clear "enactment" on my part of unconscious irritation at him for his posturing and defensiveness in the group. By asking him to share painful memories of his father, I had clearly pushed him, possibly too soon, into his "inferior" split-off part-personality with all its "disgusting" aspects. On the other hand, the complex was now unfrozen and his own private story was being enacted between us, with me carrying his hurt feelings, feeling like a failure as his therapist, while he raged at me like his father had raged at him—a relational out-picturing of the two poles of his previously split-off complex or self-state—his self-care system (Kalsched, 1996, 2013).

There followed a long process of repair and negotiation between us. As we processed our "moment of meeting" (Stern, 2004) the dream proved to be extremely helpful to both of us because it gave us a dramatic picture of "our story" together. In particular it gave me an image of his hurt, neglected, and abandoned self. The rage that protected it was, for the first time, directed outside the "system" in a protest against "insensitivity" (mine, his father's, and finally, his own). In our mutual attention to this injury, he witnessed my own vulnerability and honest struggle with guilt and remorse for having inadvertently re-injured him, despite my "good intentions."

We realized I had repeated in the group what his father had done to him, humiliated him publicly—something that understandably hurt and enraged him. However this time his angry protest was fully voiced and registered, and after it had been expressed Barry was slowly able to get closer to his heretofore unbearable pain—to the neglected boy in himself in need of acceptance and integration. The fact that I was cast in his dream as the "lifeguard"—an image that even he could see as a positive—helped him in working through his anger. It also helped us to see that "buddies!" is what lifeguards *do* in order to keep track of all the swimmers in a pool or lake, i.e., to insure that no one gets lost under water—i.e., dissociated in unconsciousness. Even in his fulminating rage, Barry could see that the poolside ritual of *safety and integration* might be in his own best interest, and that the lifeguard in his dream was not only myself, but a caretaker part

of him that somehow stood for integration and had his potential wholeness in mind. He didn't know he had this mysterious inner resource.

This example illustrates many of the features of what I have called the self-care system as it operates relationally in the reciprocal "volleys" of projection and counter-projection (victim/perpetrator, imperfect child/perfectionist parent, etc.) that occur in dyadic interaction. It also demonstrates that what is broken relationally, must be repaired relationally, i.e., not with interpretation and insight (left brain) but with genuine heart-to-heart meetings (right brain to right brain communication). As Schore so aptly puts it:

> In order to maintain a holding environment during moments when an inter-subjective field is dynamically generating an increasing density of negative affect, the clinician needs to resist, at an implicit level, a homeostatic impulse to counterregulate a state of right brain psychobiological disequilibrium by shifting into a left hemispheric dominant state.
>
> (Schore, 2003b)

This meant my staying with the unsettling feelings that were evoked in me and staying with them long enough to explore them, both within myself and with Barry—without interpreting. As Bromberg reminds us, "An interpretive stance by the analyst not only is . . . useless during an enactment, but also escalates the enactment and rigidifies the use of dissociation" (2006). Somehow I was able to avoid this. And having the dream as an intermediate "transitional object" in the otherwise rapidly closing space between us was helpful in this process. It kept me connected to my right hemisphere.

My experience with Barry reminded me once again how easy it is to be catapulted out of psychic reality (and the right hemisphere) into the space of literal enactment or interpretive abstraction. It re-impressed me how dissociation creates an *inner world* of unconscious "presences" that help us understand what is at stake during episodes of defensive projective identification such as the one Barry and I lived through to a new outcome. These "presences" make a difference in our being able to "see" what parts of the self are being dissociated.

Finally, the case illustrates how "standing in the spaces" of dissociated self-states (Bromberg, 1998) is sometimes a much stormier affair than we read about in the literature. It suggests how much of the energy of dissociation is aggression—leading to perilous moments of intense anxiety and emotional stress that must be metabolized by the therapeutic partners. When Jung (1946) said that the transference was like a chemical reaction between two substances in which both parties are changed he didn't mention that if those two substances have been kept apart by dissociation for years—perhaps decades—their coming together again can be explosive—like sulphuric acid and water! One must proceed carefully. And there are risks. But then as Jung

(1946, p. 400) often said, quoting an old alchemical treatise, "*Ars requirit totum hominem*"—the art requires the whole man.

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Chapter 8

"A queer kind of truth"

Winnicott and the uses of dissociation

Dodi Goldman

A forgotten file marked, "DWW's Notes for the Vienna Congress—never given" was recently rediscovered in the Winnicott archives in London. It contained Winnicott's handwritten preparation for an IPA Congress panel scheduled for the summer of 1971. Although Winnicott had booked a room at a hotel in Vienna, this was a Congress he was destined not to attend. He died on January 25th of that year.

The significance of these notes is that they constitute Winnicott's final word on therapeutic matters close to his heart. They open with the words: "I am asking for a kind of revolution in our work. Let us re-examine what we do" (Abram, 2012, p. 461). "Revolution" is a word uncharacteristic of Winnicott. While he spent his life innovating and extending existing theory, he believed originality is only possible on the basis of tradition. But at the same time, Winnicott recognized that "mature adults bring vitality to that which is ancient, old and orthodox by re-creating it after destroying it" (Winnicott, 1960a: 94).

At the very end of his life, Winnicott was poised once again to *destroy, re-create and thereby bring psychoanalysis to life* by placing his ideas about dissociation front and center. The Notes for the Vienna Congress continue:

> It may be that in dealing with the repressed unconscious we are colluding with the patient and the established defences. What is needed of us, because the patient cannot do the work by self-analysis; someone must see and witness the parts that go to make the whole, a whole that does not exist except as viewed from outside. In time we may have to come to the conclusion that the common failure of many excellent analyses has to do with the patient's dissociation hidden in material that is clearly related to repression taking place as a defence in a seemingly whole person.
>
> (Quoted in Abram, 2012, pp. 312–313)

One can hear Winnicott's plea as an attempt to more fully integrate into psychoanalytic theory a view of dissociation that had always been important

to him. Despite operating within an *espoused* theory privileging repression as an explanatory construct, *in practice* Winnicott demonstrates a keen awareness of dissociation—both as a healthy natural capacity and as a defensive response to trauma. For Winnicott, *it makes a vast difference how and in what context dissociation is used*.

As a *natural capacity*, dissociation may be employed to allow playful or artistic absorption—a focused tapering of attention that necessarily narrows the phenomenal field. One reason Winnicott valorizes both artistic immersion and playing is the opportunities they provide for healthy "voluntary" use of dissociation. The artist risks entering dissociated states dreading he may either fail in his endeavor and remain "haunted" by presences clamoring for expression or else succeed and remain stuck in the altered dissociated state. Similarly, in the precariousness of playing, one need not be fully integrated. There is room to be safely surprised by the unexpected so long as there is no premature disruption of the "real"/"not real" double bookkeeping by which playing is contained within its own illusory space. For Winnicott, *health includes a relative freedom from needing to prematurely integrate*.

As a *response to trauma*, however, dissociative processes may be triggered fleetingly or harden with deadening effect into a structured disposition as a defense against unmanageable arousal. It remains an open question in a given case whether this use of dissociation is brought about by the overpowering *effect* of emotions occasioned by a traumatic event or as a *defense against* those emotions. Whichever the case, unlike repression, dissociation does not simply restrict access to potentially threatening feelings, thoughts and memories. Instead, it is akin to a "quasi-death," an obliteration of the self to whom trauma might reoccur.

In the course of development, Winnicott suggests, dissociation as a natural capacity precedes repression as a defense. Indeed, unlinked dissociated states are at the root of all self experience. "Dissociation," he writes, "can usefully be studied in its initial or natural forms." For example,

> there are the quiet and the excited states. I think an infant cannot be said to be aware at the start that while feeling this and that in his cot or enjoying the skin stimulations of bathing, he is the same as himself screaming for immediate satisfaction, possessed by an urge to get at and destroy something unless satisfied by milk.
>
> (Winnicott, 1945, p. 151)

Rather than focusing on the active separation of conflictual repressed mental contents, Winnicott's description of a normal dissociative process places in the foreground how the infant cannot yet be aware of how "*he is the same*" across disparate states of mind. The excited self is not yet linked to the quiet self. Similarly, in describing a child dreaming, Winnicott contends that:

> there is not necessarily an integration between a child asleep and a child awake. This integration comes in the course of time. Once dreams are remembered and even conveyed somehow to a third person, the dissociation is broken down a little . . . It is a valuable experience whenever a dream is both dreamed and remembered, precisely because of the breakdown of dissociation that this represents. However complex such a dissociation may be in child or adult, the fact remains that it can start in the natural alternation of the sleeping and awake states, dating from birth.
>
> (1945, p. 151)

Notice that according to Winnicott what holds the potential for bridging the dissociative gap—in both the child and adult—is the telling of the dream to a *third* person. It is the affectively safe relationship with an engaged other that facilitates the linking of naturally unlinked dissociated selves and with it—as dream and awake states enrich each other—the possibility of being more fully alive.

Earlier in the same article, Winnicott notes that,

> there are long stretches of time in a normal infant's life in which a baby does not mind whether he is many bits or one whole being, or whether he lives in his mother's face or in his own body, provided that from time to time he comes together and feels something.
>
> (1945, p. 150)

At the root of earliest self-experience, Winnicott suggests, is an unintegrated state that periodically gels into dissociated self-states or partial integrations. The infant is free to drift about as there is not yet any built-up version of a self or hardened way of representing "me" and "not-me." What makes the pulses of drifting and gelling life-enhancing as opposed to terrorizing is the tether of maternal holding and handling (Winnicott, 1962, p. 59). Mother's love and enjoyment as expressed through physical care allow natural dissociative states to be entered into, shifted out of, and gradually integrated such that the infant comes to feel that his body is himself and that his sense of self is centered inside his body.

In the absence of adequate care, however, the child's affect states become too discontinuous. An alive drifting and gelling is replaced by arousal, alarm and abyss. The breakdown of holding and early object relating means that *the child cannot move seamlessly between dissociated states without a disruptive loss in the continuity of being.*

For Winnicott, the self is formed and found through "desultory formless functioning" (1971, p. 64)—recursive unplanned flow from unintegration through dissociation to relative integrations (and back again). But for this creative coming together (and unwinding) of the self to occur

non-traumatically, a particular environment is necessary. "It is only here," writes Winnicott:

> in this unintegrated state of the personality, that that which we describe as creative can appear. This if reflected back, *but only if reflected back*, becomes part of the organized individual personality, and eventually this in summation makes the individual to be, to be found; and eventually enables himself or herself to postulate the existence of the self.
>
> (1971, p. 64, italics in original)

Repeatedly created anew, a Self—the inclusive symbolization of one's own being—follows from the meeting up of the imaginative freedom of the psyche with an environment safe enough to allow the individual to be surprised without being shocked by what comes unbidden from within. Pathology, from this point of view, results from a dissociative disconnect between a person's imaginative and adaptive capacities, a failure to weave oneself with the world (Goldman, 2012).

Winnicott's description of "ego distortion" in terms of "True" and "False" Self is a way of theorizing about the dissociative process in which the "center of gravity of being" transfers from "the kernel" to the "shell" (1952, p. 99). He is clear that false self functioning originates in the "infant-to-mother living" and *not* in the "early mechanisms of ego defence organized against id-impulse" (1960b, p. 144). Indeed, for Winnicott, instinct life itself might be experienced more dissociatively than through the derivatives of repression. As he puts it: "The instincts can be as much external as can a clap of thunder or a hit" (1960b, p. 141). The question that concerns him is how the True Self, or 'sensori-motor aliveness" is at risk for becoming dissociatively split off for adaptational purposes.

A close reading of the text suggests three potentially distinguishable "False Selves": a "shielding false self" whose function is to act as a stimulus barrier, a "defence against that which is unthinkable, the exploitation of the True Self, which would result in its annihilation" (1960b, p. 147); a "split-off compliant false self" charged with gaining the awards of compliance at the expense of personal expression or growth (1960, p. 150); and a "compensatory false self" that takes the form of a "caretaker self" compensating for deficiencies in environmental care (1960b, p. 142). Whether one prefers to conceptualize these varied constellations as structural entities or as transient processes, what they hold in common is a depleted presence, a shallowness of being, an impaired capacity to allow full-bodied meaning to be created. In short, a dissociative strategy designed to ensure that nothing new, unpredictable, and alive ever happens.

The link between dissociation and pathology is also central to Winnicott's distinction between "mind" and psyche-soma. In health, as mother reliably shields her baby from undue "complications beyond those which the infant

can understand and allow for" (1949, p. 245), the outcome is a smooth "*interrelating* of the psyche with the soma" (1949, p. 244). In ill health, failures of the environment produce an "over-activity of the mental functioning" (1949, p. 246). In such a case, there can develop what Winnicott calls "an opposition between the mind and the psyche-soma" such that the "thinking of the individual *begins to take over* and organize the caring for the psyche-soma" (1949, p. 246).

To be clear: the "opposition" between mind and psyche-soma is not to be mistaken for "splitting" or internal conflict. Winnicott's focus is not on repressed symbolized content but rather, on a dissociative disconnect whereby the "mind" ends up functioning somewhat autonomously from the center of self to protect from potential traumatization.

Two clinical examples illustrate Winnicott's sensitivity to the evidence of dissociation that often appears as enacted but unsayable in words. With luck and patience, Winnicott hopes the delicate play between therapist and patient might allow a bridging of unhealthy dissociative gaps.

In the paper "Dreaming, Fantasying, and Living," Winnicott describes a middle-aged woman who gradually discovers "the extent to which fantasying or something of the nature of daydreaming has disturbed her whole life" (1971, pp. 26–37). Dreaming and real living are, he contends, "of the same order" while fantasying is of "another order." Dreams "fit into object-relating in the real world and living in the real world fits into the dream world." By contrast, "fantasying remains an isolated phenomenon, absorbing energy but not contributing-in either to dreaming or to living." That is why dreams and living can contribute to growth while fantasying can "remain static over the whole of [a patient's] life." These two orders of mental life are further distinguished by the fact that whereas "a great deal of dream and of feelings belonging to life are liable to be under repression," the inaccessibility of fantasying is "associated with dissociation rather than with repression."

As the youngest of several siblings, this patient would fit in to other children's games but never really enjoyed or was enriched by them. The games were not personally enriching because "she was simply struggling to play whatever role was assigned to her and the others felt that something was lacking in the sense that she was not actively contributing-in." What the older siblings were unaware of was that their sister was essentially absent. "From the point of view of my patient," he writes,

> while she was playing the other people's games she was all the time engaged in fantasying. She really lived in this fantasying on the basis of a dissociated mental activity . . . and over long periods her defence was to live here in this fantasying activity and to watch herself playing the other children's games as if watching someone else in the nursery group. (1971, p. 29)

As this patient grew older, she managed to construct a life in which "nothing that was really happening was fully significant to her." Her life, Winnicott concludes, "was dissociated from the main part of her, which was living in what became an organized sequence of fantasying." Her activities "brought no joy. All they did was to fill the gap, and this gap was an essential state of doing nothing while she was doing everything."

Through collaborative work, the patient recognizes that in her choice of wardrobe she is dressed for a child as well as for her middle-aged self. She also begins to experience "a wave of hate of her mother which had a new quality to it. It was much nearer to murder than to hate." Together they are able to understand how "material that had formerly been locked in the fixity of fantasying was now becoming released for both dreaming and living." Yet even as they explore how the dissociative activity of fantasying makes her ill, the very notion under discussion is enacted between them. As Winnicott speaks, the patient notices distracting herself by fiddling with the zip of her bag: ". . . why was it this end? How awkward it was to do up!" The patient could feel, Winnicott reports:

> that this dissociated activity was more important to her sitting there than listening to what I was saying . . . Suddenly she had a little insight and said that the meaning of this fantasying was: 'so that's what *you* think." She had taken my interpretation of the dream and she had tried to make it foolish . . . At this moment she reported that she had already "gone off to her job and to things that happened at work" and so here again while talking to me she had left me, and she felt dissociated as if she could not be in her skin. She remembered how she read the words of a poem but the words meant nothing.
>
> (1971, p. 32, italics in original)

The clinical material captures how *as long as dissociation is used to safeguard survival, there is a collapse of the potential space necessary for aliveness*. As the dissociative gaps are actually experienced in the new context of Winnicott's holding, the woman gradually becomes aware of how vitally she has relied upon them. She is able to reflect upon how the cocoon of psychic web-spinning to which she retreated early in life eventually entombed her. The relational bridging of the dissociative gap *loosens the rigidity of the dissociated structure and allows greater access to self-reflexivity*. In the session, she becomes aware of "making Winnicott's interpretation foolish" while simultaneously retaining her connection to him. *A new experience of bearing the conflict in mind replaces the old strategy of absenting herself through dissociation.*

A second example of Winnicott's work in the dissociative domain involves a middle-aged married man who felt, despite years of beneficial analysis, that "what he came for, he has not reached." He went through life convinced

that his analysis was doomed to interminability. On one particular occasion Winnicott found himself saying:

> I am listening to a girl. I know perfectly well that you are a man but I am listening to a girl, and I am talking to a girl. I am telling this girl: "You are talking about penis envy."
>
> (1971, p. 73)

The remark had "an immediate effect in the form of intellectual acceptance, and relief, and then there were more remote effects." After a pause the patient remarked: "If I were to tell someone about this girl I would be called mad." Winnicott was quite surprised to hear what he then said in response:

> It was not that *you* told this to anyone; it is *I* who see the girl and hear a girl talking, when actually there is a man on my couch. The mad person is *myself*.
>
> (1971, pp. 73–74, italics in original)

The patient experienced enormous relief because finally feeling sane in a mad environment released him from a dilemma that had plagued him most of his life. As he subsequently said to Winnicott: "I myself could never say (knowing myself to be a man) 'I am a girl.' I am not mad that way. But you said it, and you have spoken to both parts of me." Winnicott writes:

> This madness which was mine enabled him to see himself as a girl from my position. He knows himself to be a man, and never doubts that he is a man. Is it obvious what was happening here? For my part, *I have needed to live through a deep personal experience* in order to arrive at the understanding I feel I now have reached.
>
> (1971, p. 74, italics in original)

The understanding Winnicott reached was that "his mother . . . saw a girl baby when she saw him as a baby before she came round to thinking of him as a boy." This man "had to fit into her idea that her baby would be and was a girl." It was the mother's "madness" that was "brought right into the present by my having said 'It is I who am mad.'"

While this constructed meaning appeared to resonate deeply, the patient arrives at the following session and reports that although he had "had a satisfactory sexual intercourse with his wife," now he is ill. What is more, he invites Winnicott to "*interpret* this illness . . . as if it were psychosomatic." Winnicott says to the patient:

> You feel as if you ought to be pleased that here was an interpretation of mine that had released masculine behavior. *The girl that I was talking*

> *to, however, does not want the man released*, and indeed she is not interested in him. What she wants is full acknowledgement of herself and of her own rights over your body.
>
> (1971, p. 75, italics in original)

The vignette illustrates how *the analytic exchange allows a channel of communication to eventually open between the previously dissociated male and female elements*. Winnicott is clear that the man's suffering has nothing to do with either repressed homosexuality or a predisposition towards bisexuality. Instead, what plagues is the "complete dissociation" between "split-off male and female elements." An implication of Winnicott's formulation is that the childhood experience of being a boy seen as a girl was an awful one that needed to be avoided. *What is avoided is not simply the memory of the trauma, but the entire experience of being that person who went through it*. The "complete dissociation" is the means adopted by the patient to guarantee that he will never again be the person who suffered what he suffered. At the same time, however, the sequestered experience of being a little girl from the mother's point of view and the little girl's demand for control over the man's body are dissociated elements hollering to be heard. And no less important: *both Winnicott and the patient come alive through the shifts in mutual dissociative processes*. The unexpected and surprising appearance of the unbidden in the encounter—both Winnicott's and the patient's—indicates relational bridging of mutually dissociated aspects of their experience. By acknowledging *he had become the mad person seeing the girl*, Winnicott locates the dissociation intersubjectively. He is neither just an interpreter of a patient's unconscious nor an absorber of the patient's projections. Instead, he becomes a subject who deeply identifies with the patient's projection and owns it as his own. By *living through together* an experience, previously dissociated elements are symbolized in thought and language. What had been unsayable in words is now contained within the self without loss of continuity of being.

Repeatedly, Winnicott notes how some patients' lives become little more than a medium through which dissociated past trauma may be actively sought out in the here-and-now with the unconscious hope of bringing about some form of integration. Meaningful existence is foreclosed by the repetitive present search for an experience that could not be processed in the past. Why do some people go on compulsively worried by something that belongs to the past? "The answer must be," writes Winnicott:

> that the original experience of primitive agony cannot get into the past tense unless the ego can first gather it into its own present time experience . . . In other words the patient must go on looking for the past detail which is *not yet experienced*. This search takes the form of a looking for

> this detail in the future . . . On the other hand, if the patient is ready for some kind of acceptance of this queer kind of truth, that what is not yet experienced did nevertheless happen in the past, then the way is open for the agony to be experienced in the transference.
>
> (1963, p. 91, italics in original)

What Winnicott refers to as "a queer kind of truth," is the mind's capacity to sequester events that occur without them being felt as something fully real to the traumatized person because "*the patient was not there* for it to happen to" (1963, p. 92). At the same time, the patient unconsciously searches for opportunities to engineer the re-emergence in the transference of the original trauma situation. For the "agony to be experienced in the transference" the patient will have to be "ready for some kind of acceptance of this queer truth." Winnicott implies that if a good enough holding environment has been created, the patient will both actively seek out aspects of the analyst that permit experiencing the trauma, while temporarily dissociating other aspects of the relationship involving goodness and trust.

The original trauma felt as unreal and the search for an opportunity to relive it are, Winnicott writes, "a fact that is carried round hidden away in the unconscious." But, the "unconscious" that Winnicott has in mind is

> not exactly the repressed unconscious of psycho-neurosis, nor is it the unconscious of Freud's formulation of the part of the psyche that is very close to neuro-physiological functioning . . . Nor is it the unconscious of Jung.
>
> (1963, p. 90)

Instead,

> in this special context the unconscious means that the ego integration is not able to encompass something.
>
> (1963, pp. 90–91)

What is required of the analyst, as Winnicott intended to say in his never-to-be-given final presentation, is to

> witness the parts that go to make the whole, a whole that does not exist except as viewed from outside.
>
> (Quoted in Abram, 2012)

As engaged witness to the "queer truth" of dissociated experience rather than as knowing interpreter of the patient's repressed unconscious, the analyst may open a space for a vital spark of life.

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Chapter 9

A Kleinian perspective on dissociation and trauma

Miscarriages in symbolization

Joseph Newirth

Kleinian theory, with its emphasis on symbolization, countertransference, projective identification, enactment, and the importance of the analyst's immediate experience (Blass, 2011) in understanding patients' disowned and dissociated experience, has opened a space for a deeper appreciation of theories of symbolization within contemporary trauma theory. Failure in the development of the capacity for symbolic thought is a consistent and critical element in both dissociation and the ability to process trauma. In this chapter, I will trace the evolution of the Kleinian concept of symbolization, and its relationship to other contemporary psychoanalytic approaches in situations where trauma and dissociation have entered an individual's life. I will suggest some clinical approaches, which may ameliorate failures in the development of the capacity for symbolic thought in patients who have experienced trauma and are in dissociative states.

Kleinian theory has two major dimensions: an interpersonal dimension, involving aggression, power, and the structure of relationships; and a cognitive dimension, which describes the development of thinking from concrete organizations of experience as absolute facts and truth to symbolic experiences of personal meaning, reflection, empathy, possibility, and hope. Both dimensions are embedded in the paranoid-schizoid and depressive positions which describe how a person organizes his/her experience in the world, rather than seeing the person as passively reacting to the push and pull of internal and external forces. Klein's (Ogden, 1992) thinking evolved from a one-person biological theory to a two-person intersubjective approach, focusing on how meaning is generated and relationships structured. It is interesting to note the similarity between Klein's Object Relations theory and Sullivan's (1953) Interpersonal Theory of Psychoanalysis. Each begins with the disorganizing experience of anxiety, emphasizes the importance of the interpersonal/familial context, development of the capacity to know the self and the world, and strategies of anxiety avoidance. These similarities are not surprising since both Klein and Sullivan were children of the twentieth century, deeply affected by the First and Second World Wars, and lived through important events including the evolution of

culture from one of industrial production to one which centered on communication. Additionally, both were deeply influenced by Ferenczi (1931) who, unlike his peers, emphasized the importance of new experiences in the analytic relationship.

The interpersonal dimension of Kleinian theory involves greed, envy, destructiveness, and aggression, which she initially conceptualized as arising out of the death drive. Few contemporary Kleinians use the concept of the death drive; however, the emphasis on destructiveness, greed and envy continues to be central to the paranoid-schizoid position and can be thought of as addressing the critical interpersonal dimension of power and control—whether I control something or it controls me. The paranoid-schizoid position dominates the experiential world of people who have experienced trauma, where dissociation structures their experience of living in a timeless, concrete world of unchanging and repetitive traumatic experiences. The sense of powerlessness, masochistic forms of relatedness, lack of control, and being a thing in the world reflect experiences within the passive paranoid position,[1] while sadism, controlling forms of relatedness, hyper-responsibility, self-hate, blame, difficulties trusting or depending on others, and a sense of grandiosity reflect experiences within the active paranoid position. The recognition of one's destructiveness and limitations is the necessary precursor to the development of the depressive position and the capacity for symbolic thought, allowing for empathy and experiencing oneself and others as whole people, who have an internal world of feelings, wishes, intentions and fantasy. People who have experienced trauma and are in dissociative states are unable to organize experience within the depressive position, where they could develop a sense of agency and an awareness of their own and others' internal experience.

The cognitive dimension describes two ways of knowing the other. In the depressive position, the other is experienced as a whole person with an internal world of feelings, thoughts and intentions, while in the paranoid-schizoid position, the other is experienced as a collection of part objects existing only to provide services and supplies.[2] Both positions represent a progressive development of symbolic processes, modes of creating meaning through internalization of structures of relationship and meaning, similar to Bowlby's (1969) internal working models, concepts of subjectivity (Stolorow, 2002; Stern *et al*., 1998), intersubjectivity (Benjamin, 2009; Ogden, 1994) and mentalization (Fonagy *et al*., 2003).

Kleinian perspectives suggest that meaning is generated differently within the paranoid-schizoid and depressive positions. Subjective experience is never unmediated but always reflects a process through which experience is given both meaning and location. Segal (1978) describes the earliest form of thinking as a dual process of splitting, involving both affect and location; the earliest meaning is either good or bad and the earliest location is inside me or outside me. For example, the infant or child faced with the confusion

and overwhelming stimulation that accompanies experiences of abuse attempts to separate his/her experience through splitting, first according to affect, good and bad, and then by location, inside me or outside me. The child might project or evacuate his/her experience into the other and as a result lives in a terrifying world of the passive paranoid position in which he/she is flooded by persecutory anxiety. Alternatively, the child might evacuate the good feelings into the other, believing that if he/she were not bad, the other who is good would not need to punish him/her. In the first position, the passive paranoid-schizoid position, the individual feels like a victim in an unstable dangerous world. In the second position, the active paranoid-schizoid position, the individual makes the world safe, while believing that he/she is in control, at fault, guilty and ashamed. This second strategy, the active paranoid-schizoid position, is more difficult because it negates the need for the other, maintains a grandiose sense of self while living in an internal nightmare world of horrible actions and feelings. This more grandiose active strategy embraces Milton's (1667) famous line from *Paradise Lost*, that it is "Better to reign in Hell than serve in Heaven."

Bion and Winnicott extended Klein's concept of symbolic functioning, focusing on how the individual develops the capacity for symbolic thought within an intersubjective relationship with a parent or therapist. Winnicott's (1971) concept of the development of transitional experience is an intersubjective process, in which the child gives an object (e.g., a doll or toy) a personal meaning which is accepted and elaborated by the parent and family, who acknowledge the child's ability to create symbolic experience through giving meaning and a physical presence to the object. The transitional object is experienced as having the quality of being alive, as when a child insists that the family pay attention to "my baby," or an imaginary companion. Winnicott's development of the concept of transitional experience is a radical two-person approach to the creation of meaning, which requires a safe, playful relationship with a parent, caretaker or therapist. The concept of transitional experience is an elaboration of the squiggle game (Winnicott, 1958; Soni, 2012) and Winnicott's (1971) evolving psychoanalytic approach, which emphasized the mutual creation of subjective meaning. For Winnicott, the creation of meaning is an intersubjective process located in an evolving domain of experience separate from purely internal experience and purely objective experience.[3] Winnicott describes this domain of meaning-making as transitional space, an intersubjective domain where play, art, religion, personal values and meanings develop. For Winnicott, transitional space differs from the purely objective space of the external world of facts, authority and rules, which he sees as being imposed on the child in a series of impingements, and which results in the development of an objective, false self, or not-me organization of experience. It is this latter experience of being a false self, being fearful and compliant, which

we often see in patients who have been abused, traumatized and survive by entering deadened states of dissociation.

Winnicott, like others who have been influenced by Klein, suggests that the development of meaning occurs differently in the objective world of facts and the intersubjective world of personal relationships—in an intersubjective world of intimacy and play and in an objective world of facts and work. Recognition of an objective and a subjective world of meaning is important in understanding people who have experienced trauma and dissociation because trauma and dissociation disrupt the development of intersubjective transitional space while allowing the individual to function in the operational world of facts, rules and authority. These patients are often able to function competently in the external world of facts but unable to function in the intersubjective world of meanings, intimacy and play; alternatively they may be unable to differentiate these two realms and experience confusion between the subjective world of meanings and the external world of facts.

In parallel to Winnicott, Bion (1959, 1962) also developed an intersubjective theory of creating meaning, of thinking. However, where Winnicott described a spontaneous, experience-near process, initiated by the child and responded to by the parent, Bion described a theoretical system of projective and introjective identification through which the child comes to terms with painful experiences. Bion starts with the premise that the child's painful experiences cannot be thought about, contained in an immature mind, and so must be evacuated or projected into a parent or caretaking other who would be able to contain these painful experiences. Bion elaborates Klein's (Ogden, 1992) concept of projective identification, making it an explicit two-person, intersubjective process in which the parent, or later a therapist, can accept, contain, and affectively and symbolically elaborate the child's anxiety-filled projections. Bion refers to this process of affective and symbolic elaboration of experience as alpha function, reverie, and dreaming. In a healthy situation, the parent or other is able to contain and tolerate the anxiety and destructiveness of the child's projection and elaborate it into a meaningful, less concrete and anxiety-filled experience, which the child can internalize and experience as a thought. However, miscarriages of this process of creating meaning, of symbolization, occur when the parent cannot contain (tolerate) the child's projection and instead rejects the projective experience and blames or accuses the child as being bad or at fault. This inability to contain and affectively elaborate projected experience often results in pathological projective identification and a tragic game of "hot potato" in which the projected disowned experience continues to cycle between parent and child, remaining an external fact, a fixed, concrete action, rather than a thought or a symbolic experience.

Pathological projective identification occurs when a parent or therapist is unable to contain and symbolically elaborate the child's or patient's

experience, becoming anxious, distraught, distracted, sleepy, unable to think, attacking or blaming the child or patient for bringing unmanageable experiences into their world. Patients who have been sexually abused by family members describe how when they were finally able to tell a family member, often their mother, about the experience of sexual abuse, their words were angrily rejected, and they were told that it did not happen, that it should never be talked about, and that they are bad, a liar, and at fault. Because these experiences were not contained and therefore could not be thought about and elaborated, they remain concrete, unthinkable experiences, which are dissociated and repeatedly enacted and re-experienced in new relationships as real events, perceptions, and facts in the external world.

Let me illustrate the complex process of a miscarriage of symbolization in a case in which the patient had profound sexual trauma and lived in a world in which she dissociated a great deal of the time, living in constant terror and anxiety. I was supervising an experienced psychoanalytic therapist who had difficulty talking about this case because she experienced a great deal of shame and was, for her, unusually afraid of being criticized for failing to help her patient and ashamed that she was barely able to stay awake in her sessions. This therapist's experience is not unusual when working with extremely traumatized patients, where the capacity to symbolize, to contain, and to affectively elaborate experience completely collapses. Bion (1959) described periods of being unable to think as attacks on linking, a collapse of the container-contained function in the therapist, who becomes completely identified with the patient's disowned and evacuated feelings. We see in this collapse of the therapist's capacity to symbolize (Shoenhals, 1996) a movement into the paranoid-schizoid position, with the development of severe persecutory anxiety and symbolic equations where thought and action are experienced as identical, as when the therapist believed that she is a "bad" person who should be shunned by me in supervision.

The collapse of the capacity to symbolize occurred in both the therapeutic relationship and the supervisory relationship. I also felt sleepy and distracted and that I was a "bad" supervisor. Experiences of sleepiness and distraction are examples of dissociation in the therapist and supervisor. No member of this or any fragmented therapy and supervision system was able to symbolize; each of us, patient, therapist and supervisor, were in a passive paranoid-schizoid state of persecutory anxiety, experiencing our worlds in modes of symbolic equivalence, dominated by guilt, shame, action and concrete beliefs. Rather than being able to contain, elaborate and symbolize, we became disconnected, helpless, and useless part objects.

Supervision can be very important when working with extremely traumatized patients. It has the potential of becoming a safe place where the therapist and supervisor begin to contain and elaborate the inevitable parallel experiences of dissociation in the overlapping dyads of patient and

therapist and therapist and supervisor. The turning point in my relationship with this therapist occurred when I, as the supervisor, was able to articulate my feelings of boredom, disinterest and sleepiness. This acknowledgement, my beginning attempts to articulate and inhabit, rather than deny, the disowned experience of being "bad," opened up a transitional space in the supervision where we were each able to begin to play with the experiences of being a "bad" supervisor and a "bad" therapist. Being able to contain, articulate and symbolize projected and dissociated experience of badness is a crucial step in moving from paranoid-schizoid states of persecutory anxiety and psychic equivalence to depressive, symbolic experiences, including those of empathy and compassion. Our capacity to symbolize in supervision, to play with various experiences, resulted in the therapist becoming able to be more present in the therapy dyad and to begin to contain and articulate the horrible incestuous, nightmare experiences that her patient reported, which flooded both her conscious and unconscious worlds.

This patient had horrific incestuous experiences from childhood to adolescence. Each night her father would come into the room that she shared with her older sister and sexually abuse her sister while she would pretend to be asleep, attempting to dissociate the sounds, smells, and sights of her father's attacks on her sister. In therapy, the patient reported being flooded by intense, painful, somatic experiences, being terrified every night, believing that she was being spied upon, worried that she would be trapped in a fire in her apartment, and feeling that she was in danger of being sexually assaulted on the streets and at work. She experienced and described all of this as if it was absolute truth, the facts of her existence; often she talked about suicide as the only possible way to escape. It is hard to describe how intense these experiences were and how it affected the therapist, who believed that she was not being helpful and was sleepy and distracted. When the patient would miss appointments, the therapist felt intense panic and concern that something had happened to her; she feared that her patient had been raped, or that she had committed suicide. In addition to being unable to contain and elaborate the patient's incestuous experiences, the therapist also felt extremely guilty and filled with shame when she would think about how much better her life was than her patient's. The patient's symptoms and the therapist's experiences of dissociation, shame, and guilt were concrete representations, symbolic equivalents, of the uncontained, unelaborated, and unsymbolized derivatives of the patient's evacuated experience. Because these experiences were not symbolized, they felt absolutely real. Often the patient experienced these symbolic equivalents as positive hallucinations (men watching her in her room), which alternated with her sleepy absences, her dissociative experiences, which can be thought of as negative hallucinations.

Slowly supervision took on the quality of a transitional experience. We became able to contain and elaborate some of the therapist's feelings as

concrete experiences, including her sleepy dissociation as a feeling that it would be better to be dead than to be lying in bed while your sister is repeatedly raped by your father. The patient's belief that she was being spied on, that her room was on fire, and her painful somatic experiences, all represented concrete repetitions of the uncontained and unsymbolized experiences of her childhood. Perhaps the most difficult work for the therapist involved recognizing and affectively elaborating her guilt about thinking that her life was much better than the patient's. Symbolizing her guilt represented an unacceptable thought for the therapist, who was committed to being a compassionate person. However, as we worked this through, playing with her guilt, it became clear that this unacceptable thought also represented the patient's intolerable thoughts as she witnessed her sister being repeatedly raped and was glad it was not her.[4] Related to this complex set of thoughts, and quite difficult to know, was the therapist's ability to recognize and work with the patient's envy, sexual desires, and destructiveness towards her and her life. This work did not happen very quickly, for not only were these experiences difficult to contain, elaborate, and symbolize, but this work went well beyond interpretation and explaining her symptoms in relation to historical events. Therapy involved having to live through, inhabit and play in the horrific transitional space, which this patient brought into therapy. In addition to processes of progressive symbolization, playfully enacting these transitional experiences, the patient began to develop her own capacity to symbolize, to contain, and to affectively elaborate experience which previously had been extremely limited and concrete because of her history of trauma.

Both Bion and Winnicott describe the capacity for symbolic experience as a developmental achievement occurring differently in the world of subjective experience and the world of objective experience. This dual mode of thought is further developed by Matte-Blanco (1975; Newirth, 2003) as a bi-logical theory of thinking in which there are two modes of thought. He described thinking which occurs in a functionally conscious realm as asymmetrical logic; this is the realm of objective reality in which experience is differentiated in terms of person, place, time, and causality. The second mode of thought, symmetrical logic, generates meaning in functionally unconscious and subjective realms, including dreams, fantasies, poetry, humor, intimate relationships and artistic productions, through creating similarities and dedifferentiating experiences. These two modes of thought also follow the developmental trajectory from the concrete, symbolic equations of the paranoid-schizoid position to the symbolic representations of the depressive position.

Symmetry and asymmetry are different forms of creating meaning, of symbolization, in which the same experience may take on very different meanings. Matte-Blanco (1988) suggests that experiences which are the result of pathological projective identification and are uncontained and

unelaborated by an other are experienced asymmetrically as facts, as immutable events in the objective world, which cannot be changed. Bion's concepts of alpha function, reverie, and dream work are symmetrical processes of affective and symbolic elaboration in which the therapist's identifications and experiences of similarities are an initial step in elaborating the patient's dissociated experience. For example, when the patient hallucinated people spying on her, it was a fact that could be understood as an internal experience, which reflected her experience of watching her sister being raped and an awareness that her father enjoyed watching her being tortured and trapped in this unbearable situation. The therapist also experienced being trapped and tortured, and had to recognize (contain) this horrific unconscious symmetrization, the dedifferentiation (identification) of herself and the patient. The therapist had to inhabit this experience, creating a transitional experience, affectively elaborating her terrible thoughts, including the thought that she was glad that her life was not as horrible as the patient's. This is a process of symmetrization, a dedifferentiation and eventual playful elaboration of concrete asymmetrical experiences, which became symbolized in the safety of the transitional space, which was created in both the supervisory and therapeutic relationships.

Matte-Blanco's bi-logical theory and Fonagy's (1996, 2000) concept of mentalization are similar approaches to the development of the concept of symbolization.[5] Fonagy *et al.* (2003) conceptualized two separate modes of representing experience, the mode of psychic equivalence and the pretend mode. They suggest that trauma interferes with the integration of these two primary modes of representing experience into a third mode, similar to the depressive position, the capacity for mentalization. Mentalization is a symbolic organization in which a person can reflect on his/her own subjective states of meaning, affect, and intentions as well as on others' similar mental states. Fonagy and Target suggest that this

> failure to mentalize adequately is compounded by the persistence of an undifferentiated mode of representing external and internal experience. This is rooted in a childlike understanding of mental states in which feelings and ideas are construed as direct (or equivalent) representations of reality with consequent exaggeration of their importance and extension of their implications. This mode of functioning tends to be self-perpetuating. The experience of unconscious as well as conscious feelings and ideas as equivalent to physical reality inhibits the individual's capacity to suspend the immediacy of their experience and to create the psychological space to 'play with reality'.
>
> (Fonagy and Target, 2000, p. 853)

Failure in the development of mentalization arises out of a mother's failure to contain and articulate the child's affective experience in a "marked,"

affectively playful, ironic, exaggerated, and less frightening way. The mother's (caretaker's) ability to contain and elaborate experience in a "marked" way allows the child to recognize that the mother is mirroring his/her frightening experience in a safer, second order or symbolic form, allowing the child to internalize this experience as something to be thought about in a less fearful way. If this capacity for marked, playful, mirroring (transitional space) does not occur, the child internalizes the experience concretely as the mother's experience, as an external reality, a fact which may be experienced as an alien object or voice occurring internally but having the character of an external event organized asymmetrically. A traumatized child unable to experience the (m)other as safe person capable of containing and symmetrically elaborating their experience will tend to withdraw into the pretend mode, which becomes the basis for dissociation, creating an isolated paranoid world which may be more adaptive than being in the actual external world. In contrast to this withdrawal into unitary and dissociative play or fantasy, Fonagy and Target (2000) describe the importance of being able to play with others as the bridge through which the pretend mode and the mode of psychic equivalence become integrated and lead to the development of the capacity for mentalization, the ability to take different perspectives, to understand motivational and intentional states, and to create meaning in relationships.

Although Fonagy does not define himself as a "Kleinian," his theoretical and clinical work has been heavily influenced by Bion, Joseph, and Winnicott. His clinical work focuses on the capacity to create meaning, emphasizing the intersubjective aspects of countertransference, the therapist's ability to overcome the pressure to dissociate, to be able to symbolize, and to maintain an intersubjective awareness of the patient as a whole person. In describing the therapeutic experience, Fonagy and Target (2000, p. 859) state: "The countertransference response is often a sense of emptiness, which we see as the result of an attempt to reduce both people to an equally unthinking state." Fonagy and Target (2000, p. 868) suggest that: "The focus of technique in such cases is thus no longer making conscious what was unconscious. We believe an appropriate technical priority is the survival of the analyst's picture of the patient's mental state in his mind." The capacity to keep the patient's or child's subjective, mental state in mind can be seen as a first step in containing and affectively elaborating experience and in creating the possible space for transitional experiences to develop.

An emphasis on countertransference, including the inevitability of dissociation and the importance of recovering the intersubjective ability to contain and affectively elaborate the experience of the patient as a subject, and to generate symbolic meaning, is the core of Kleinian technique. This "here and now" (Blass, 2011), moment-to-moment experience is extremely important in working with traumatized and dissociative patients where the therapist almost always finds him/herself in dissociative states, unable to

think, inhabiting paranoid-schizoid states of self-hatred and inadequacy. These countertransference experiences reflect a collapse of the therapist container-contained function, resulting in concrete symmetrical identifications with the patient and the patient's projections. This inevitable collapse of the container-contained function requires a great deal of work by the therapist (and supervisor) to repair the capacity for reverie, to be able to affectively and symmetrically elaborate their own and the patient's experiences. Following Bion, Ogden (2003) describes this process of containing and affectively elaborating symmetrical experience as becoming able to dream the patient into existence; which he notes may take a long time to achieve while the analyst himself is in a distracted, dissociated state. It is very important for the therapist to be able to utilize symmetrical forms of thinking, including associations to similar personal experiences, uncomfortable fantasies, songs and humorous thoughts which help create a playful, transitional space. As the therapist is able to subjectively play with these experiences, it will allow the treatment to move towards a transitional space which will allow the patient to develop the capacity for symbolic thought, to mentalize their past experiences, and to know others as whole persons who have separate internal experiences.

Notes

1 See Newirth (2003) for a more extensive discussion of the passive and active paranoid-schizoid position.
2 The use of people as part objects includes exploiting individuals as sexual objects, the use of individuals for particular functions, and the lack of recognition of an inner life of feelings, beliefs, and thoughts.
3 Ogden's (1994) and Benjamin's (2009) concepts of the third are developments of Winnicott's concept of transitional experience and describe an intersubjective perspective on the mutual development of meaning.
4 This seems to be an example of survivor's guilt.
5 Fonagy *et al.*'s use of the concept of mentalization parallels the Kleinian concept of symbolization. Their work seems to reflect an integration of Kleinian Object Relations theory and developmental research. We will use mentalization and symbolization as highly related concepts arising out of overlapping areas of psychoanalysis and developmental psychology.

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Chapter 10

"It never entered my mind"[1]

Philip M. Bromberg

> Once you warned me that if you scorned me
> I'd sing the maiden's prayer again
> And wish that you were there again
> To get into my hair again.
> It never entered my mind.
>
> (Rodgers and Hart, 1940)

This chapter is about "secrets," so let me begin by telling one of mine. I've always felt an oddly satisfying self-contradiction in my having become a psychoanalyst, given how much I hate change. I was the last kid on my block to have a new bike because I felt such loyalty to my old one, and I was also the last kid on my analytic block to buy a computer, because I couldn't bear to part with my yellow pads and my typewriter. Even after I capitulated, my friends who couldn't easily open my attachments or who stumbled over my formatting, talked about the outdated version of my word processing program as if they had just run into Norman Bates's mother—I wouldn't admit she died and I was refusing to bury her. I'm not arguing that this is a good way to be; it's just the way I am. The most flattering account of it I've heard is from a patient from whom I can't seem to hide anything: She has referred to it as my "retro approach to modernity."

Attachment to what I know, even with its limitations, is part of my comfortable familiarity with my ways of being in the world. From one vantage point I'm talking about "procedural memory" (Bromberg, 2003b); from another, I'm talking about fidelity to my different selves as I live them.

The same attitude can inform my work. I remember an initial consultation with a man who came to me only because he was in a state of total desperation. His marriage was falling apart, and he couldn't "get" why none of the things he did to improve it seemed to help. But even as he was saying this, I could feel the presence of another part of him that was being dragged unwillingly into my office, a part that felt it was being required

to obliterate its existence for the sake of learning some "better" way of being—a way that it knew in advance would feel irrelevant. My heart went out to him and I found myself saying, "I want to share a secret. Even though I'm an analyst I hate change; so don't worry, you'll be the same when we end therapy." He didn't laugh, and I could see he didn't exactly know what I meant, but I could also see that his eyes were teary. I could see that a part of him could *feel* what I meant. He cried even though he had no conscious awareness of *why* he cried. That moment became a watershed that helped us during future moments when we were struggling to stand in the spaces between different self-states with different agendas. As the poet and scientist Diane Ackerman (2004), in *An Alchemy of Mind,* has put it, "consciousness is the great poem of matter." Conscious awareness, she writes, "isn't really a response to the world, it's more of an opinion about it" (p. 19).

> Life feels continuous, immediate, ever unfolding. In truth, we're always late to the party . . . Part of that delay [is] so that the world will feel logical and not jar the senses . . . All that happens offstage. It's too fussy, too confusing a task to impose on consciousness, which has other chores to do, other fish to fry . . . Instead, we feel like solo masters of our fate, captains of our souls, the stuff of homily and poetry.
>
> (2004, pp. 20–24)

What Ackerman is describing as the "stuff of homily and poetry" I have tried to capture in my concept of "staying the same while changing" (Bromberg, 1998), a phrase that itself contains a secret. The secret is that "staying the same while changing" is logically impossible. It embodies two phenomena that can't coexist, even though they do. Somehow, the process of "change" allows a negotiation between different internal voices, each dedicated to *not* changing, that is, dedicated to "staying the same" in order to preserve self-continuity. This impossible coexistence of staying the same and simultaneously changing is why trying to track "change" in psychoanalysis (Bromberg, 1996) calls to mind Gertrude Stein's (1937, p. 298) comment that when you finally get there, "there's no there, there." The direct experience of "self change" is indeed a secret that eludes conscious awareness. It seems to be gobbled up by the relatively seamless continuity of being oneself, which necessarily includes parts of the self that remain secret from what is "me" at any given moment.

Robert Frost (1942, p. 362) wrote: "We dance round in a ring and suppose, / But the Secret sits in the middle and knows." (Every therapist knows the truth of this, particularly when developmental trauma has been a significant issue in a patient's early life. The therapist can feel the inadequacy of words as a means of reaching his patient, and often experiences a growing sense of futility about "really" knowing her. This feeling of

futility is a small sample of the abysmal hopelessness felt by his patient at being unable to communicate in language from the place that Frost calls "the middle." Therapist and patient "dance round in a ring and suppose," but their dance of words does not unite them within the place of the secret because the secret that "sits in the middle and knows" is a subjective form of reality that is incommunicable through ordinary human discourse. It is organized by experience that Wilma Bucci (1997, 2001, 2003, 2010) has termed *subsymbolic*, and is communicated through enactment.

Enactment is a dyadic dissociative process—a cocoon within which the subsymbolic communication taking place is temporarily inaccessible because it is deadened to reflective functioning. In a human relationship, no person's capacity for aliveness can be sustained without an alive "other," so if the other is a therapist, and is for too long listening to the "material" without being alive to his own internal experience of the relationship itself, a dissociative process often begins to develop in the therapist that may have started in the patient but quickly becomes a cocoon that envelops both patient and therapist. Typically, the sequence of events is more felt than cognized by a therapist because the therapist's self-state almost always switches dissociatively so soon after the patient's that the switch is usually not perceived by the therapist until it becomes noticeably uncomfortable to him—what Donnel Stern (2004) calls "chafing." Until then, a clinical process that may have been experienced by the therapist as alive at the outset of a session subtly diminishes in aliveness, typically without the therapist's cognitive awareness. This change in the therapist's state of mind eventually compromises his ability to retain his focus on the "material." Why? Because when one's affective need for an alive partner is being disconfirmed by another mind that is dead to it, a therapist is no different than anyone else. Through dissociation, he escapes from the futility of needing from an "other" what is not possible to express in words. What begins as "material" evolves into empty words.

Because therapist and patient are sharing an interpersonal field that belongs equally to both of them, any unsignalled withdrawal from that field by either person will disrupt the other's state of mind. The disruption, however, is usually not processed cognitively by either person, at least at first. It becomes increasingly difficult for the therapist to concentrate, and only when this experience reaches the threshold of perceptual awareness by becoming distressing will the therapist's struggle to concentrate become the pathway to perceptually experiencing the deadening power of what is taking place between them in the here-and-now. Invariably, the therapist's own response to this (some might say lack of response) contributes, interactively, to the construction of a communication process that both acknowledges the recapitulation of the patient's past experience and establishes the context for a new form of experience at the same time.

Just a pebble in her shoe

The relationship between dissociation and enacted "secrets" is best grasped clinically, so I'm going to present a vignette from my work that shows me in the middle of an enactment as well as showing how I was thinking about it while in it.[2]

A bulimic patient, whose dissociated acts of purging were starting to become more emotionally recallable by her during therapy sessions, began to have flashbacks of abuse at the hands of her parents. At first, she couldn't let herself think clearly about these images, describing them as like "having a pebble in my shoe that I can't get rid of." But as she began to talk about what the pebble felt like, she recognized that the part of herself holding the memories of abuse was keeping them secret and that the pebble substituted for having to relive her actual emotions. Moreover, the experience during her sessions of feeling something so painful about her *vomiting* was making her past pain feel "real" rather than something she was never sure existed. Her pain was becoming increasingly complex and more intense the more she relived it with me. The more real the experience felt the more its existence threatened to betray those who had hurt her, and betray the parts of herself that identified with them. For all these reasons the possibility of ever talking about the abuse "never entered her mind." But the pebble, which was supposed to remain no more than a pebble, was starting to feel like a boulder.

The session I'm going to describe was in some ways the same as those that preceded it, but in other ways it was memorably different. "Why would I want to hurt the people I feel closest to just because I need someone to know?" she agonized. At that moment I began to feel some of her agony, and I also began to experience shame attached to my desire to help her reveal her secret. The shame was about inflicting what felt like needless pain upon a person to whom I felt close at that moment—I was hurting her just because I wanted to know. Until that moment I had been ignoring, *personally*, the extent to which she was vulnerable to dissociated pain inflicted upon her by another part of herself, for allowing "longing" (I *need* someone to know) to become "desire" (I *want* to tell you). The only part of her that had come to feel worthy of being loved existed by protecting the family secrets. By starting to remember and disclose them because she wanted to, she became vulnerable to internal attack by other parts of herself. I had not wanted to experience the degree to which she was being punished and denounced, internally, as evil. In this session, which followed a particularly violent night of purging, she screamed angrily at me, "You'll never get me to stop vomiting. I'll never spill the beans."

At that moment I became painfully in touch with my own dissociated feelings of shame about hurting her, and *I* decided to "spill the beans." I shared with her what I was in touch with, including my awareness and personal regret that I had been leaving her too alone with her pain because

I was so enthusiastic about our "progress." I then asked if she might be aware of feelings of her own about what I had just said to her, including feelings about my having said it. After a pause, she allowed that she was feeling two ways at the same time, and that they were giving her a headache to think about: She could feel herself furious at me but at the same time she knew she loved me and didn't want to hurt me. I said that it was only when she got openly angry at me and said, "You'll never get me to stop vomiting. I'll never spill the beans," that I woke up to what was there all along under her anger—her pain and shame in having to go through this so alone.

What I had been seeing as my therapeutic "success" in bringing about the reliving of her past had finally triggered within me an affective experience of her unmet longing for me to know, personally, what this was like for her, and to care. I had been dissociating the part of me that could feel it most personally. My "spilling the beans" and sharing the experience of how I awakened to her pain connected with her longing for me to know it personally. Her longing could not be put in words; it had not reached the level of cognitive awareness that would allow it to become conscious "desire." Yet, as longing, it remained operative; it remained true to that self-state. When dissociation is operating, each state of consciousness holds its own experientially encapsulated "truth," which is enacted over and over again. The secret that is being revealed through an enactment is that while your patient is telling you one thing in words, to which you are responding in some way, there is a second "conversation" going on between the two of you. Buck (1994, cited in Schore, 2003, p. 49) refers to this as "a conversation between limbic systems."

As my patient and I continued to put our dissociated states into words, her longing, a somatic affect that possessed her, began to be expressible as "hers," and evolved little by little from an affect into an emotion, an emotion we know as "desire." By sharing and comparing our respective experiences that took place during the enactment and finding words for them that had consensual meaning (Bromberg, 1980), she was able to move from *being* the secret to *knowing* the secret that had only been "supposed" by us until then. Until this moment we had, in Frost's words, been forced to "dance round in a ring and suppose." Now the doubly shameful secret was out and we could both "know."

Secrets and the corruption of desire

Secrets, such as my patient's, contain affective experience in the form of implicit memories of selves that became "not-me" because the subjective realities they held were "lost in translation." These self-states remain uncommunicable through words because they are denied symbolic meaning within the overarching canopy of a "me" that is allowed to exist in human relationships. My own clinical experience leads me to believe that these

self-states most frequently become dissociated when the person is quite young, but that regardless of age they occur in a context where self-continuity is threatened. I'm speaking of experiences that have been invalidated as "real" by the mind of some significant other who used language not to share these experiences but to "translate" them out of existence. When the original "other" is a primary attachment figure, a parent or an other whose significance is interpersonally similar to a parent's, that person holds the power to destabilize the child's mental state by rupturing a relational connection that organizes the child's sense of self-continuity. In order to preserve the attachment connection and protect mental stability, the mind triggers a survival solution, dissociation, that allows the person to bypass the mentally disorganizing struggle to self-reflect without hope of relieving the pain and fear caused by the destabilization of selfhood. Dissociation narrows one's range of perception so as to set up nonconflictual categories of self-experience as different parts of the self.

Inevitably, desire becomes corrupted. The child's healthy desire to communicate her subjective experience to a needed other is infused with shame because the needed other cannot or will not acknowledge the child's experience as something legitimately "thinkable." The attachment bond that organizes self-stability for the child is now in jeopardy. She feels, not that she *did* something wrong, but that there is something wrong with her *self,* that is, something wrong with her as a person. To survive this destabilization of selfhood, she sequesters the now "illegitimate" part of her subjective experience by dissociating the part of herself that knows it to be legitimate. She has dissociated a part of her subjectivity that originally felt real and thus "legitimate," and because it is dissociated the child starts to doubt her own legitimacy as a person. She is thereafter in doubt both as to her own legitimacy as a person and the reality of her internal experience. As an adult, she is left with a sense of something bad having happened to her but that sense is not organized as a cognition; she is left not with a memory that is felt as belonging to "me" (a declarative memory), but with its affective ghost in the form of an uncommunicable state of longing that shrouds the implicit memory. The longing is a "not-me" ghost that haunts her (Bromberg, 2003a) because her own desire to communicate it to her therapist from her internal place of "illegitimacy" becomes a source of shame in itself. Thus, her sense of shame is compounded: The first source of shame comes from her belief that what she feels will not be real to the other. The second source of shame derives from her fear that she will lose the other's attachment (and thus her core sense of self) because she believes the therapist will not attribute validity to her desperation that he know what she is feeling. This fear of attachment loss makes her even more desperate for evidence that the other has not indeed withdrawn his attachment, and the more evidence she seeks the greater is the shame she feels for seeking solace that is somehow tinged as illegitimate.

A patient's "longing" to communicate dissociated self-experience must be recognized by the analyst, but what must simultaneously be recognized is that she cannot mentally experience this longing as legitimate without being shamed by other parts of herself, leaving her feeling undeserving of consolation or solace. When she tries to tell you her secret, she is *always* "at a loss for words" because the real secret can't be told, at least not in words. The affective truth with which the patient lives becomes suspect by her as a "lie" or at least an exaggeration, and she is never sure a secret really exists or if she is making it up.

There are no thoughts that bridge past and present so as to link her subjective world of pain with the subjective world of another person. The patient, in this respect, lives in tortured isolation, and this experience becomes the patient's essential truth, her "secret," and words and ideas become empty "lies." What could not originally be said without traumatic pain could not come to be thought, and what cannot now be thought cannot come to be said.

As Masud Khan (1979) wrote about his patient Caroline in his famous paper "Secret as potential space": "Caroline's secret encapsulated her own absent self" (p. 265).

> The location of a secret of this type is that it is neither inside nor outside a person. A person cannot say: 'I have a secret inside me'. They *are* the secret, yet their ongoing life does not partake of it. Such a secret creates a gap in the person's psyche which is reactively screened with all sorts of bizarre events—intrapsychic and interpersonal.
>
> (pp. 267–268)

Khan makes it clear that what was important for Caroline in their work was not his interpreting the symbolic meaning of her secret, but that in making such an interpretation, his mind needed to be alive to what he called her "absent self" (see also Chefetz and Bromberg, 2004, pp. 445–455). Thereby he was relating to the part of her that *was* the secret in a way that became an act of mutuality.

I believe that what Khan accomplished, relationally, in Caroline's treatment must take place with every patient to one degree or another as part of every analysis in order to free the patient's capacity for self-reflection. In other words, in every treatment the *development* of self-reflection is part of what is achieved by the analytic process; it is not something that the analyst requires a patient to already possess as a prerequisite called an "observing ego." Because each of the patient's dissociated self-states holds its own agenda about the patient's "secrets," each must become available in its own terms to the analyst's range of self-states. This requires that as part of the clinical process, the analyst increasingly recognizes his own dissociative contribution to the enactments and becomes more and more able to reflect

upon and use this recognition, relationally, with each of the patient's selves or self-states. As this is taking place, the patient's dissociative subjectivity evolves, nonlinearly, into self-reflective subjectivity (and intersubjectivity). Through unfreezing the developmental process that Fonagy and his colleagues (2005) term *mentalization*, a patient becomes able, more freely and more safely, to experience another mind experiencing her mind experiencing their mind in those areas of mental functioning where dissociation had held intersubjectivity captive.

A final comment: As the reader may have deduced from my epigraph, the title of this chapter, "It never entered my mind," is borrowed from a song by Rodgers and Hart (1940) about the aching emptiness in a person's soul as he longs for an absent other he didn't think he would even miss. The song begins whimsically but ends poignantly. "It never entered my mind" isn't just a refrain. It is a low moan of anguish made all the more poignant because when, at last, the shock of loss does enter a person's mind it hits in a wave that floods the heart with pain. I'm sure that when Lorenz Hart wrote, "You have what I lack myself" he didn't have attachment trauma in mind, but more than a few people have told me they get goose pimples every time they listen to it.

Notes

1 An earlier version of this chapter, "'It never entered my mind': Some reflections on desire, dissociation, and disclosure," was published in J. Petrucelli (Ed.), *Longing: Psychoanalytic Musings on Desire* (London: Karnac, 2006, pp. 13–23). It was originally presented at a 2004 conference at Mount Sinai Medical Center in New York City, sponsored by the Eating Disorders, Compulsions and Addictions Service of the William Alanson White Institute.

2 An abbreviated description of this enactment can be found in *Awakening the Dreamer* (Bromberg, 2006, p. 89). My reason for returning to it in this chapter isn't just that I can't bear to let go of my old bicycle. I've chosen it because I feel it highlights especially dramatically a number of key issues relevant to the present discussion that were insufficiently elaborated earlier. One of these is the way in which the relationship between longing and desire exemplifies the broader relationship between implicit and declarative forms of mental experience.

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Chapter 11

Precarious places

Intersubjectivity in traumatized states

Jennifer Leighton

Martha, a close friend of mine, recently confided in me about a therapy session she had in the 1980s. She had reported to her therapist a memory of a naked man emerging through a wall in her childhood bedroom. In the session she recalled shaking and hyperventilating. She had had no idea where the image came from, only a vague sense that the man looked like an old friend of her father's. The therapist told her it must have been a dream, otherwise she would remember more. Before she left the session that day he comforted her and helped her regain her equilibrium. For the next many years she continued to experience symptoms that had plagued her most of her life—an eating disorder, abuse in intimate relationships, and frequent states of feeling poisoned and poisonous. Fortunately, in a more recent self-psychological therapy my friend took the risk of telling her new therapist a disturbing dream. This therapist's reaction was different in that she responded with what Self Psychologists call "sustained empathic inquiry," a moment-by-moment attention to the patient's moods, facial and body changes, dreams and cognitions. This allowed Martha to eventually uncover and process multiple memories of early sexual abuse. She has benefited enormously from her realization that her symptoms were expressions of what actually happened to her, not that there was something terribly wrong with her. Following this recent analysis, her symptoms have abated, and she is leading what she now feels is a good life.

What happened to my friend in the original treatment was not unusual. For many years, patients' dissociated, verbal and non-verbal (body language, voice tone, dream images, etc.) experiences were mostly disregarded by psychoanalysts. However, as the therapist's ability to listen more closely to the patient's experience has increased, and as theories of trauma and dissociation have been reintegrated (albeit unevenly) into mainstream psychoanalysis, there has been a seismic paradigm shift: the patient is now more frequently understood in the context of what it took for her to manage the world of her childhood and beyond, and organize it in a way that she could best survive. (See, for example, Stolorow, 2000; Howell, 2005; Grand, 2000; Bromberg, 2011.) I am not alone in my belief that important trauma and

dissociation theories have been a strong undercurrent in psychoanalytic theory since Janet, Ferenczi, Balint, and Bion. Winnicott (Goldman, 2013), Fairbairn (1952, 1954), and Bromberg (1998, 2006, 2011) are just a few who come to mind. And then, in the 1980s, relational theory came to the forefront of psychoanalytic thinking. The relational turn provided a theoretical home for psychoanalysts to combine the paradigms of all relational theories, which then gradually opened to embrace and integrate past theories of trauma as well as the newer fields of trauma and neuroscience.

The study of Self Psychology is one of the relational theories that emerged during this time and has also been one of the prime movers in this paradigm shift. The traditions of Self Psychology offer the overarching principle that it is essential for the therapist to be engaged in a patient's experience.

Although Self Psychology is my theoretical home, I want to make it clear that the following is not an overview of Self Psychology. I apologize for missing many valuable contributions. Furthermore, Self Psychology has expanded and cross-fertilized with many other theories—interpersonal, trauma, relational, attachment, affect, complexity, dynamic systems, as well as philosophy and neuroscience.

In the 1950s Heinz Kohut, the founder of Self Psychology, joined the growing trend in psychoanalysis in asserting that psychopathology originates in the child/caretaker unit and the resulting derailment of the child's ongoing development—a trauma to the developing self. The child was not threatened by overwhelming desires and drives from inside, as Freud thought, but instead was trying to manage what was experienced as overwhelming and threatening from the outside world. Kohut (1971) explicitly redefined the nature of what it is to be human. Freud's "guilty man" was replaced by Kohut's "tragic man," who was vulnerable to trauma, both developmental and acute.

Kohut (1971) foregrounded the development of healthy narcissism and understood narcissistic development as separate from object relational development, emphasizing the central importance of the maintenance of self-cohesion throughout the life cycle. It is the thwarting of what Kohut termed "selfobject" needs for recognition and idealization that results in relational trauma—splitting, loss of cohesion, shame, rage, and catastrophic fragmentation. Kohut, like many psychoanalysts who came before and after him, was searching for a construct that would help us understand the interiority of a patient whose world was upended and, in doing so, he revisited Janet's notion of dissociation (see the Introduction in this volume). In Kohut's terms, as in Howell's (2005), dissociation refers to parts of the personality that have been split off and have not been interpersonally influenced. Self Psychologist Atwood explored further notions of dissociation: "the trauma that can be dissociated . . . leaves sustaining ties intact to some degree, so that a stable platform of selfhood and worldhood survives through the encapsulation of the traumatic event" (Stolorow, Atwood, and

Orange, 2002, p. 173). He differentiated this configuration from what he called the "psychoses" where the trauma "annihilates and subverts connections at fundamental levels of selfhood" (ibid.). To my knowledge there is nothing in the Self Psychology literature that speaks about DID or Complex PTSD per se. Self Psychologists, even when describing dissociated parts, generally tend to use the language of "self states," rather than "parts." As far as I know they do not recognize the concept of "alters" that is central to the understanding of dissociative identity disorders today. Yet these two traditions seem to be grappling with similar, if not the same, phenomena.

By situating narcissistic development in the interpersonal system, Kohut privileged the motivational importance of affects—especially the affects of shame, and narcissistic rage. In fact, shame is the principal affect of "tragic man." Shame is the antithesis of selfobject experience. Narcissistic rage is what Kohut calls a "fragmentation byproduct." While shame is usually understood as the initial reaction to selfobject derailments, and narcissistic rage as the defense against unbearable feelings of shame, it is also true that shame can defend against breakdown and rage, and that both shame and/or rage can function to keep a dissociated system intact. Both are the result of lack of human contact; later they can also defend against the vulnerability of human contact.

The concept of empathy flows through self-psychological theories like a steady river. In 1959 Kohut defined empathy as a way of knowing a patient, of getting data from inside the patient's experience. Although in many psychoanalytic circles empathy was misunderstood and scorned largely because it was confused with feeling sympathy for and joining with the grandiosity of the patient, in fact Kohut's 1959 treatise on empathy was a major voice in the articulation of the new relational paradigm: If we are to know and heal our patient, we must immerse ourselves in his experience and the context of his development. It is a process that involves both emotional resonance and cognitive integration with the therapist's personality and theoretical constructs. This listening perspective was something that the therapist who treated my friend Martha lost. He did not consider her nascent memory and striking body reactions as material demanding his attention. Kohut's concept of empathy allows the experience of the patient to be recognized and valued, challenging the overriding authority of the analyst's theories and constructs. It is this function of empathy, as in the case of Martha's second therapy, that begins to break down the walls of closed-off dissociated systems.

Kohut's concept of empathy has been expanded from a unidirectional process to a mutual interactive attunement. Intersubjective systems theory represents a milestone in that expansion. Stolorow's intersubjectivity is an epistemological construct, assuming the indissoluble unity of two subjectivities in a dyadic system whether or not they are conscious and articulated. While the patient's experience is the center of clinical articulation, the

analyst's subjectivity is equally important in the creation and development of the treatment narrative. I maintain that developmental (if not also acute) trauma is in all of us and therefore *both* therapist and patient are narcissistically vulnerable to shame and dissociation. (I single out the experience of shame in this construct, rather than narcissistic rage, because I believe shame is the core affect and narcissistic rage is an attempt—often misfiring—to reestablish self-cohesion.) When a therapist is triggered into traumatic states, she can no longer hold her theories of intersubjectivity in a complex way. The therapist is vulnerable to destabilization by expressions of horror and terror in a patient, states which are frequently entangled with the therapist's beginnings.

I have written elsewhere (Leighton, 2004) that the therapist's theories reside largely in cognitions, which, when her traumatic states are awakened, can be dissociated from her affect. And in that unintegrated and traumatized state she is vulnerable to dropping out of a two-person system, pathologizing and shaming the patient and/or herself, even as she still cognitively asserts that all events are co-constructed. In other words, the theory of intersubjectivity gets dissociated. I think a substantial antidote to this problem is to open up our writing in a way that elucidates our fragility and difficulties with experiences that destabilize us. If our clinical writing can move in the direction of greater transparency, there can be more clinical dialogue; we can help each other with our most difficult clinical interactions. Self Psychologist Janicke writes: "Shame, the ghostly jailor, prevents us from accepting [that] . . . our own suffering plays an intricate, ongoing and irrevocable part in each of our encounters with our patients" (2013, p. 249).

In an enactment or an impasse, we must travel the difficult path, exploring *both* subjectivities in order to help repair ruptures. Rupture and repair cycles that speak to authentic recognition of the other person's subjectivity are hallmarks of self-psychological treatment and speak to the way two subjectivities understand and misunderstand each other. Self Psychology's consistent articulation of the paradigm shift in psychoanalytic thinking flows seamlessly (at least for this Self Psychologist) into trauma theorists' models of the dissociated mind. These models are an important expansion of my "home" theory of Self Psychology (see Leighton, 2006).

For the remainder of this chapter I will attempt to convey a self-psychological approach to trauma and dissociation in the context of a clinical case. I will explore my own subjectivity, my understanding of the patient's subjectivity and the "us" in various moments of the treatment. I will also attempt to track dissociative parts of both therapist and patient.

First, two backstories to the case – hers and mine

I graduated college in the mid-1960s and was drawn to social work at a time when babies were glutting the hospitals, suffering severe neglect, and as a

result, failing to thrive. My first job in a foster care/adoption agency was on a "baby placement project" that was designed to move babies out of these institutions quickly.

Early on in our treatment Gloria told me her mother worked in the evening, leaving Gloria in the care of a father who hosted nightly drug parties. Later in her life (when he was sober) her father told her that when as an infant she would scream from her crib, he would turn the radio up so that he and his friends were not disturbed by her screaming. As she told me this I felt my heart breaking, and then I remembered again (and later told Gloria) that I was told that as an infant I was on a four-hour feeding schedule, popular with the experts at the time. I was left screaming in an upstairs room where I could not be heard, in between feedings. I did not link both of our experiences as unattended screaming babies with the mission in my first job (to save screaming babies), until just now six years later, as I draft this chapter. The notion of multiple selves and/or self-states that are often dissociated from each other, helps me understand that the process of "linking up" can move at a snail's pace throughout one's life and can then be surreptitiously triggered in intersubjective moments in treatment.

In Gloria's initial telephone call to me she sounded opaque, intelligent, and polite. But the chaos of her current circumstance emerged during our first session. She was living with a previous therapist, caring for the therapist's children, one of whom was very disturbed. I had to listen closely in order to understand that this was not the immediate crisis. What actually drove her to once again seek treatment was that her psychopharmacologist, who was also part of her care team, had just learned that Gloria had been living with her therapist for the past three years. He told her he could no longer work with her. His abrupt termination bespoke yet another loss and upheaval for Gloria. Four years earlier, she had begun treatment with this same therapist and psychopharmacologist as a result of a life crisis that had reinstated strong OCD and PTSD symptoms she had suffered in childhood. At that time she was also suicidal. She was then and remains to this day prone to nightmares and flashbacks that are still, after six years of our treatment, mostly unsayable, but seem clearly embedded in the infant chaos of those drug parties. Severe gastro-intestinal problems she suffered as a child persist to this day. As I see it, these symptoms reflect the unattended, abused, screaming baby as well as the later neglected and abused child.

Gloria was beautiful. She was 24 years old and had large brown intelligent eyes that latched onto mine as she tried to explain her situation, evoking in me a hunger for engagement and connection. She had dark curly hair and a face adept at both revealing and obscuring intense feelings. In the beginning I tried stabilizing exercises, such as deep breathing, grounding, etc., to mitigate her extreme emotional and physical dysregulation. The exercises went over like lead balloons, although she didn't say so at the time. We later understood that to feel safe or even unguarded threatened her system—a

"closed system," hypervigilant and unavailable to interpersonal influence (Howell, 2005, 2011). This part of her that knew no safety was scared of me and also "knew" I hated her. I was initially puzzled at what she "knew," and I could not respond empathically to her conviction that I hated her. Hated her? Hate was not part of my felt experience with her in this early time. Eventually I was able to shift to a listening perspective and find my way into her feelings of interpersonal terror that were threatening to overwhelm her.

She told me a little of her history. In addition to nightly drug parties featuring all kinds of abuse and a mother who was emotionally and often physically unavailable, she had to grow herself up (she knew how to get her own bottle and put herself to bed at an age when most of us are just beginning to learn how to run around). In short, she had to count on the fact that there was no one to help her manage the screaming baby inside her. A brother born when she was three later became violent, egged on by their father to beat up and torture Gloria. When threatened with feelings of catastrophic terror and fragmentation, the only power she felt she had was to torment her brother in return and inhabit a mean uncaring part of herself. (To this day she is haunted both by having tortured her brother in the ways she did and also by knowing that her protective part is still mean. It is "proof" to her of her core badness.) A large extended family offered no substantial help. Only some teachers and a war-torn but loving grandfather, who died when she was five, supported the forward-moving parts of Gloria that sought relatedness and genuine connection. (All theories of Self Psychology assume the developmentally traumatized child also has "tendrils of health" (Tolpin, 2002, p. 168) which flourish with proper nourishment in adulthood.)

At the same time that Gloria was convinced I hated her, within the first month it was clear that another part of her wanted closeness and connection to me. When she felt close she felt calm. At the time I had room for all her feelings and shifting states—her conviction that she was bad, her grandiosity that she was clever and resourceful enough to "make" someone love her, and her little-girl need for genuine connection and affection. I was quickly able to refer her to a top trauma psychiatrist in New York City and after some kinks were worked through, her immediate crisis abated. However, she was still living with her previous therapist and taking care of her kids. Although at the time it felt to me to be a destructive arrangement and certainly no long-term solution, it seemed counterproductive to expect her to do what she couldn't do (leave). I also did not demonize the therapist, since this same therapist had done many good things for her, including save her life during a previous crisis.

The connection between us had grown strong now—several months into the treatment. It felt bonding, and yet I worried about the strength of my attachment: Was it too intense for her? How much of my unknown matching unmothered parts were destined to be in the mix? My hope that I could

negotiate these waters prevailed. I thought my good, experienced therapist part could hold the unknowable.

But the part of her that was scared of me and "knew" I hated her, along with the part of her that contained both the desire and capability to connect, needed to be useful to me in some way. She knew that I was a technological third grader, and so she thought she might help me get Netflix. I wouldn't let her. She scoffed and said that it wasn't like asking to live with me and take care of my children (a black humor joke because by this time she was integrating the destructiveness of the misconduct of the previous therapist). I told her I would rather err on the side of caution here, given her deeply held conviction that she could be loved only if she was useful. I held my ground, not because it was some psychoanalytic rule (under other circumstances I might have made another kind of decision). But I was trying to find my way with someone who had been seriously violated—violated in her original family, then used by a beloved therapist.

Here is another thread of the story: I was consciously aware that something else in me was activated in our relationship. Many years ago I wanted to adopt a child—a plan that got upended by my husband's terminal illness and death. And in the chaos of my complicated reactions, overwhelmed both by continual care taking and the eventual loss of my husband, I found no space to mourn the loss of the baby I had briefly conceived in my mind. So, even though I was vigilant that Gloria not be a function for me, lo and behold, here was her opening to function for me. She rather quickly became the imagined baby and child I had never mourned. Within this part of our relationship my love and affection for her filled me.

I am trying to convey something very complicated here, which is important because in my opinion, it occurs frequently in treatments where severe dissociation is involved. I was cognitively aware that Gloria could be for me a fantasy replacement for the baby I had lost, yet I did not know the force of the grief for the imagined baby I had left behind. Rather, I knew and didn't know (Howell, 2005). But that self-state—that part of me—could not surface until I was ready to process that loss and thus allow it to be triggered in the treatment. It is my view that for many therapists, our patients oblige us with such opportunities. The self-psychological tradition recognizes the selfobject needs of the therapist. The dissociative model of the mind spells out the intersubjective tangle in a way that helps me understand and hold my intense and shifting states.

In our deeply held fantasies I became the mother Gloria never had and she became the daughter I lost—the articulation of corresponding parts we were both living and examining. Allowing these parts their space embodied the mutual empathic process that Self Psychologist Richard Geist describes as a necessary part of the healing process. We would talk about the timing of my adoptive forays. I should have come for her. She would not have a perfect mother in me, but she would not have been subjected to catastrophic neglect

and abuse. By this time I had a felt sense of the longing in both of us . . . longing to do the whole thing over.

Not surprisingly eruptions occurred. Gloria could suddenly produce a thunderous glower and total shut down along with the accusation that I was mean and I really hated her. I would live through week after week of what I experienced as a gatekeeper part in her that would attack herself (for not healing fast enough) and me (for not healing her fast enough). This gatekeeper part that kept her screaming baby away from our process, would offer up no reflection on the excruciating suffering in her nightly flashbacks, only harsh accusations that I was doing nothing about it. Sometimes I would collapse into shame states, feeling like a deer in the headlights. I had my own traumatic reaction to feeling so abruptly hated and shut out. I was internally catapulted from blissful states of being a loving mother to painful states of feeling inadequate and hated, all the while feeling the driving need to be a good enough therapist. Gloria drew a picture of a girl sitting on a couch and a woman sitting on a chair very calmly with a huge waterway in between which she labeled a gulf. Part of me blamed her for the gulf, and part of me blamed myself, even though I knew cognitively that this was the intersubjective enactment I had theorized previously (Leighton, 2004).

I consulted as well as relied on "theory as a mother" (Preston, personal communication). I reminded myself that Gloria's flashbacks held younger unsayable dissociated self-parts that encompassed her daily torture as an infant and child. I understood that Gloria's infant parts had an unavailable mother and a father who by his indifference made her feel hated every day. All the while I continued to struggle with my overriding need to be a good therapist to my patient, not the child who was hated by her own mother or the hated and inadequate mother I sometimes thought I had. I walked the tightrope of shame and hope.

After a year and a half Gloria left treatment for several months. She lost her job and her insurance, and I would not agree to see her for free. I did not know if she would return. This was a stormy time. Her emails were filled with rage; mine—veiled rage mixed with unsuccessful attempts to make things better. In Interpersonal Relationalist Bromberg's (2011) language, the "collision" had happened, in Self Psychologist Russell's (1998) we were deep in "the crunch." The aforementioned screaming babies project looked like it might not work after all. Although I knew Gloria was devastated that I couldn't actually be her mother—she would have no new beginning—I felt I had to stop our email rants and to do whatever I could to leave the door open for her to return to therapy. I hoped that time would calm us both down. In this last sentence, I hear myself sounding like a therapist in control. The truth is I was broken-hearted, like a mother who lost a daughter she might never see again. However, both mothers and therapists must cope with the fact that they are not in charge of their adult daughters' or patients' comings and goings. My cognitive understanding did not mend my broken

heart, but it helped me stabilize while I waited in that terribly uncertain place.

Six months later she returned and I was thrilled to see her. I marveled at the work she had done on herself during our hiatus. I wanted to do well by her. I knew my job was to strengthen my role as therapist and mourn the fact that I could not be mother, nor could she be daughter. I had to learn to sit through her silences and unspeakable terror. At times she would say to me, full of blame and shame: "I've been with you for six years and you haven't helped me."

A series of recent practical life crises plus an intimate relationship that is alternately helpful and emotionally abusive has left Gloria feeling unraveled. This relationship has created a devastating combination of a neglectful mother and a hating father—which I believe is its function. She has sometimes lost track of our relationship and missed her therapy sessions. Gloria will "forget" that she had made the deal to keep her sessions when she returned to treatment four years ago. When I request she keep her scheduled appointments, she can become aggressive: "How dare you ask me to change my plans [keep to the therapy schedule] when you just abandoned me for three weeks [my vacation]!" At other times she will write me a short bit of news of her day (sometimes prompted by a check-in by me) and ask me if she is going to be okay. To which I say: "Yes," because that is what I believe. Another phone message says in response to my brief email queries: "Thanks so much for keeping track of me. I love you."

My work continues to focus on finding a handle on my triggered, dissociated shame states. I less frequently feel so paralyzed or triggered by her attacks, but understand them to be the "mean" self-state she retreats to when she feels it is the only way to protect the screaming baby. More often, now, I am apt to feel grief for her childhood horrors. I am glad for my own growth. Over time I feel more like the therapist/mother I want to be. And I want Gloria to feel like the amazing person she is. My hope is that like my friend Martha, Gloria will realize bad things happened to her, not that she is bad to the core.

Many of us who have our home in Self Psychology have an "integrative sensibility" and delight in bringing in new ideas to our "home theory." I have attempted in this chapter to elucidate some of the ways Self Psychology contributes to new relational paradigm thinking and also leads to current theories of trauma and dissociation. In my conviction about the continual presence of intersubjectivity, I also emphasize the contribution of the therapist's shame and dissociation in the treatment and the need to address them.

Addendum

Subsequent to submitting this chapter, much has happened in treatment. Gloria immediately responded to reading the chapter with enormous hurt,

manifested as mostly rage and contempt. In her view it was solid proof that I did not love her. After eight months of rupture that created inordinate pain for both of us, we were finally able to articulate what was "wrong" with the chapter. This articulation initiated a long process of repair. Limitation of space does not allow elaboration, but recently I received a letter from her that demonstrates the dire necessity of the analyst hanging on to the authentic connection in the treatment. I quote a paragraph from Gloria's letter:

> We are approaching our 8-year anniversary this Friday, and through everything, every struggle we have been through, you've never ONCE let go! I was so scared so many times that I couldn't hold on to you. I tried to let go many times, but you ALWAYS had my hand. You've held on to me for dear life . . . Thank you from the bottom of my heart.

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I refer the reader to the *International Journal of Self Psychology*, 2014, vol. 9, no. 1, published just after I completed this chapter. The articles therein represent Self Psychology's continuing integration of new perspectives on trauma, dissociation, and neuroscience.

Most of all I would like to thank Gloria for going this hard way together.

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Chapter 12

Latah, an ethnic syndrome with dissociative features

A sadomasochistic pattern?

Elizabeth Hegeman

> It began when my mother died. I was very sad. I was sitting quietly like this, thinking my mother is gone. Someone came from behind. He grabbed me and said, "What's up?" I was startled! My body trembled like this. My mind went blank. When my body stopped trembling he did it again . . . I couldn't think—how could I? Later, wherever I went people liked to watch me . . . They poked me in the ribs over and over until I became ill!
> (Simon, 1996, p. 163)

The woman who spoke above is suffering from latah, a "startle-matching" or imitating syndrome found in rural Malaysia and Indonesia, and widely recognized by people from those countries. It always begins in adulthood, almost always in women (probably because of their lower status), and often during a time of loss or life crisis like menopause or the death of a relative. Everyone in the community participates, either as a latah (a woman with these symptoms), as someone who provokes episodes, or as a spectator.

This chapter raises controversial questions: Can we use what we know about trauma theory and dissociation to understand and analyze a trauma that is primarily interpersonal and relational, occurs primarily between adults, and is shame-based rather than based on intimate betrayal, physical pain, or adult/child exploitation? What if the symptoms occur in another culture?

The statement above is a description of how the latah syndrome is learned: first an exaggerated startle reaction is observed (the word "latah" means startle). It is then intentionally provoked over and over again, by anyone in the community, and while she is in the state of emotional disorganization and trance that follows her hyperarousal, she is given a command—"Dance!" "Hit!" and is likely to obey, even if the act is violent or embarrassing. Latahs may also be taught/provoked to imitate movements, and may spontaneously curse and use crude language that they would not ordinarily use, upon being startled. The experiences connected with the exaggerated startle response become a part of the latah's public identity, and seem to give everyone in the

community permission to provoke her with impunity. The motive for eliciting the latah's responses is for the amusement of the spectators. According to Ronald Simon, ethnographer,

> Informants frequently told me that virtually anyone could be made into a latah if startled by others frequently enough. As one latah, Cik Layut Ali, explained, if startled enough, a Westerner might develop latah too. (1996, pp. 162–163)

In fact, a recent study found eleven women who met criteria for the diagnosis of latah in a survey of a hundred North American women psychiatric inpatients (Ross, Schroeder, and Ness, 2013). These women reported high rates of physical and sexual abuse as well as extensive dissociative symptoms, so it seems that the Indonesian informants were correct in their assertion that latah could be taught to a Westerner. Ross *et al.* conclude that the so-called "culture-bound" syndromes might be better understood as primarily dissociative in nature.

In the DSM-IV-R, twenty-nine ethnic syndromes were described. These were conditions whose symptoms were recognized, named, and responded to by local members of the same culture, and were very often reactions to stress or trauma. The number of these syndromes was reduced in DSM-V. Taken out of context, these entities may sound bizarre and senseless, even psychotic. As I have argued at length in "Ethnic Syndromes as Disguise for Protest Against Colonialism" (Hegeman, 2013) these syndromes are very often the product of colonial conditions or domination of one group by another, and the symptoms may represent aspects of political protest, as well as the internal individual struggle against the unfair exercise of power by a dominant group.

It follows, then, that if the syndromes originate in traumatic power relations, dissociation would be an effective and preferred defensive style as it allows for forbidden rage and destructive impulses to be excluded from awareness. I also argue that the dissociated affects and meanings can resurface and be expressed in disguised form. I have described how the dissociative features of ataque and zar work to disguise and suppress rage, and also how rage then is displaced and surfaces in the content of the demands of the possessing spirits, and in the satire of the powerful figures from the controlling group (Hegeman, 2013). These forms of mental activity in the spirit world and in the communal group, often with other women, can allow access to aspects of power and a sense of agency that are not threatening to the dominant group.

Latah, one of the ethnic syndromes dropped from the DSM-V, illustrates even more clearly how dissociation operates for some members of the community throughout parts of Indonesia and Malaysia. For years there were arguments among psychiatrists and social scientists as to whether latah

was a "real" condition; arguments were advanced that it could not be real because no one had been injured from losing muscular control, and no babies had died from being dropped. The argument seemed to be, therefore, that the symptoms must be under conscious control, and thus pretended. (A motive for pretending the symptoms was not offered.) These arguments became known as the "latah wars" (Simons, 1985). But in evidence for the existence of the condition, the same cluster of symptoms is widely recognized as far away as Bali (Suryani and Jensen, 1993). In many rural Indonesian villages, women will come forward or be pointed out—mostly post-menopausal, single women who are living alone or as household help with a family, in other words women holding a devalued or unprotected status. Latah was probably dropped from the DSM because of controversy over its existence. I think this is because of the relentless modernization and urbanization which brings all local culture into a homogenized global world and makes people ashamed of traditional customs. The absence of evidence in urban settings shows how effective dissociation and denial are in normalizing a sadomasochistic custom. And except in Bali, where it is said to be a source of amusement rather than shame (Suryani and Jensen, 1993), being a latah or even being related to one could bring embarrassment, especially if a Westerner were asking (Simon, 1996).

Indonesian culture emphasizes the importance of self-control, which makes latah and its related (more usually masculine) syndrome, amok, so striking in that they violate that norm. Although early forms of amok can be traced to rituals of revenge in clan wars, it became formalized and recognized more fully during the period of colonial occupation. Amok shares certain features with latah: an altered state of consciousness, the reversal of accepted norms of self-control, and the lack of a specific object of attack. But it differs from latah in that the trigger is usually a loss (of a job or a relationship) or an insult, followed by a period of withdrawal to the point of catatonia, stopping eating or sleeping to brood alone, and then an extreme outburst of diffuse violence until exhausted or injured. The anger is directed outward rather than at the self.

A latah (a woman with all of these symptoms) will show the following features in an episode:

1 An exaggerated startle reaction, as when poked in the ribs from behind and surprised. This reaction gets worse over time, as people in the village become accustomed to poking her for fun, to see the reaction, even against her protests.
2 Trance or the appearance of a highly altered state of awareness;
3 When startled, shouting or saying a string of obscene or forbidden words in an uncontrolled way—coprolalia;
4 Obeying commands from others, even if they go against conventional judgment, like taking off one's clothing;

5 Echolalia—repeating what is said by another, and sometimes matching, or imitating the actions of another person in mirror image.

The potential for becoming an object of mockery seems obvious, and the identity of the latah is known to all. In the descriptions I have read, she does not seem to express resentment or anger about her condition, but rather tries to laugh it off with embarrassment. She seems to feel shame at having done the behaviors that make others laugh, without acknowledging that she has been provoked, or openly recognizing that she is being scapegoated and bullied. There is no mention of defending herself, fighting back, or objecting to how she is being treated.

Let us analyze the features of the syndrome one by one in terms of their defensive function, and how they indicate the inability to process the initial stimulus:

1 Startle reaction: This is the trigger that initiates the sequence of unfortunate reactions. No doubt the women who become latah have a greater susceptibility or neurological reactivity, which is consistent with the tendency for latah to run in families. But key to our theorizing is the inability to process the sudden startle. Rather than being able to process the poke in the ribs or other startling stimulation, the latah becomes overwhelmed neurologically, goes into trance, and falls back on a stereotyped verbal reaction, cursing and obscenity, within seconds of being poked.
2 Trance and altered state and echolalia: The stereotypy suggests an inadequate processing, an inability to bring the events to the level of integrated memory, perception, and sensorimotor experience. It may be that the latah does not have cultural permission to protect herself—she is living in the hell of "only kidding" that deprives so many people of their right to object to their treatment. "Where's your sense of humor?" is the Western version of this double-bind. In Indonesia, teasing is a way of life, and it starts early. Political analysts have speculated that President Obama's time living in Indonesia as a child played a formative role in his famous unflappability. David Gardner (2011) in his review of *A Singular Woman: The Untold Story of Barack Obama's Mother* by Janny Scott, quotes an Indonesian woman: "Self-control is inculcated through a culture of teasing."

   If latah women with their low social status are not entitled to defend themselves, the multiple dissociative symptoms may be a form of internal defense.

   Howell (2002) discusses the role of imitative behavior as defensive in victim–victimizer relations. The latah victimization is a pale version of the adult–child sex abuse examples discussed by Howell, and the examples she discusses from Eagle (1999) and Ferenczi (1949). Latah is,

at its worst, social humiliation of one adult by another, usually with no bodily injury. But it does show extreme "learned helplessness" and the concept of mimicry as a dissociative, neurologically primitive behavioral response that Howell formulates as incorporating both the victim and the aggressor state, rather than the non-dissociative defensive concept of identification with the aggressor (2002, pp. 932–933) which may help us understand how the latah is led to undertake acts she would not normally perform. As Howell (p. 934) points out, "although the terror-filled relationship is dissociated, it frames the survivor's world view as an inescapable, constant background definition." In this view, the "bad objects" never go away (Fairbairn, 1952).

This certainly describes the experience of the latah who lives in dissociated dread of being sneaked up on and poked, when she is daydreaming while washing dishes or peeling vegetables. Howell (2002, p. 932) describes the coexistence of "strange, unblended combinations of intense feelings of both innocence and guilt." Again it is important to emphasize that the victim–victimizer relations are very different here, with shame being the predominant affect rather than guilt, and the victimization being of a social-relational nature rather than a primarily physical intrusive one. (There have been only a few reported cases of latahs stabbing or wounding others while in trance.) But even though the trauma may be a micro rather than a macro trauma, the suggestion Howell cites by Emch (1944, p. 9) that "imitation may serve as a kind of substitute for memory and may represent an attempt to master essential knowledge about significant others" is a striking fit with the latah pattern. The knowledge may just be that others care more for their own amusement than for whatever the latah herself might be experiencing; not life-threatening, but arguably traumatizing.

3 The cursing and obscenity described in the ethnographic record might be an expression of aggression aimed at others, otherwise absent from this whole configuration. Howell (2002, p. 13) suggests that the states of hypo and hyperarousal or freezing/victim and rageful affect can alternate and be split off; the cursing and obscenity, objectless, do seem split off. This defense is not effective, however, in protecting the latah from further attack, and in fact brings further shame and disapproval. The fact that it is generalized—not aimed at any particular person such as the aggressor—blunts any perception of autonomous aggression or agency. The cursing and obscenity have the impact of a double message, a forbidden rule-breaking which is excused because the latah is in trance, and further excused because the words are not directed at any particular person.

4 Obeying commands: Again, action while in trance "doesn't count," but does open up the latah to shaming and further bullying. Especially if gendered exposure is commanded, like taking off clothing or dirty

dancing, it may invite sexual exploitation or devaluing not limited to when she is in latah states. Obeying commands is also one of the well-known hazards of hypnosis in Western cultures, when lower-level brain functioning takes over and people make fools of themselves in stage shows. An important difference about the person volunteering to be hypnotized on stage is that they are at least on some level knowingly accepting that they may be made into a laughing stock, while the latah does not seem to have that choice.

5 Echolalia is a neurological sign of defective or lower-level brain functioning. Here too we could make connections with the inability to process the sudden startling stimulus, especially if the poke is experienced traumatically.

Latah symptoms indicate disruption of: (1) verbal systems—falling back on echolalia and stereotyped cursing and obscenity rather than being able to generate speech from fully conscious, integrated experience; and (2) attachment systems—blind obedience, even to strangers who issue commands that are very much against the self-interest of the latah. These descriptions sound like the revictimization of helpless people who have internalized the shame and blame for their condition and feel the feelings their persecutors might feel (Howell, 1996). In fact, many of the experiences we might regard as traumatic are normalized in the cultures anthropologists study, which makes it hard to define and study "trauma" in cross-cultural contexts. As outsiders to another culture, we are of course imposing a meaning that is different from that acknowledged by the members of that culture itself; it is as if we are saying that we know better, or that our meaning is better. But it seems from a Western perspective that some combination of neurological susceptibility, position in the community, and a vicious circle of bullying, self-identification—"I am a latah"—and revictimization work together to maintain the pattern of a sadomasochistic custom that is normalized as a joke within the culture. Furthermore, the victimized person takes on a sense of responsibility for their own victimization, however mild or severe it is estimated to be.

In his book *Boo!*, Ronald Simon (1996) has studied the startle reflex in different cultures and has found the hyperstartle-echolalia-obey syndrome in places as widespread as Siberia, Lapland, Sweden, Yemen, Japan, Philippines and North America (Canada and Maine). He feels that the components of startle syndromes and the capture of attention that follows have a universal biological basis (p. 222). People with the exaggerated startle reaction react strongly to stimuli that others find innocuous. It begins in adulthood, it never reverses, and similar stimuli elicit the response in each culture. Startlers are likely to be of lower status and are expected to fulfill a certain culturally prescribed role. However, cultural factors lead to different patterns. For example, beliefs about what causes it, how it began for each person, how

deviant or stigmatized the person is, and the proportion of men versus women affected will vary according to cultural context.

In conclusion, my answer to the earlier question is: Indeed, we can use trauma theory to understand interpersonal trauma in other cultures, even though it may not be as clearly horrific as child abuse or rape. The physiological response to a startle is undeniable and seems to lead to a repeated pattern of experience of being used as an object for amusement by others, which must have some negative impact. The study by Ross *et al.* (2013), cited earlier, confirms the universality of vulnerability to syndromes that have been called "culture-bound."

Addendum

The January 19, 2014 *New York Times* reported recent episodes of collective fainting, spirit possession and speaking in tongues among Cambodian garment factory workers which are very similar to ethnic syndromes previously described. The article takes the position of interpreting the phenomena as having political and religious significance, making it seem expedient, even intentional for the women who might be seeking better working conditions. It does not consider the possibility that the conscious explanation within the culture, of a violation of a religious norm, can coexist with unconscious or dissociated feelings of resentment, exploitation and helplessness.

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Part 3

Aspects of psychoanalytic treatment of complex trauma and dissociation

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Chapter 13

Thoughts on working with the dreams of DID and DDNOS patients

Richard P. Kluft

This paper is dedicated to my analyst, the late Harry W. Cohen, M.D., a man of great wit and greater wisdom. In lieu of an inevitably inadequate tribute, I will let him speak for himself:

Dr. Kluft: I had a dream. I don't remember it. I wrote it down on a little pad on my nightstand, but when I left to come here I couldn't find it.
Dr. Cohen: Dr. Kluft, do you know why people in analysis write down their dreams on little pieces of paper?
Dr. Kluft: No, Dr. Cohen. I don't.
Dr. Cohen: People write down their dreams on little pieces of paper so they will be easier to lose.

I also acknowledge the influence of the late Ernst Hartmann, M.D., in whose sleep lab I worked as a research assistant many years ago.

My dissociative disorder patients' most common dream reports resemble my own words to my analyst. They have dreams they don't remember. They may recall some emotional state, usually dysphoric, that eludes further clarification. Their associations can neither be grasped nor verbalized, although metacommunications may suggest particular types of discomfort. Occasionally other alters could report the dream, but may decline or be prevented from responding. All too often Freud's "royal road" to the hidden regions of the mind seems barred to meaningful therapeutic traffic.

We generally dream four or five times a night during the REM sleep phases of 90-minute sleep cycles. Few remember more than one per night, if any. Our recalled dreams are usually from cycles immediately before awakening, or have disrupted our slumber. Traumatic flashback dreams, like night terrors, need not occur during classic REM or "dream sleep."

Limitations of space preclude summarizing and synthesizing the literature. Readers are referred to Clow and McNamara's 2010 review of sleep/dream physiology. Comparisons of three recent dream-relevant

bibliographies—(1) Pulver's (Pulver, 1978; Pulver and Renik, 1984; Pulver, 1987) on modern psychoanalytic dream theory, (2) Howell and Itzkowitz's (2013) on dreams in dissociative patients, and (3) Fredericks and Phillips's (2013) on dreams and trauma—disclose that no single article or book appears in all three lists. Only two appear in more than one! Reconciling their startling divergence is beyond the scope of this communication.

Nonetheless, the literature raises many issues of importance. Recurrent dreams based on traumata with powerful elements of shame (e.g., Lansky and Bley, 1995), flashback-like nocturnal phenomena (e.g., Hartman, 1996), modified and revised representations of trauma (Hartman, 1996; Herman, 1992; Howell, 2005, 2011; Kluft, 1996, 2013), unpleasant dreams involving recurrent relational/attachment dynamics (Howell, 2005, 2011; Kluft, 2013), and brief and rapidly tapering bursts of traumatic dreams stimulated by intercurrent events or triggered by connections in life and/or treatment with past traumata (e.g., Hartmann, 1996) occurred in most of my DID/DDNOS patients.

The modern study of the dreams of DID patients begins with the pioneering contributions of Marmer (1980). Unfortunately many studies of the dreams of DID patients are based on data-remote theories or older formulations inconsistent with newer findings. Barrett (1994, 1995, 1996) described ten phenomena in the dreams of DID patients, but only three occurred in a majority of the studied cases. Further, Barrett's conflation of dreams, fantasies, daydreams, and reveries without considering sleep physiology or hypnotic phenomena is problematic.

Howell (2005, 2011) summarizes issues and observations, both previously noted and novel, from a relational perspective. Dreams often reveal matters of importance not expressed directly, and thereby vulnerable to being overlooked. Sometimes recurrent dreams seem to be literal depictions of trauma; sometimes they offer altered or symbolic portrayals. They may demonstrate the patient's strategies of affect regulation and defense. Personalities, both known and previously unencountered, may be depicted. New historical material, both remote and related to recent amnestic events, may emerge. Relationships/conflicts between/among the alters and their different perspectives on a given dream or situation may be represented.

This literature neither has developed nor reflects a consensual foundation. My remarks are derived from clinical experience. Some were presented previously in workshop settings, psychoanalytic articles (2000), and illustrative vignettes (2012, 2013).

I utilize three possibly unfamiliar approaches. First, I avoid offering classical drive interpretations of materials that may appear erotic or aggressive. Instead, I focus on their meanings as communications. Guilt and shame-ridden DID/DDNOS patients often are wounded, even destabilized, if superficially erotic or aggressive wishes are taken at face value. Misunderstanding their meanings and intentions may cause DID/DDNOS patients to feel that they are just as bad as they were told or that they feared they were.

When victims of recurrent sexual overstimulation and abuse are told that they are expressing erotic wishes, they experience such assertions as confirmations of abusers' taunts (e.g., "See, you like it! You really want it!").

Further, many have developed erotically responsive alters to defend against the punishments meted out for refusal or expressions of distaste for the sexual performances demanded of them. All too often these erotized emergency defenses are misread as true longing, to patients' utter mortification and the detriment of their treatments. Self-destructive impulses frequently ensue.

Such remarks occasionally mobilize parts specialized to display putatively erotic coping styles. They may experience such interpretations as suggestions to enact these behaviors.

When DID/DDNOS patients perceive that their dreams/associations are unequivocally erotic/seductive, I focus on "Why now?" to solidify rather than destabilize our working together.

Pt. Does that mean I want to have sex with you?

Dr. K. (*after conventional inquiries/responses*) We've learned to avoid jumping to conclusions. Recently you've been worrying whether I'm angry with you and want to get rid of you. You've told me that X got pretty brutal if you didn't seem delighted to give him what he wanted. You learned to pretend you loved it. I wonder whether your dream refers to what you were forced to do to please him. You wonder whether acting like you want me sexually will stop me from rejecting you.

Pt. Will it? (*laughing*)

Dr. K. (*laughs as well*) We'd be pretending a rape was a consensual sex. This dream is about your fears, not your sexuality. You feel I may be displeased with you, and think sex seems the way to make things safe.

Pt. I think you're right. I've been feeling aroused since I got here, as if I was getting ready.

Dr. K. Well, after we hear your thoughts, we should ask if anyone else behind the scenes got caught up in this and feels a pressure to go into action.

Second, after exploring the dream with the alter that presents it, I ask which alters have a sense of ownership of the dream, and elicit associations from whichever alters have something to contribute. This approach frequently leads to a more complete and nuanced understanding of whatever memories, current events, and conflicts play a role in the dream's formation. It is also my indirect reminder that the alters are aspects of one individual, that our focus encompasses not only the alter in executive control at the moment, but also the total human being.

Continuing the above illustration:

Pt. When I told you that I didn't believe what some of the others said about X, I was sure you were angry with me.
Dr. K. Hmm. I wasn't aware of being angry, but you've told me about X and then taken back what you said about X many times. I may have shown some exasperation. Is there more to say?
Pt. I don't think so.
Dr. K. Well, let's see if any of the others have something to add, especially whoever was getting ready for sex.
Pt. (*switches*) It made him happy.
Dr. K. Him?
Pt. X (*switches back to the personality who spoke first*) Shit! Why doesn't she shut up? She shouldn't say that.
Dr. K. Do you think that you are so conflicted and afraid of getting close to something you don't want to face about X that dreaming you and I are sexually involved, however upsetting, is easier to handle than the stuff about X?

Her powerful wish was to avoid facing her distressing experiences with X. In comparison, violation by me was experienced as a minor indignity.

The third characteristic approach is the identification of shame scripts as defined by Nathanson (1992; see also Kluft, 2007). If I identify their presence, I often make some psychoeducational remarks, and might say, "At times subjects come up that the mind would like to avoid forever." My remarks are indirect suggestions for more open communication when that becomes tolerable. My patient's jest, "Will it?" was a mild "attack other" script within a humorous defense.

How do therapists make use of dreams?

Beyond understanding the manifest and deeper unconscious levels of the dream itself (Freud, 1958), dreams are studied for: (1) typical manifestations of transference and resistance (and countertransference if the therapist's dreams are considered); (2) the expression of surface vs. deep conflicts; (3) confirmation of interpretations; (4) gauging prognosis; (5) reviewing therapeutic progress; and (6) assessing readiness for termination (Pulver, 1987). Dreams can be ongoing indicators of relational elements and therapeutic progress. Dreams and associated materials might refer to actual experiences (traumatic and non-traumatic), fantasies, or theories. Pulver noted that analysts underestimate dreams' expression of actual trauma. He cautioned that while patients' histories and fantasies may be expressed in dreams, so may their consciously and unconsciously-held theories about their pasts. This latter observation is useful with dissociative disorder

patients, who may hold problematic understandings of themselves and their circumstances, often associated with primitive paradigms of cognition in which children believe that whatever happens is caused by their own wishes, feelings, and behaviors, or explanations foisted upon them by others. These patterns of thinking may be fixated by trauma, regressed to under stress, and repeatedly reinforced by historical and internalized abusers.

Therapists' directly or covertly preferred theoretical paradigms may determine aspects of a dream. We jest that Freudians' patients have Freudian dreams, and Jungians' patients have Jungian dreams, but rarely reflect that trauma therapists' patients might tend to have traumatic dreams, and relational therapists' patients relational dreams. Failing to consider this risks unspoken collusions in which the therapists, finding dream material confirmatory of their beliefs, may "coast in the countertransference" (Hirsch, 2008), to the detriment of treatment.

The differential diagnosis of phenomena reported as dreams

Clinicians rarely wonder whether dreams presented to them are actually dreams. Clarification of this matter may help explain certain puzzling reports (e.g., patients disowning dreams, alters attributing dreams to other alters, alters claiming to have imposed a dream or inflicted a nightmare on other alters, some alters claiming not to have slept while others state they were sleeping, etc.).

Sleep disruption is a core symptom of posttraumatic psychopathology. Like some physical illnesses, it may disturb sleep maintenance and sleep architecture. Repeated interruptions and resumptions of sleep may result in recollections of nocturnal experiences that include material from wakeful periods not distinguished from sleep (e.g., alters' activities, fantasies and reveries recalled retrospectively in waking states), hypnagogic and hypnopompic hallucinations, and periods of dysregulated desynchronized sleep-related behavior.

A patient with recurrent dreams of being tied down and lying helpless, unable to move, was studied in a sleep lab. Experiences of sleep paralysis during nocturnal awakenings had been misunderstood as betokening terrible traumatic experiences. Another's elaborate apparent dreams were actually related to nocturnal switches. She reported as dreams: (1) what she observed of her alters' activities in reality or her inner world; and (2) various degrees of awareness of what her alters did as she gradually "awakened" from what she believed was sleep.

Many patients cannot distinguish between falling asleep and entering trance. DID/DDNOS is characterized by high hypnotizability (Frischholz *et al*., 1992). Some alters either have developed autohypnotic approaches or learn them rapidly from the therapist (Kluft, 1982). Such skills may be used

to inflict psychological abuse, impose domination, dictate reenactments within the inner world, and sabotage the treatment (Kluft, 1982). Many initially bizarre-sounding instances reflect alters' imposing all manner of suggestions and indignities upon one another, often while major alters believe that they are asleep. Some phenomena reported as traumatic dreams are actually flashbacks, including flashbacks of nocturnal maltreatment.

Medical events may be mistaken for dreams, their associated discomforts misconstrued as memories of abuse. These include vague recalls of medication-induced parasomnias. Many of my DID/DDNOS patients reported experiences of awakening abruptly in a panicked state, gasping for breath. Most attributed these experiences to traumatic events, notwithstanding that no traumatic dream, or dream of any kind, was recalled. Almost all were diagnosed with obstructive apnea.

Some patients present falsehoods and fabrications designed to affect me (and/or other alters) in particular ways as dreams, often to evade confrontations with unpleasant realities or anticipated dangers. Some patients present dreams of such Byzantine complexity that entire sessions become hijacked and diverted.

The phenomena of lucid dreaming and hypnotically suggested dreaming can prove confusing. Theories and polysomnographic findings about lucid dreaming, dreams in which the dreamer knows he or she is dreaming and may or may not be able to direct the course of the dream, remain contradictory and inconclusive. My study inclines me to hypothesize that lucid dreaming encompasses a variety of different phenomena sharing certain features in common.

Hypnotic dreams (Sacerdote, 1967; Tart, 1964) are dreams experienced subsequent to suggestions. In one form, subjects in trance are instructed to have a dream. In another, subjects are given posthypnotic suggestions (by alters as well as therapists) to have particular nocturnal dreams.

Psychodynamics and dreams

While therapists' approach to the dreams of severely traumatized dissociative disorder patients should include classic consideration, trauma patients are ill-served if they become the dominant frame of reference. More recent analytic tendencies to include reality considerations (e.g., Gubrich-Simitis, 1984; Kogan, 2004; Bohleber, 2010) offer stances more congruent with the realities of trauma treatment.

Premature flights to fantasy, symbolism, hermeneutics, or postmodernist perspectives misunderstand, insult, shame, and injure trauma patients. Conversely, failing to look beyond the traumatic dimensions is an egregious confession of psychological shortsightedness. Ideally, knowledge accumulates, and new knowledge is added to old, rather than assumed to replace it.

Some varieties of recurrent and other dreams with significant implications

Several kinds of repetitive dreams are characteristic: (1) dreams expressing recurrent interpersonal relational dynamics; (2) dreams of vivid traumatic events; (3) dreams representing unresolved psychological reactions to traumatic events; (4) dreams representing intrapsychic coping with these first three phenomena; and (5) dreams of fragmentation. The first two are analogous to varieties described by Hartmann (1996), the third acknowledges Lansky and Bley's (1995) observation on the centrality of shame, and the fourth condenses observations by Hartmann (1996) and Pulver (1987). Many dreams combine two or more of these themes. My views of the fourth and fifth owe a debt to the work of Heinz Kohut (1977).

The first type, recurrent dreams reflecting dysfunctional relationships, often prove better entry points into understanding patients' intrapsychic and interpersonal worlds than dreams of traumatic experiences. They depict our patients' strain as opposed to stress trauma, illustrating their everyday misery and problematic relationships. One patient reported recurrent dreams in which she felt rejected, devalued, and misunderstood; e.g., "I came to my appointment here to see you, but someone was already in the office. You seemed to be listening to her. You didn't pay any attention to me, etc."

It is vitally important to recognize the second type of dreams, the flashback-like dreams of vivid traumatic events, for what they are, notwithstanding the vicissitudes of memory. Treating them as if they were dynamic material dismisses and disrespects patients' pain. I inquire into the sense of ownership of the trauma and elicit associations from other alters. Such dreams may persist because treatment has not addressed all part(s) understood to have endured the trauma. Simply bearing witness for these alters (Herman, 1992) may be quite helpful. Pursuing associations often reveals that switches or even the "death" of an alter and/or the creation of another occurred during traumata. As such experiences are processed, painful dreams may increase in frequency and intensity before weakening and diminishing. Additional flare-ups may be expected if previously unknown alters are encountered. I do not rush to push through trauma. Initial estimates both of the number of alters involved and links to other traumata are often seriously underestimated. Aggressive processing may activate unexpectedly overwhelming forces. Circumspect gradual processing is discussed elsewhere (Kluft, 2013).

Clinicians often worry whether the prescriptions of medications known to have some capacity to reduce traumatic nightmares, such as clonidine or Prasosin, will interfere with therapy and the processing of trauma. It has been my experience that nightmares need not be allowed to persist unchecked in order for trauma treatment to proceed.

The third type of dream (those representing unresolved psychological reactions to traumatic events) reacts to the psychological inferences that

trauma victims have drawn about themselves from their experiences, either in the moment or retroactively. Common themes are survivor guilt, shame over failures to evade or halt the mistreatment of self and/or others, and discomfort over what one was forced to do or to witness being done to others. Dreams in which patients find themselves repeating patterns of unwanted behavior that have become part of their lives, despite their shame and misgivings, overlap with the fourth group.

The fourth variety, which reflects intrapsychic coping with the first three categories of dream phenomena, may co-occur with the third, showing the inner world's reaction to traumata (including relational trauma) and to work with traumata in treatment. They often reflect or anticipate changes in treatment. Often associations and exploration of the affective charges of these dreams prove illuminating.

I regard this fourth type of dream as a variant of self-state dreams (Kohut, 1977), conveying the nature of the alter system and/or the sense that the stability of the mosaic self (Brenner, 2001) is endangered. Exploration reveals no deeper unconscious dimensions. Associations remain focused upon perceived threats to the stability of the self. Kohut (1977) observed that supportive responses to such dreams were unavailing, but clarifying the nature of the perceived danger is helpful.

This presumably relates to the transmuting structure-building capacity of the therapist's expression of empathy when that empathy is based on accurate understanding instead of being a non-specific expression of concern and understanding. The self-object function of the therapist in mirroring back an accurate picture of the patient's plight reduces the likelihood of fragmentation, while mere sympathy leaves the patient confused and without enhanced mastery. Many forget that Kohut insisted that insight was necessary to solidify the impact of empathy and enhance the patient's autonomy.

Sometimes self-state dreams declare themselves directly by the representation of alters or proxies for alters reacting to a threat of some sort; sometimes only associations identify the dream as a self-state communication. While often such dreams reflect matters within the alter system, or the alter system's fearful anticipation of some mistreatment, in my experience such dreams most commonly address relational issues, threats or damages to the stabilizing capacities of important self-objects (either related to those who play major roles in the patient's actual or psychological life, or to transference/relational or reality-based issues with the therapist), or to the self-object functions that alters serve for one another.

The fifth and final type includes dreams of fragmentation, of catastrophic dehiscence, representing a disaster or a feared disaster in which things fall apart, usually due to some terrible explosion or equivalent event. Most express fears that the alter system or patient as a whole will come apart if particular information, traumata, or emotions are shared/acknowledged, some alter or group of alters is accessed, or some stabilizing self-object

is lost. Less frequently, they express concerns about overwhelming and unacceptable feelings.

I pay particular attention to studying the fantasies underlying these catastrophic representations across as many alters as possible. Some are held throughout the alter system. Some are instigated by threats from some alters to others. Others reflect the contagious spread of fears from particular alters to others.

Less frequently, increasing pressures that either will not be acknowledged or are so disguised that they cannot be recognized for what they are generate catastrophic fears. Victims of sexual trauma may experience normal varieties of sexual pressures as so foreign and/or unacceptable that all they can acknowledge is "I feel like I'm going to explode." Further, sexual exploitation victims stimulated against their wills to the point of orgasm may register the pressure of those dissociated/denied experiences as an indescribable discomfort and fear exploding in session. It is easy to become confused by such complaints, especially when they are displaced upwards and experienced in the upper abdomen or chest.

Further thoughts on working with the dreams of dissociative patients

Therapists addressing the dreams of DID/DDNOS patients must contain countertransferential enthusiasms and pressures to share all they know and/or hypothesize with the patient. These patients characteristically employ avoidance and disavowal-based defenses. Too much information may prove assaultive and overwhelming, unfortunately suggestive, damaging the therapeutic alliance and intensifying traumatic transferences. Yet what may be too much or too upsetting to be shared at one point may form the foundation of healing and empathic communications on a later occasion.

Beyond what is discussed above resides another dimension, rarely considered, but incredibly valuable. Faimberg (2005) has described "listening to the patient's listening." Significant discrepancies may be found between what therapists understand themselves to have said and their patients' perceptions of their messages. Exploring these discrepancies offers illuminating insights, often related to the patient's trauma-driven view of the matters under discussion, both autobiographical and transgenerational. In listening to listening the therapist may gain insight into whether alters with different perspectives are intruding into the process. Given constraints on the dosage of communication that can be tolerated safely, therapists must be prepared to offer incomplete interpretations and/or to interpret upward to avoid overwhelming the patient (Glover, 1931).

The patient's acceptance or non-acceptance of her or his trauma history may prove spotty and inconsistent. At times the entire patient may slide into global denial or recant all traumatization in the stress of the moment,

whatever its source. Before I comment on the dreams of a patient, I try to remind myself that while some parts of the mind may acknowledge or aver a particular event occurred, others may disagree. In my remarks (see above) I try to acknowledge my patient's often conflicted and mutually incompatible perceptions. I strive to avoid arguments over whether an allegation is or is not historically true, plus other potential problems.

The above comments might be reframed as underlining the importance of appreciating both historical reality and the personal truth that the DID patient is endorsing in the moment. This must antecede efforts to interpret classic non-traumatic conflicts and transference paradigms. For most dissociative patients, the cost/benefit ratio of focusing on such matters will remain prohibitive.

Selected aspects of dream exploration

When do dreams begin and end as clinical events? Dreams undergo secondary revision during their translation into verbal form. They are presented in the context of sessions nested within an ongoing treatment and an ongoing life. I try to make a mental note of how my patients enter the office, make or fail to make eye contact, and otherwise share information via metacommunications. The degree of dissociation, denial, and disavowal encountered in work with DID/DDNOS patients enhances the importance of their non-verbal communications. Valuable information may be severed from the dream as narrated, but expressed elsewhere.

I ask myself why dreams occur and are shared at particular points in treatment. I make this distinction because often my patients may have had certain types of dreams for considerable periods of time before they share them. Sometimes issues have been gradually working their way into awareness, or patients have become strong and secure enough to manage what they could not dare to approach before. But quite commonly "why now" is more related to transference-countertransference or relational matters.

Why is a dream recounted at a particular time in a particular session? Is it presented early on, indicating willingness to explore it? Is it withheld till toward the end, precluding exploration? Is it offered when another matter is being pursued, suggesting that whatever the dream's content or importance, it was presented primarily to derail a potentially unsettling line of inquiry?

I look for manifestations of transference. Dreams may express dynamics not yet apparent, or not yet within the patient's conscious awareness. I would rather catch a dynamic or a difficulty *in statu nascendi* than address it when it makes a forceful and unanticipated appearance. Most commonly, such events express negative dynamics hidden behind a defensive idealizing false positive transference (Kluft, 2000).

Likewise, I consider relational/countertransferential matters. The treatment of DID/DDNOS occurs in the context of insecure and mistrustful relatedness. Any expression (or failure to respond) perceived as critical or threatening in any way may make an appearance in dreams, associations, or the patient's reactions to my interpretations and observations.

I remain mindful of reality factors impinging upon the treatment. While some patients, whether defensively or realistically, are so preoccupied with coping and the vicissitudes of daily events that exploratory treatment becomes impossible, others focus on the past with a fixity that leaves the therapist in the dark about major reality events, those important per se, and those expressing enactments evading the scrutiny of treatment. The day residue is quite important. Sometimes exploration reveals that the last session, family interactions, and triggers, etc. are of more immediate importance than the dream itself.

Recently I had to inform my patients about my upcoming surgery and an anticipated two-week absence from my practice. In the subsequent week twenty DID/DDNOS patients reported dreams of catastrophes, natural disasters, approaching menaces of any and all varieties, and deaths, in connection with which groups of individuals, which almost always involved some who were identified as alters, were either rushing about frantically, running for shelter, or trembling as some unwanted threat came their way. Had I reacted to the manifest content alone, it would not have been productive. In each case, associations ultimately led to my imminent surgery, and to fears of losing me and/or experiencing a psychological debacle in my absence.

I study all the above phenomena for suggestions that shame issues and shame scripts are in play (Lansky and Bley, 1995; Nathanson, 1992: Kluft, 2007). Signs suggestive of the four classic shame scripts encompassed in Nathanson's "Compass of Shame," withdrawal, denial (frantic activity or substance abuse to distance the self from shame), attack self, or attack other, suggest the withholding of material that might cause intolerable mortification. Alerted, I anticipate that crucial elements may be omitted. I tend to remark, "You know, some things bring up levels of embarrassment that make it agonizing to share everything there is to share." Usually, my patients nod an affirmation, and I leave it to them whether or not to pursue these matters at that point in time. The shameful issues generally involve memories in which patients, whether accurately or inaccurately, hold themselves accountable for unacceptable events and/or actions; experiences that overwhelm their capacity to acknowledge the degradation they have endured; incidents in which they failed to protect or were forced to assist in the mistreatment of others; situations in which they experienced unwanted arousal and/or excitement; and instances in which they feel they are not good enough to be cared about by others.

Following Pulver's observations, I am eager to see whether the nature of the dream suggests progress (or regression) of some sort. In repetitive

dreams, a reduction in traumatic affect or a change in the dream's scenario suggests possible diminished vulnerability or enhanced mastery. In general, if a patient has had dreams involving a large number of vulnerable individuals, usually children, a reduction in their number may indicate a degree of unexpected integration.

It is important to explore the subjectivity of the DID/DDNOS patient's dream experience. These inquiries relate to Kohut's (1977) concept of the self-state dream, an expression of the patient's system of selves or alters. Aspects of these matters, with remarks on self-objects, were discussed above.

The representation of self/alters in the dream may be informative per se. Not only may unsuspected alters be suggested by dream elements, but alters that are active only in the inner world or third reality of the DID/DDNOS patient (Kluft, 1991) may become manifest in altered states reported as dreams, or in actual dreams. It is useful to ask for details of alters' representations. Several of my patients have had sexually aggressive child parts whose representations in dreams depicted grown seductresses. With perfect trance logic, they often experienced themselves both as children and voluptuous adults. Such alters usually reflect grooming in adult-like behaviors by their abusers. Often frightening abuser alters show signs consistent with their childhood origins, and also prove to be child parts enacting quasi-adult roles.

Representations of groups of people and numbers deserve study. Often they suggest the presence of previously unknown alters, especially those that resemble those already known. Alters nearly isomorphic with others are easily overlooked in session.

Hidden or obscure elements deserve attention; e.g., "maybe there's something in the shadows," "there's someone else, but I can't see that person/person's face clearly," or "there's something else there but [a dream figure] shakes its head 'no.'" Such representations, if impossible to clarify at the time, should be noted for future reference.

Not only the ownership of the dream, but also the ownership of its narrative and affects deserve exploration. A dream may be owned by one alter, its narrative provided by a depersonalized observer alter, its affects held by alters specialized to hold them, and its physical sensations held by still others. This information facilitates the processing of traumata recounted in dreams (Kluft, 2013).

The way the dream characters relate often illuminates the functioning of the alter system. I often will describe an interactional pattern and ask, "Is that how things work in general?" and be told, "Yeah, whenever A complains, B hits her on the head."

Concluding remarks

These observations reflect an experienced clinician's perspective on understanding and making therapeutic use of the dreams of DID/DDNOS

patients. They expand upon the previous largely anecdotal literature on this subject, but should be understood as preliminary rather than definitive. Hopefully future contributors will provide more thorough and nuanced understandings.

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Chapter 14

Who moved my "Swiss" cheese?

Eating disorders and the use of dissociation as an attempt to fill in the "whole"

Jean Petrucelli

> Everybody is dealing with how much of their own aliveness they can bear and how much they need to anesthetize themselves.
>
> (Adam Phillips, 2014)

Ella uses food to drown out the noise in her head. Her early memories of "noise" involved vitriolic screaming fights between her parents, but the later adult noise is a perseverative angst and constant worry, from the mundane to the multifaceted. The intensity of the whirring noise in her head is profound and never matches the force of the problem at hand—it is a constant internal prison. Ella binges and purges six to seven times a day, clenches her jaw, grinds her teeth (causing numerous root canals), snores when she sleeps, and hunches her shoulders when she sits. She has extreme allergic reactions to most medications, and comes to my office with a swollen face on many occasions. Ella wears a baseball cap to hide her face, and walks with her eyes always averted from the gaze of others.

The disconnect she feels in her body experience is torturous. It fills her with pain, tormenting her every step. Her bodily-based behaviors take place without an intellectual understanding of what she feels or a concerned curiosity about how her body holds her angst. Just to note—Ella is a beautiful young woman with an athletic body and, if one were to see her on the street, one would have no clue as to how riddled with self-conscious loathing and shame her inner world keeps her. Ella's only source of freedom from this pain has been to manage one pain with another: By bingeing and purging, she dissociates to quiet her mind.

Within the past two decades clinical interest and research in the connection between eating disorders and dissociative phenomena has steadily taken root. There is a growing body of research that suggests links between trauma, dissociation, and eating disorders (Everill, Walter, and MacDonald, 1995; McManus, 1995; Hallings-Pott *et al.*, 2005; Waller, 1995). The relationship between dissociation and disordered eating has also been studied as it relates to dissociative disruptions to body image (Mussap and Salton, 2006).

Mussap and Salton (2006) propose that dissociation undermines normal integration of appearance-relevant information and might, in turn, contribute to body-image vulnerability, i.e., an internalization of society's notion of the thin ideal, an unrealistic standard that leads to body dissatisfaction. Dissociation may also be a mediating factor between sexual trauma and an eating disorder (Vanderlinden *et al.*, 1993). Patients with eating disorders who have a history of sexual abuse have higher levels of dissociation and may be more symptomatic (McShane and Zirkel, 2008). There is also a relationship between dissociation and binge eating (Fuller-Tyszkiewicz and Mussap, 2008). Studies demonstrate that dissociative experiences, facilitated by bingeing, increase significantly during bingeing and last until after purging (Chandaran and Malla, 1989; Heartherton and Baumeister, 1991; Vanderlinden *et al.,* 1993).

Dissociation is a core component in bulimic and binge eating behavior, which is experienced as movements and sensations rather than meaningful actions. Sensations are constricted, disorganized, and mired in inertia; the degree to which these patients cannot feel their own interior often reflects the degree to which they crave excessive external stimulation, like binge eating, drugs, or drinking. As previously noted, post-traumatic and eating disordered symptoms are often co-morbid. Patients with histories of trauma and patients with eating disorders share difficulties with affect tolerance and regulation. Thus painful emotional states are experienced as flooding, terrifying, and unmanageable, or not experienced at all because of the reliance on some form of dissociative behavior or defense that effectively numbs affective experience.

Patients with eating disorders assume that if they experience their sensations and feelings they will be overwhelmed permanently. When these patients grow accustomed to relying on an eating disordered behavior, which is, in and of itself, part of a dissociated state invoked to make the sensations and feelings go away, they also lose confidence that they can learn to tolerate feelings without engaging in these maladaptive behaviors. The fear of being consumed by these terrible feelings leads them to believe that "not feeling" is the only answer. Behaviorally, many eating disordered patients become "absorbed" in the process of binge eating or purging, and report—if asked later what they were feeling—the experience of being in a fog, doing something without thinking, being on automatic pilot, as if they did not "know" what they were doing. Phenomenologically, this is typical of how people experience dissociated states. In a Winnicottian sense, this dissociative experience is a collapse of "potential space." In the act of binge eating or purging there is a narrowing of thinking and perception of reality. The more feelings need to be avoided, the more energy is spent on keeping them at bay. What is not felt remains unchanged or gains internal pressure, which "forces" a person suffering from an eating disorder to escalate his or her symptoms. This, in turn, becomes the "preferred" method of avoidance.

Add to this picture the temporary neurobiological feeling of transient relief that accompanies the increased serotonin levels in the brain, and the vicious cycle of dissociative behaviors remains in place.

An interpersonal/relational approach takes as a starting point the idea that an eating disorder symptom is not something to simply get rid of, but rather something that holds dissociated parts of oneself and one's relational history (Petrucelli, 2004, 2015a, 2015b). Clinically, understanding the function of eating disorders in creating dissociative states and the function of dissociation in creating eating disorder symptoms is vital to treatment. The compulsions of bingeing and purging can be thought of as futile attempts to control bodily sensations—which are alternately chaotic, overwhelming, shut down, or numbed. Furthermore, we can also think of bulimia as an ineffective attempt to rid the body of something that is "not-body"; something that was forced onto or into the person's body. The idea of "not-body" could be thought of as an extension of the idea of "not-me" (Bromberg, 2006), but here the experience is located, viscerally felt, and contained in the body. Therefore, part of the work is helping patients make the connection between "not-body" as a temporary body-state and then facilitate the connection to something that is "not-me." In this sense, the symptom becomes a self-state—not just a behavior that has to be dissociated.

Ultimately, what is dissociated has more to do with failures in human relatedness to regulate and respond to affective states, or self-experiences of unbearable need in various forms that result in eating disordered symptoms. This is also why the concept of "white-knuckling" it, or just deciding "rationally" to *not* do the behavior and talk oneself out of it, does not ultimately bode well for long-term recovery. The brain *and* the body have to be reset together.

The relational world of food

When we begin working with an eating disordered patient, we start by entering into her or his "relational" world of food. We do this in an attempt to help our patients generate new, sustainable relationships with food, people, and us as therapists. We help them recognize, and identify unformulated feelings to assist in the creating, contouring, deconstructing, and re-constructing of their life narrative. This inevitably involves mourning, accepting, and relinking some of the parts of their self-experience that have been disowned and dissociated. Sometimes the relationship to their body is characterized by hatred, control, and the suppression of needs and desire. Patients with eating disorders dissociate, displace, and concretize their intolerable need states in the body where they can be ruthlessly controlled and attacked by means of bingeing, purging, starvation, cutting, compulsively exercising or engaging in compulsive sex. The dissociated behavior becomes a dissociated body-state—one which holds, in turn, a dissociated self-state.

The process of treatment involves creating a new template—in a manner of speaking—by filling in the dissociative "holes." The "holes" in the Swiss cheese, the lacunae, the gaps in the continuity and coherence of the patient's life story, as Levenson (1982, 1987, 1988) has illuminated time and time again, can only be "filled" by listening to a patient's story, getting the background data, looking for what is *not* being said. So we inquire further into these blind spots, these inattentions, the moments when the symptoms take over: heads in the toilet, mouths stuffed with garbage—the shameful secretive behaviors, feelings of body hatred, produced by anxiety, and dissociation. We attempt to delineate them because the patient does not dare to see what is there to be seen. Our inquiry puts its "foot into the holes of this veritable Swiss cheese of avoidances" (Levenson, 1988, p. 486) that we then try to fill and expand.

The use of dissociation to deal with affect and desire

During the process of clinical work with our patients with eating disorders, we discover the disowned or dissociated parts of a person, we experience and witness various self-states and body-states that accompany eating disorders, and we observe the "adaptive" function of dissociative processes as well. Given that patients with eating disorders communicate through dramatic bodily actions, they comprise a population where alexithymia (Barth, 2001; Krueger, 2001) and unformulated experience (Stern, 1997) rule. Helping them link various parts of their self experience—their different self-states that have been sequestered—requires gaining psychic entry to parts to which they do not have access. Each part of the patient has its own agenda that needs to become known and then safely felt as a source of internal conflict before it can be experienced (or internally "judged" as "good" or "bad"). For example, the "bulimic part" of a patient may be dissociating anger because this affect cannot be regulated: It feels unsafe to express it directly. The "part" that cannot be regulated is unable to participate as a source of conflict because the threat of real or imagined abandonment may loom too large. Thus, the patient takes matters into her or his own hands and sticks fingers down the throat. We need to understand this patient's self-protective agenda and try to understand it from the voice of the "bulimic" self that holds it. In knowing our patient's different parts, we have the opportunity to develop a relationship with each part that can be respected for its own function and purpose.

Not only do these patients have difficulty identifying their emotions, but they often also have difficulty distinguishing and appreciating the emotions of others. And for those who *do* have a sense of what they feel, spoken words may not be enough to completely express their experience. The fear of not being understood and the shame they bear dampens the curiosity

that is required for self-exploration. Not knowing what they feel can be unbearable in and of itself. Words lose their reliability as a means of communication, and to the degree that language becomes untrustworthy as a medium of relational communication, the more a patient's trust in the reliability of the "other" is broken. The underlying hope is that our eating disordered patients' relationship to food, people, and their own bodies as *objects*, will undergo a gradually increasing capacity to experience their "Otherness" as a part of themselves, rather than as "not-me." From a slightly different perspective, as Bromberg (1998, 2001, 2006, 2008) has eloquently expressed over the years, the hope is to help our patients experience new pleasure and safety in shared affective intimacy—a *new* pleasure and safety—because human relatedness can now be experienced as something that can be affectively regulated.

If you consider eating disorders to be disorders of desire, the mechanism of dissociation results in the renunciation of desire and the body itself becomes the theater of war, where the feelings, memories, longings, and stories that have led to the symptom feel so dangerous that they are dissociated from the behaviors themselves. Bromberg (1998, p. 232) writes, "The essence of dissociation is that the mind is disconnected from the psyche-soma to protect one's illusion of unitary selfhood from the potential threat of traumatically impinging experience it cannot process cognitively."

In his writings, Bromberg (1998) focuses on the adaptive function of dissociative processes in maintaining self-continuity and self-organization, and shows how someone who has developed a dissociative mental structure in response to trauma diminishes, or sometimes completely sacrifices, the capacity for conflict, intersubjectivity, and mentalization. We can, in part, conceptualize and understand the symptoms of bulimia, binge eating, as well as states of malnourishment through anorexia, as an outcome of dissociation as well as a manifestation of dissociation in the self-state of the symptom itself. The dissociated self-state that is in the throes of bingeing and purging has limited agency and a narrowed cognitive field that necessarily limits choices. In those symptomatic moments, the eating disordered patient does not have access to other aspects of her or his reality, self-expression, or other modes of relatedness. Therefore, the body speaks when the mind cannot through the acts.

The use of dissociation to "deal" with relating

Bodily symptoms such as starving, bingeing, and purging represent the eating disordered patient's unlinked states of mind. It is through the effort to self-protect—the maladaptive function of dissociation—that an individual with an eating disorder is protected from the felt impossibility of holding two incompatible modes of relating. In addition, as Bromberg (1998) points out, there is a "psychic paralysis" in anorexia, simply because

the psyche-soma is always disconnected from the mind with regard to the process of eating. Bulimic behavior can be used as a dissociative mechanism, whereby the individual engages in bingeing and purging as a way of producing a dissociated state. When this occurs, the relationship between bulimia and dissociation is episodic, rather than constant.

We can understand dissociation within the context of one's abilities to regulate internal psychological processes and experiences, as well as one's interpersonal capacities *in* relationships. These capacities include the ability to regulate affect, maintain positive self-worth, and maintain connections to others. Viewing eating disorders through understanding the role of dissociation helps us examine the impact of self and affect regulation as it is developed in early attachment relationships and comes to the fore in the present, as these patients attempt to regulate their relatedness with us (Petrucelli, 2010, 2014, 2015). An eating disordered patient may feel like the symptoms have "minds of their own" as these patients find voice through the body. But our work requires helping our patients learn how to have a different relationship to self-states, body-states, and their bodies—a relationship that allows them to "feel generative and animated as well as alive to ordinary discontents and longings" (Orbach, 2009, p. 76). When it goes well, our work also helps patients remain connected and engaged with themselves while also maintaining meaningful connections with others, rather than retreating from the potentials as well as the risks, of human relatedness.

Thus, in the eating disordered patient, symptoms are "used," not only to manage overwhelming feeling states or to numb access to parts of oneself, but also to compensate for a lack of a capacity to reflect and deal with conflict or to bypass difficulty in mentalizing. Mick, a patient who binge eats, does not know how to use or have access to his imagination to relax and enjoy the possibility of possibilities. In our work together, we have come to understand that he has never learned "how" to mentalize. When I suggested that he might try to take a yoga class, he responded with, "so I could be tortured by seeing all those young 'pretty things' in their yoga pants." I responded, "Well it might also be inspirational to go and just have a field day and enjoy them in your head." To which he said, "If I see it I JUST WANT IT AND THEN I WOULD BE FRUSTRATED AND FEEL MISERABLE FOR NOT HAVING IT!"

The link between Mick's intellectual understanding of why he feels these things and how his body holds his angst is missing—he has no filter, no cushion, no sense of how *not* to have worry go into his body. His response is undoubtedly multi-determined, relating to his sexual frustration, his own sense of "body" shame, and what he feels is unavailable to him because of his "deficient" sense of self. He does not know how to relax, or self-soothe without bingeing on food. Before he began to binge, he used to smoke pot and watch old comedy sitcoms or grand movies that would engulf him into

an abyss greater than the one he feared. He could "lose himself" in this pursuit. He tells me I underestimate the level of his self-conscious anxiety; it starts as he leaves the front door of his home. As we explore what his fear is, the threat of being criticized or judged reveals a deep reservoir of shame. Shame binds him, so he steps carefully into any social situation. He fears that everyone is judging him. So being in a yoga class with "all those young pretty things" is really challenging. He tells me, "I was insecure and shy as a child and I feared and believed that people could hear what I was thinking in my head." I suggested that he might have shut down his ability to imagine so that other people would not hear him.

Unable to reflectively experience these different parts of himself, Mick has difficulty experiencing the presence of "a mind of his own." He is a man of "many minds" and they are not supposed to interfere with one another. His self-development and sense of coherence is derailed. On a gut level, a patient with an eating disorder, like Mick, believes that others cannot possibly imagine what he feels on the inside. He never feels he is good "enough." For such patients, the dissociative structure that isolates their self-states from one another determines what they can be curious about or aware of, relative to the self-state they are presently in. The symptom expresses a self-state that feels not only incompatible with, but also very threatening to, the state they are currently in and what it represents in connection to the important attachment relationships that feel threatened. In other words, that current self-state also holds a connection to these patients' important attachment relationships—and such internal connections are also threatened by the dissociated symptom state.

In working with patients with severe trauma coupled with eating disordered symptoms, the analyst may at times feel affectively overwhelmed—unable to think, reflect, or empathize. When a patient relies on dissociation, the analyst may feel the patient's dissociated affect. Sands (1997, 2007) points out that, sometimes, what is needed is for the patient to experience that we can *know* the experience and feel it viscerally in *our* bodies. This creates an uncanny, "shared" body-state which is often the "only" way patients feel they can be "seen" and "known." It is as if we know their experience, physically, from the "inside out." It is in this sense that such patients often relate to the analyst as another body in the room by projecting the physicality of their dissociated parts and relating to the analyst as an embodied other. For example, I have had the experience (when I was *not* in a state of physiological hunger) of my stomach growling in response to an obese patient starving herself. Through my sensate experience I became aware of something that was not visually apparent. Processing this mutual experience allowed us to experience body-states relationally and to reflect upon this experience. A body-state has to do with embodiment: how one lives in the body, at a given moment, relative to the felt experience. This can be internally accepted as a part of oneself—or not. By definition, body-states

are non-verbal experiences and may not be known through the mind with words. The body "articulates" the "unspoken," the "unheard," and the "un-responded to."

Human relatedness as a process

In treatment, the successful development of the capacity to regulate *human* relatedness can be compared to "break dancing"—a way of "pop and locking," sometimes with mindfulness, sometimes just letting the beat take over, but with the therapist trying to stay as attuned as possible to her or his dissociated aspects and those of his or her patient. These aspects are participating off stage while the dance that is taking place on stage is in progress. Regulating relatedness with an Other is a way of dancing with mindfulness alongside dissociated parts.

In collaboration with our patients with eating disorders or disordered eating, we work to give voice to the neglected and disowned parts of these patients' minds and bodies. These are the parts of their minds and bodies that are separated from the individual patient's experience of "who she or he *really* is" at that moment. Often, this requires our attunement to our *own* disowned and dissociated parts—including those related to our bodies. The emotional work of being present is a time-consuming, arduous process of step-by-step, morsel-by-morsel learning and embracing new ways of being, relating, forgiving, accepting, and finding solace. With an eating disordered patient struggling with food and body image issues, we engage in the daunting task of helping our patient navigate finding beauty in imperfections. Eating disordered patients have accepted the diminished substitute of food over people; if we accept their preference by colluding and not speaking about the very painful parts of their shame-based experiences with food *and* people, then we too become diminished substitutes in our therapeutic effectiveness. There is a predominance of concretization in these patients' thinking, both restriction and dysregulation of affect, and a paucity of symbolization. Eating disordered patients who become accustomed to saying little, become accustomed to feeling even less.

Our work requires a certain kind of psychic attentiveness and corporeal compassion: one that entails empathic attunement and affective attunement. It requires attention to subtlety, nuances in shifting emotional tones, and the use of words. And it requires attention to somatic resonances, a focus on the body, and an understanding of shifting attunements and misattunements. Embodied awareness has been viewed through various lenses, rather than through one comprehensive theory of mindbody or bodymind. But the struggle between the necessity of and difficulty with relatedness is seen in all patients with eating disorders and in all problems for which dissociation becomes the "solution."

As clinicians, we try to be attentive to the needs of others—the messy, the painful, the impossibly difficult feelings of shame and behaviors that result in hypervigilance and hyperdeadness. This is poignantly evident in a patient's writings about things stuck in her body. She writes:

> I am an organism fueled by shame. At my core I feel defective and my organism is hypervigilant to all the evidence that confirms this. It invades everything I do or feel. I see images in my head and feel something very strong in my body.
>
> I would call it a level of horror. I don't know how to put words to this feeling state . . . no words that I can use can really capture this feeling. Shame is a painful thing. It's something that's hard to describe because it feels very physically painful. My organism is so pained by it that blackness comes immediately after the visions. I feel a force making me smaller. Something is driving my head down. There is a hot flushed feeling in my heart and the pit of my stomach. There is crunching pain in my chest as if all the muscles in my heart are in spasm. My body is in a state of panic . . . as if trapped in open space during a world war with no means of escape. I carry the most shame in connection with my body, eating, and my intelligence. I don't know how to describe the emotion that I feel when I look and feel myself—the ultimate shame. There are no words that come . . . only the visions and the painful feelings that I have to translate into words.

For many patients with eating disorders, like my courageous patient struggling to put words to nonverbal experiences held in her body, shame is the organizing principle—their demon. One of the ways to understand how prevalent eating disorders are in women is to think in particular about shame experiences that are organized by gender. In general, shame promotes patients' feelings of not being good "*enough*." To reiterate, it promotes an internal sense of core "badness" in defining who they feel they *really* are. For women, it is often fueled by a collage of competing, conflictual, and unattainable messages of who women are "supposed" to be. Empathy and connection can be antidotes to shame and, in turn, antidotes to the dissociation required when such shame feels unbearable. These are important factors in furthering sustainability for recovery and health.

Patients with eating disorders or disordered eating have lost hope as they live with despair, yet still quietly hope that we, as therapists, may be able to find new ways to inspire them and make a difference. Stimulating change that can become sustainable in recovery is the job required of us as we offer our wisdom, our care, and ourselves to our patients. Yet, sustainability over time is the hardest part of this work; the immensity of the task demands real change. Symptom reduction is not the end goal of treatment but rather a means to accomplish better interpersonal relationships, to find a life purpose,

to develop and sustain healthier thinking as well as creative ways to approach problems in living, and to finding ways to fulfill one's dreams. It is a long and winding road: three steps forward, one step back.

Summary

It is through the relationship with us that we challenge our patients' defensive dissociative systems around their eating disorder symptoms—systems historically created for "survival." Exploring and understanding the barriers to change—and the underlying vulnerability that demands these barriers—is central to the therapeutic process because, without it, these patients never feel safe enough to open themselves to new possibilities. We engage them in developing alternative adaptive skills to assist them in the physical, psychological, and interpersonal/relational changes necessary for health. Forming new relationships—be it with food, substances, or people—takes courage, mindfulness, vulnerability, forgiveness, and moving beyond blame. It requires developing compassion, a presence of being, a belief in the possibility of possibilities, and tolerating the risks of uncertainty and the uncomfortable emotions that follow. The constant inner critic they struggle with works against their ability to tolerate ambiguity and uncertainty.

Real recovery takes a long time. Maintenance, consistency, reliability, being centered and grounded, comes through the sustainable practice of living. As clinicians, we need to recognize what we can and cannot do. It means recognizing our shortcomings, becoming aware of our moments of dissociation and the collision of our dissociative lapses with our patients. This helps in not perpetuating more shame-based feelings in our patients by owning our pieces and having the courage to stay real. Being—rather than knowing—means showing up, being conscious, staying present, and being seen.

When working with our patients with eating disorders and coming face-to-face with feelings of helplessness—theirs and ours—we are often tempted to think that if we just do more, we will feel more secure, less anxious or worried. This leads to despair, as, in the clinical conundrums we encounter, it is easy to lose sight of the importance of helping our patients remember or regain the value of who they are—*as is*. The vulnerability we share with our patients involves ruptures, repairs, and the necessity of both in the therapeutic process. This is what allows us to be fully engaged. Ideally, the message we impart to them is that we are not simply offering our understanding, but *ourselves*. We are in it together, facing our own dissociated selves and opening ourselves as well as our patients to new possibilities. We inspire, enliven, infuse, care, struggle, metabolize, digest, frustrate, cry, succeed, and fail as we fill in the "holes." Yet, in this work, we endure, as we try to connect where, once, only disconnection was imaginable.

I return to the question posed in the title of this chapter—"Who moved my 'Swiss' cheese?" It may not be *Who* that ultimately matters, or even *that* the cheese was moved. It may *simply be* that perhaps *together we*, can help fill in the "*Swiss cheese*" holes of dissociation . . . and then move on to different challenges. Provolone, perhaps?

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Chapter 15

Dissociative attunement in a resonant world

Karen Hopenwasser

Imagine the ebb and flow of ocean tides: periodic, predictable, influenced by large forces and local topography. Imagine a flock of geese, or a murmuration of starlings: synchronized in flight, a single wave of many units in formation. Now imagine us inside a consulting office, each visit a periodic iteration, being together within a space. Often, when we focus on the psychotherapeutic dyad, we uncouple this small system from a deep ecology of place, space, and time. What then becomes manifest within the dyad is a felt sense that is known but not necessarily understood. I've been thinking about the paradigm shift introduced with concepts such as "implicit relational knowing," and "the two person unconscious" (Stern *et al.*, 1998; Lyons-Ruth, 1999). Dissociative attunement is another way of talking about conscious, unconscious, embodied and embedded flow of information, addressing the biophysical, neurobiological and mental synchronization of information processing within the therapeutic dyad. If dissociation "represents a failure of integration of ideas, information, affects and experience" (Putnam, 1997, p. 19) and attunement "is a synchronized awareness of implicit knowing that is nonlinear and bidirectional" (Hopenwasser, 2008, p. 349), then dissociative attunement is an unintegrated, out of awareness synchronization between two individuals.

Dissociated memories of developmental relational trauma tell a story. We try to make the story fit into words, but it does not fit. The narrative is fragmented, elusive, inconsistent. After a psychotherapy session with dissociative individuals sometimes I feel confused, unable to organize and write down more than a few details about what transpired the previous hour. This can leave me feeling anxious and deskilled. Momentarily, I have lost my capacity for recursive human linguistic narrative. Poet and essayist, Gary Snyder, wrote how language,

> goes two ways: it enables us to have a small window into an independently existing world, but it also shapes—via its very structures and vocabularies—how we see the world. It may be argued that what

> language does to our seeing of reality is restrictive, narrowing, limiting, and possibly misleading.
>
> (Snyder, 1996, p. 174)

The very language we use to describe the psychoanalytic treatment of severely traumatized individuals lands us in that paradox of opening a window through which we narrowly squeeze even what does not fit. When we do not have a language to speak about experience we are not always cognizant that there is an experience about which to speak. When I am feeling confused after a session, I am being given an opportunity to think differently about the moment.

An antidote to the anxiety I feel when I cannot write a note is a mindfulness that narrative and embodied cognition, or even felt sense are not the only means of communicating information; that translation is difficult work, and that a Westernized schedule of back-to-back appointments does not always avail the time to do that work.

Something happening here but don't know what it is

Narrative communication actually allows us to dissociate or disconnect from other life on this planet, and even allows us to dissociate information within our own bodies. The ecologist and philosopher, David Abram, writes,

> we learn our native language not mentally but bodily. We appropriate new words and phrases first through their expressive tonality and texture, through the way they feel in the mouth or roll off the tongue, and it is this direct, felt significance—the *taste* of a word or phrase, the way it influences or modulates the body—that provides the fertile, polyvalent source for all the more refined and rarefied meanings which that term may come to have for us.
>
> (Abram, 1997, p. 75)

But as we grow up, as we socialize into an industrialized and digitalized culture, we often lose the felt sense of a narrative and tragically lose the narrative of the felt sense. To give you directions to my office I can send a printout from Google maps, and the closest it will ever come to a felt sense are the few landmarks noted along the way. A good example of a narrative that maintains the felt sense is the dreaming tracks of Australia's indigenous people (the Songlines). Going from point A to point B required singing the landscape as they walked about, mapping their routes through the telling of a creation story (how the world came into being through song), noting sacred places and landmarks within the song, weaving the mind and body and spirit (Chatwin, 1987), i.e. communicating directions with the felt sense of the land.

Psychoanalysts struggle with the relationship between felt sense and narrative. Ogden wrote "In the analytic setting, analyst and analysand are viewed as engaged in an effort to use language in a way that is adequate to the task of creating/conveying a sense of *what it feels like* for the patient to be human" (1997a, p. 1). Ogden also wrote about reverie in the analytic process as a jointly held "unconscious intersubjective construction . . . the intersubjective analytic third" (1997b, p. 570). Others have elaborated thoughts about rhythm, tempo and the body in the psychotherapeutic dyad, e.g., Benjamin's (2004) rhythmic third, Knoblauch's (2011) polyrhythmic weave, Rappaport's (2012) somatic third. In contrast to unconscious intersubjective constructions, dissociative attunements are not necessarily unconscious, and dissociative attunements extend beyond our minds. Rhythm and resonance pattern dissociative attunements. These attunements are self-organizing, systemically self-emergent synchronizations in which multiple self-states are shared. When I first introduced the term dissociative attunement, I used the metaphor that "Empathically attuned clinicians are like microtonal tuning forks. They resonate with a variety of emotional pitches and will resonate with nuanced shifting of emotional tone" (Hopenwasser, 2008, p. 358). As Buzsaki says, "the rhythms of the brain are also the rhythms of the mind" (2006, p. 372). And the rhythms of our minds reflect a "deep continuity of mind and life" (Thompson, 2007, p. 157).

Body memory

I am sitting at my desk writing a draft of this chapter, when I hear outside my window, reverberating into a small cityspace courtyard, an intensely rageful male voice: "GEET OUT OF HEERRE," followed by a slamming door and a startled infant begins to wail. It is so disturbing that I go to my window. All I see is the empty space between four windowed walls. I can locate the general direction of the crying infant, a wailing into the empty space, and can feel the fright linger as a memory of startle in my body. Imagine now the child, too young to understand and likely too young to maintain any narrative memory other than his or her own terrified body state at the moment of a violent disruption.

Body memory (somatic memory), expressed so often in poetry and literature, was introduced as a neurobiological concept in relation to posttraumatic stress disorder and elaborated by somatic therapists working with traumatized patients (Rothschild, 2000; Levine, 1997, Ogden, Minton, and Pain, 2006). Increasingly we have come to understand the role of the autonomic nervous system in flashbacks and body pain. But the link between posttraumatic activation and dissociation remains more mysterious. In dissociation we see somatic memory, affect memory and cognitive beliefs shifting through state changes over time. We will better understand these

shifts as we integrate research about multiplexed, repetitive neuronal firing that is dysregulated by chronic stress during development.

Default mode network

My mind wanders. Suddenly my sharp focus on piles of books and articles surrounding my laptop shifts to a distant memory. I am daydreaming. I have just experienced the activation of the default mode network, interconnected specific areas of my brain that line up front (anterior) to back (posterior). Much of the psychoanalytic literature on attunement, informed by the writing of Allan Schore (2011, 2013), focuses on right brain to right brain affective transactions in development. Another way to understand the neurobiology of attunement in adult life is to explore the periodic synchronization of neuronal oscillations across brain regions, a multidirectional and rhythmic integration of various cortical and subcortical areas. The default mode network (DMN) consists of midline brain areas[1] that are activated in the absence of environmental stimuli. We are actually activating our default mode network every time we blink our eyes, momentarily disengaging from attention (Nakan *et al.*, 2013). The DMN is associated with self-referential thinking and is key to understanding the neurobiological component of the experience of self. The DMN is of keen interest to those who research the effects of meditation practice on brain function (Brewer and Wahunsky, 2011; Sood and Jones, 2013; Jang *et al.*, 2010) as well as those who study various psychiatric disorders. In individuals with PTSD secondary to developmental, relational childhood trauma it is thought that "early-life trauma may interfere with the developmental trajectory of the DMN and its associated functions" (Daniels *et al.*, 2011, p. 56).

The neuroscience of dissociative attunement

A therapeutic dyad is a dynamic system nested within larger systems. You and I, inside the consulting office, are two individuals shaped by and responding to our families, communities, cultural and national groupings, etc. There are systems nested within each of us and then between us. My sleep/wake cycle, insulin/glucose responses, stress hormone ultradian rhythms are unique to my body. What I know about myself, so dependent upon a personal set of memories (places, times, contexts, perceptions), is organized, at least in part, by frequency-specific neuronal correlations in large-scale cortical networks, or what is called a "spectral fingerprint" (Siegel *et al.*, 2012).

Spectral fingerprints are synchronizing parallel pathways of neurons firing at low frequency. Neuroscientists are exploring how disruptions of these oscillations are significant in illnesses such as Alzheimer's and schizophrenia. But little research has been directed toward dissociation and

complex PTSD. Is this an example of "not knowing" that dissociation is there to be studied? Fortunately, we have the work of those dedicated to understanding the impact of abuse on brain development and function: Bruce Perry, Ruth Lanius, Martin Teicher, amongst others, who have given us a template to explain not just the neurobiology of dissociation, but the biophysics of shared dissociated states.

So what is happening in the brain when we remember an episodic event coupled to a specific time in the past (spacial location correlated with temporal order)? Certain areas, such as the medial temporal lobes, the prefrontal cortex and parts of the parietal cortex are multiplexing. In the absence of severe stress during development this multiplexing can feel seamless and linear, giving a sense of a coherent narrative history. Now we can put together a few pieces of the dissociative discontinuity puzzle: multiplexing synchronous oscillations between brain regions feeding into the default mode network (an area crucial to the sense of self); extreme, chronic stress during the developmental years; heightened input from the right amygdala (repeated registration of fear); altered cortical integration leading to dissociated self-states.

Attunement as a means to knowing what we do not know

Fran had many years of psychotherapy before a previous therapist realized she had named dissociated self-states since childhood. She suffers brief episodes of lost time, episodic self-mutilation, voices in her head that "won't stop talking," constant self-criticism and episodes of despair. Despite this cacophony of internal parts she is hard working and successful in her career. She is married to a man who is brutally emotionally abusive, and much of her treatment with me has gone on within the larger frame of living with chronic emotional abuse.

I have come to know the different parts of Fran in both verbal and body language and have become increasingly aware of a kind of attunement between us that constantly surprises me. In each moment of surprise, I understand this attunement is held in a *mutually* dissociated space.

Fran does not allow me to be nice to her. Here are a few of her self-states: she writhes in pain if I say anything that reveals that I care about how much she suffers; or she mocks me when she perceives me as kind; then she accuses me of lacking an ability to nurture. Years ago she told me that as a child she killed small animals. She told me this more than once, though as many times she also says she is not sure—did she actually kill the hamster in the basement, or does she think she killed the hamster in the basement. I am able to imagine a part of Fran that would kill a small animal. I can also imagine that she is capable of believing she committed an act that never actually happened. I am able to know about these self-states, whether they hold veridical truth

or not. Fran also knows about me. She knows, in the here and now, that I am empathic when faced with the tyranny of trauma. She also knows something I did not directly show her, that I have a self-state that struggles with nurturance, a self-state that would prefer to be left alone rather than comforted. She accuses me of lacking nurturance, not because I have ever been cold and removed with her, but because she is attuned with the part of me that could be. This attunement is dissociated. In the moment, neither Fran nor I know this is attunement. She is afraid of me, angry about what she knows is possible and what resonates with her past experience. For years I unwittingly allowed Fran to "torture" me in her "help me, help me, you can't help me" tirades because I did not understand the attunement of these self-states. I had been to her the hamster in the basement that she may or may not have tortured. In retrospect I understand that I was not able to see her as an abuser of animals. Though I could recognize the tortured animal within her I was not cognizant of the tortured animal within myself.

The knowing and not knowing of abuse is a powerful mechanism of adaptation that balances an otherwise affectively unstable system. When Fran is feeling the depth of her helplessness and frustration she is prone to cutting. When she cuts I feel helpless myself, unable to alleviate her suffering. So what use is this dissociative attunement? Does it help me to help her? Perhaps it does, in an indirect way. A mindful experience of dissociative attunement allows me to access information about myself as a clinician that would otherwise be inaccessible to me. This information, specific to the therapeutic dyad, cannot be known solely through personal analysis or self-reflection. It is information that emerges through a bi-directional process, unique to the system of the therapeutic pair. This attunement then informs therapeutic action. With dissociative patients we often find ourselves entangled in the discontinuities inherent in dissociative identity disorder. It is not unusual for this attunement to happen between dissociated parts of both patient and therapist, leading to a felt sense that is not integrated with narrative cognitive function. The work can feel like an unsung journey through the woods with no trail map. The uncharted territory can be as much within the therapist as within the patient.

Entrainment

The neuroscience of dissociation is a neuroscience of discontinuities. It is this shared felt sense of discontinuity that makes note-taking so difficult. When we participate in any group process, over time our brains synchronize to some degree, a process called entrainment. This biological coordination can account for an array of patterns: the contagion of depression, mass "hysteria," even the paranormal perception of information that is called intuition. If continuity is achieved through multiplexed coordination of

neuronal oscillations (Watrous *et al.*, 2013), then the extreme stress of terror and pain interferes with developmental integration of these neuronal networks. Information is available but not temporally integrated. The lack of temporal integration leads to renegade memories: memories out of sequence, out of context, off the arrow of time. The intimate and reiterative experience of psychotherapy in our sequestered space becomes an ideal holding environment for these discontinuous bytes of information.

The felt sense

Renegade memories are experienced as a felt sense, a bodily awareness of life's ongoing process (Gendlin, 1997). The neurophysiologic basis of felt sense may well be associated with unmyelinated fibers in the vagus nerve that transmit signals from our internal organs to our brain through a process of ephaptic transmission ("ephaptic" refers to electrochemical flow between cells not transmitted through the neuronal synapse). Damasio and Carvalho speculate that the evolution of myelinated pathways favors action and cognition, while the leaky action of unmyelinated fibers favors interoception and feelings. They state:

> A model commonly accepted for cognition is that synaptic firing at the single-neuron level is amplified, via temporal synchronization, into a systems level phenomenon. The same process could conceivably be applied to feelings. Changes at the cellular level would temporally synchronize across many individual neurons (for example, via ephaptic communication), ultimately contributing to the experience of feelings.
>
> (Damasio and Carvalho, 2013, p. 149)

Just as neuronal oscillations within our brains synchronize through entrainment, so may the unmyelinated pathways carrying this information flow of sensation entrain with the outside world. This level of entrainment opens the door to the most mysterious aspect of dissociative attunement: intuition. Is it possible that through entrainment we develop a *cognitively* integrated felt sense?

Ingrid, the bandit identity

The story of Ingrid illustrates the power of dissociative attuned intuition. Ingrid has struggled with binge eating and purging for most of her life. Despite constant criticism as a child (nothing she did was ever good enough), and physical abuse by an older brother, she went on to be extraordinarily competent in her profession. She is well regarded with a large social network of friends. To the world around her she appears engaged in a high-power

career for which she is paid well. She donates both money and time to philanthropy. A couple of years into Ingrid's treatment I happened to attend a performance of an opera in development about Phoolan Devi, the Bandit Queen. Phoolan Devi, born in India in 1963, was physically abused as a child. She grew up to become an infamous bandit. As a teen she was gang raped. In 1981 she participated in a massacre of upper caste villagers. After spending a decade in prison pending trial she was released by the government, successfully ran for a seat in Parliament and then was gunned down on a street in Delhi. She has since become both revered and reviled, a controversial representation of the violent life experienced by so many girls and women in India.

Ingrid told me that even though she lives alone she hides food in a drawer, just in case she "needs" it. I knew that as a child she would often hide food from her mother. I understood hiding food in a drawer in the present as a dissociative enactment—off the arrow of time, it did not matter that there was no one there to criticize or reprimand her, nor did she ever eat the food in the drawer. Suddenly I realized that the part of Ingrid who hid the food was a bandit part—a self-state that was neither obedient nor self-critical. I blurted out, "You are a bandit." Her reply, in a solemn whisper, was "I need to tell you something. Sometimes I shoplift." This turned out to be a pivotal moment in Ingrid's treatment. In a previous treatment when she told her therapist about the shoplifting, the information quickly slipped away from awareness in the therapeutic work. It was never brought up again. My inadvertent attunement to the bandit part allowed us to hold it in the room and keep it in mind. She had been making progress in understanding her experience of mistreatment in childhood. She was becoming less brutal in her self-criticism. Now, following the disclosure about stealing, she has become able to focus on the dissociation evident when she, a highly ethical woman, pockets food from a store. On her own she had understood the shoplifting as risky, potentially self-injurious behavior. But on her own she could not see it as an act of liberation from self-criticism. Ingrid is now increasingly able to bring a mindfulness into these moments in the store, an awareness of dissociation as it is happening. While the secretive eating was always bathed in shame, the bandit identity is felt as a more positive, albeit paradoxical way to manage helplessness and shame.

The extended mind

We make these intuitive leaps all the time, associating clinical moments with information culled from outside experience, film, music, poetry, etc. With dissociative individuals, this kind of knowing is sometimes the only access to information that is compartmentalized, split off, just outside of awareness. It demonstrates the way in which our minds, our sense of self/selves extends

outside the body into the ether of relational communication. Our sense of self is both embodied and embedded in the world around us. Our minds and the environment act as a coupled unit, our minds not boundaried by our bodies, resulting in the "extended mind" (Clark and Chalmers, 1998; Clark, 2008). Our minds (or consciousness) cannot be reduced to brain activity, "Perception is an activity of sensorimotor coupling *with the environment*" (Nöe, 2006, p. 5). Phenomenologists of the twentieth century, e.g., Husserl (1977) and Merleau-Ponty (2012), expanded our awareness of the participatory nature of perception and laid down the philosophical groundwork for a twenty-first-century appreciation of the mind as embodied, embedded and extended (Rowlands, 2010).

The philosophical shift—from the mind as a boundaried embodied entity to a sense of self as a dynamic flow of information through the space surrounding our bodies—deeply informs our discussion of dissociation in the therapeutic process.

Teresa

Dissociative attunement is bidirectional. Just as clinicians may know something about the patient that feels strangely intuitive, so do our patients know about us in an even more uncannily intuitive manner. Teresa is a woman who can talk circles around me—immensely clever with words, learned in social and political theory. She has been in therapy three times previously, at different transitional stages in her life. In her first treatment, she began to recognize that she was abused as a child. Our current work is facilitating an appreciation of her core resilience. As she increasingly tolerates memories of pain and suffering she is slowing down, allowing for an intimacy and connection with me. She presented this dream:

> She is in a parking lot, her father's car is parked in spot 99 and she meets her first therapist who will not say hello. She asks her why she will not acknowledge her and the former therapist says it would be unprofessional. Then they are in the car and the therapist is looking at swatches of carpeting, trying to choose a new carpet for her home.

Teresa explores her associations to the dream. She does not perceive this as a reflection of intimacy with me. Sitting across from her I wonder what to do with the following awareness: I have just returned from a three-week vacation to my home on 99th Street. The night of this dream I was choosing new carpet for my home. Coincidence? Perhaps. But this is far from an isolated experience in my work with dissociative patients.

I could give many more examples of dissociative patients 'knowing' things I never told them. To understand dissociative attunement in therapeutic process we have to step out from under the microscope of dyadic interaction.

We have to relax our narrative organization of process and embrace resonant encounters that do not sit clearly on the arrow of time.

Perhaps we can stop seeing ourselves in a linear fashion as the species on the top of the pyramid, and instead see ourselves as interdependent resonant creatures like any other animal on the planet. The flock of geese, or colony of ants that mesmerize us with their leaderless, synchronized behavior teach us that life itself is information flow.

Despite great effort to clarify and define what we mean when we use words like "self" and "knowledge," at best we can agree that it is challenging to use the tool of self-awareness to explain self-awareness (the 'hard' problem of defining consciousness). Throughout this chapter I have made many references to biological, psychological and social systems. It is impossible to explore the rhythm of attunement without, in the words of Louis Sander (2002), "thinking differently." As psychologists apply theoretical concepts of self-organization and emergence to development and psychotherapy (Maturana and Varela, 1987; Piers, Muller, and Brent, 2007; Thelen and Smith, 1994; Palombo, 1999; Orange, 2006) neuroscientists are studying how complexity explains neuronal organization and brain function (Buzsaki, 2006, Nunez, 2010).

Thinking differently helps us to understand clinical moments of intuition, a kind of cognitive quantum entanglement.[2] Language emerges from our bodies. Snyder notes "language is a part of our body and woven into the seeing, feeling, touching, and dreaming of the whole mind" (1996, p. 176). And the whole mind, which is nested in the space between self and other, encompasses bodies within a natural world.

When we engage in a talk therapy inside our urban four-walled offices, cut off from the sights (blinds shut), sounds (white noise machines) and smells of the ambient world outside, we are using our ability to formulate thoughts into words in an intrinsically dissociated manner. When we see hours of patients, in back-to-back sessions, we are dissociating our minds from our bodies, which surely need to walk and stretch and see the sun shine or feel the wind blow.

To find the words that capture the felt sense of our clinical experience, we must hold in mind these concepts: self-organization, emergence, resonance, and entrainment (rhythmic attunement) and be interested in sound, vibration and rhythm as much as image and thought. Then we can legitimate and weave the felt sense into our formulations, not as a solely subjective parallel experience to narrative, but as an integral component of memory and relationships.

The concept of dissociation is so exiled from the post-industrial Western world that we do not recognize it when we see it, and we do not understand it when we are living in it. What is happening when I finish a session and cannot write notes? Another kind of tide, an undertow, has swept me into a dissociative sea.

Notes

1 Posterior cingulate cortex, anterior cingulate cortex, middle temporal gyrus, inferior parietal cortex and medial prefrontal cortex.
2 Quantum entanglement, or as Einstein described "spooky action at a distance," describes the non-local properties of particles that remain energetically linked despite vast distance. This concept is now making its way into complex information theory and cognitive neuroscience.

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Chapter 16

Divide and multiply

A multi-dimensional view of dissociative processes

Wilma S. Bucci

When the young man, her cousin, Shui Ta, is put on trial for killing her, Shen Te, the title character in Brecht's play *The Good Person of Szechwan*, reveals her double identity to the judges (who are the Gods). She knows that she is both, Shui Ta and Shen Te; the injunction of the Gods to be good and yet to live tore her in half; she could not be good to others and to herself at the same time. The Gods agree that she can have (be) her cousin, but only once a month. They return to heaven smiling and waving; they have found a good human being; the world is in order and does not need to be changed; they don't hear Shen Te's desperate cries for help (Brecht, 1942).

The context that Brecht wrote about was societal; Europe in the late 1930s. It was essentially impossible to function in an integrated way in that terrible and fragmented world. We can see similar processes operating in many familial as well as societal contexts today, and similar inability to recognize cries for help.

There is a fundamental theoretical tension underlying our understanding of dissociative processes: on the one hand, an assumption of a basic level of self integration, so that it is necessary to account for disconnection of components or states, as Brecht attempted to do; alongside, a view of the self as inherently characterized by multiple modes of being and experiencing, so that we need to account for how, or to what degree, integration can occur. In her discussion of writings on self-organization, Howell offers a metaphor that captures very well the tension I am addressing here:

> Our intellectual heritage includes both unity and multiplicity. Often these two visions of the self seem to switch, like a Necker cube, as if one view repudiates the other.
>
> (Howell, 2005, p. 38)

The theoretical tension in current views of dissociation can be seen as a product of the historical roots of the concept and the recent shifts in psychoanalytic theory and technique. The concept of dissociation as

developed by Janet, Ferenczi and others has until recently been largely excluded from the mainstream of psychoanalytic thought with its emphasis on repression and other defenses. The increased focus on psychological trauma, particularly PTSD, in recent years has led to increased interest in dissociative processes, while developments in psychoanalytic theory and technique have led to a recognition of these processes as operating in a wide range of emotional difficulties, and to new ways of addressing these problems in treatment. Some clinicians have acknowledged the operation of dissociated states and processes in patients with severe personality difficulties, while retaining the concept of repression as more applicable to an understanding of "neurotic" patients. Other clinicians now see dissociative processes as operating in all emotional disorders, but this has in some cases carried with it a problematic view of trauma as ubiquitous, in chronic or acute form (Bucci, 2007a, 2007b).

A general psychological view of dissociative processes: The multiple code theory

I came to the concept of dissociation from a different route, in my development of multiple code theory, before I was aware of the interest in dissociative processes as related to the psychology of trauma, and also before I was aware that dissociation was a controversial concept in the clinical field. The multiple code theory is a model of mental and emotional functioning that incorporates disparate processing modes connected only partially and to varying degrees. The limited connection among systems is inherent in the human condition; stress and trauma then interact in many ways with this disconnection.

From an evolutionary perspective, Tattersall has characterized the human mind as a particular kind of complex apparatus:

> not in the sense that an engineered machine is, with many separate parts working smoothly together in pursuit of a single goal, but in the sense that it is a product of ancient reflexive and emotional components, overlain by a veneer of reasoning.
>
> (1998, p. 234)

Outline of multiple code theory

I've discussed multiple code theory in detail elsewhere (1997, 2002, 2011a); I'll review it briefly here. The theory has been developed in the context of current work in cognitive science, affective neuroscience, developmental psychology and related fields. The basic concepts of multiple code theory include *symbolic* and *subsymbolic* processes and the corollary concepts of *emotion schemas* and the *referential process*.

Symbolic processing

In technical terms, symbols are defined as discrete entities that refer to other entities and that can be combined to generate infinite varieties of new forms. Symbols may be images or words. Thus we combine words to form clauses, sentences, and larger units, representing various levels of meaning. Similarly, we may combine elements of images to form larger units such as an image of a face or body, and also combine these units to form larger scenes. The police artist will attempt to compile an image of a suspect's face based on a witness's description of individual facial features.

People generally associate *thought* with symbolic, primarily verbal processes. We are familiar with verbal thought; it is the mode we feel able to access and control. In the moments after Vronsky and Anna Karenina's desires for one another had been fulfilled for the first time, Anna was distraught. Later, even after several days, as Tolstoy describes her, she could still not find the words to express the complexity of her feelings; she could not even find the thoughts in which to think out what was in her soul (Tolstoy, 1878/2000).

Subsymbolic processing

What Anna did not recognize was that she was indeed carrying out complex forms of thought—in subsymbolic rather than symbolic forms. Subsymbolic processes are defined technically as operating in continuous formats, generally based on analogic functions. They involve gradations in sensations and feelings in all sensory modalities and in bodily and motoric experience, rather than combination and manipulation of discrete elements or features. The distinction between subsymbolic and symbolic processing may be seen in comparing a police artist's composite sketch of a suspect's face to a photograph of the same person. A composite sketch based on discrete facial features will not capture the global impression made by a photograph; what are missing are the subsymbolic aspects of the image, the nuances that cannot be broken down into discrete elements and communicated in verbal form.

Subsymbolic processing may be highly systematic and complex, occurring in many activities of everyday life, in the arts, in all forms of sports and in creative scientific and mathematical work. Changing lanes in a highway requires judging the speeds and distances of vehicles approaching and passing, in relation to one's own speed, in the real time of driving, and directing one's steering, accelerating and braking motions using those judgments. Grandma is not holding back when she cannot give you the recipe for her special light-as-air dumplings; she must feel the amounts of each ingredient and sense how the dough feels when it is ready; one learns her secrets by watching and feeling. Subsymbolic like symbolic

processes may occur within or outside of awareness: the driver shifting lanes must attend to his perceptions and decisions if he is to live; grandma will stop talking at critical moments of feeling the texture of the dough. The state of mind that has been characterized as a "flow" experience (Csíkszentmihályi, 1990), is a state of consciousness, highly prized by athletes and artists that has features of subsymbolic processing without interference of symbolic modes. Scientists and mathematicians have also described such experience in their work. Einstein characterized the elements of productive thought as "in my case, of visual and some of muscular type" (quoted in Hadamard, 1996, pp. 142–143). The driver, the chef, the artist, the athlete, as well as all of us in the activities of life, are continually engaged in subsymbolic thought, in some cases within attention, in some cases outside of awareness.

Emotion schemas as building blocks of psychic integration

Processing and communication of emotional experience occurs in subsymbolic form from earliest infancy and throughout life. Given the inherent difference in formats between subsymbolic and symbolic systems, and the multiple and varied nature of subsymbolic processes, in all sensory systems and in bodily and motoric forms, the primary questions become how disparate systems can be integrated in emotional experience, and the nature and degree of such integration, rather than how and why dissociation occurs.

Subsymbolic sensory, bodily and motoric processes flow continuously within and outside of awareness, in multiple contexts that involve other people, objects and events. Clusters of such subsymbolic processes occur together with some regularity in relation to different objects and different people, in different contexts of time and place. Repeated moments of such interactions attended to in the present, and registered in memory form types of memory schemas that we term "emotion schemas."

For example, a group of bodily processes—heart beating faster, choking in the throat, feeling dizzy and faint, shallow breathing—may occur together fairly consistently, associated with particular types of action such as attempting to run away or hide. Such clusters of processes may occur in different contexts, with different people—visiting a doctor's office, hearing footsteps late at night in a dark street, giving a public performance, or beginning a yearly holiday visit to one's family; the contexts and the events will be connected on this basis. Through operation of these clusters of processes, the events of one's experience are evaluated and distinguished as supporting or interfering in different ways with the sensory and somatic functions that serve to maintain life. By this means, the events of life build the emotional meaning for the arousal that is experienced. The clusters of experiences may be given emotion labels such as "fear" or "anger"; the

nuances of experience will be captured not by such terms, but by descriptions of the specific episodes of one's life.

Emotion schemas and the schema of the self

The emotion schemas with their various configurations provide a basic framework for the concept of the self. The self schema, as I am discussing it here, is a phenomenological construct, the *sense of self* that is dominated by subsymbolic sensory and bodily processes. I suggest that the underlying sense of self, the subjective sense of remaining the same through the changes of life, is rooted in the sensory, somatic and bodily processes that constitute what we term the *affective core*, and these include the experience of the core bodily functions associated with maintaining life. Different situations and different people may evoke different bodily experiences; and these change gradually throughout life; but the continuing sense of self based on particular characteristic clusters of sensory and motoric patterns of experience—elements of experience that move and sense and feel together—remains.

Major features of emotion schemas

The formulation of emotion schemas as types of memory schemas incorporating sensory, bodily and motoric processes is compatible with current evidence concerning complex interaction among brain networks (Pessoa, 2008; Damasio, 1999), contrasting with views of emotion and cognition as separate systems. The emotion schemas are similar to all memory schemas in incorporating one's knowledge of the world, changing with each new interaction, and determining how one sees the world (Bartlett, 1932; Edelman, 1989). They differ from the general category of memory schemas in two major ways: (1) they are dominated by the sensory, bodily and motoric processes that constitute the *affective core* of the schema and that are involved in maintaining physical and mental well-being; and (2) they are inherently interpersonal.

Dominance of the affective core

The subsymbolic processes of the affective core include sensory experiences in all modalities; changes in the functioning of circulatory, respiratory, visceral, endocrine and other physiological systems; and motoric functions involving activation of muscles throughout the body, changes in body posture and movements of face and limbs. The special nature of the bodily functions associated with the affective core of an emotion schema is that many of them are also associated with maintaining survival in physiological terms.

The multiple code characterization of the emotion schemas and the sense of self as built on an affective core composed of bodily and sensory processes

is compatible with Damasio's (1999) formulation and was in part based on that. As I have discussed (Bucci, 2002), part of Damasio's central thesis is that the deep roots of the self are based on organized ensembles of neurons, representing ongoing aspects of the body, that serve to maintain the body state within the homeostatic range required for survival. Damasio calls the state of activity within these neural networks the *proto-self*. In terms of multiple code theory, this would relate to the underlying experience of subsymbolic components of the affective core.

The next level involves what Damasio calls a *core self*, which he characterizes as an imaged account of how the organism is affected by the processing of an object. In multiple coding terms, this would be the initial basis on which emotion schemas are constructed—the flow of experience as it connects in a particular moment to a particular person, in a particular event, and that includes the multi-faceted representation of the other.

The third level identified by Damasio is the *autobiographical self,* which he defines in neurological terms as based on coordination of personal memories, and as involving a network of what he terms *dispositional representations*; these are patterns of neuron activity that connect sensory and higher order cortices and have the potential to reactivate and reconstruct memories with their multiple components. These dispositional representations rest on the clustering of core events in memory, and include schemas representing various ways of being of the self in relation to others, in subsymbolic and symbolic form.

The inherently interpersonal nature of the emotion schemas

The emotion schemas are inherently interpersonal. Aspects of bonding and nurturing experiences, largely in subsymbolic mode, are incorporated in the affective core, and retained throughout life. We now have greater understanding of the representation of other people in an individual's emotion schemas based on current work in the areas of mirror systems (Iacoboni, 2009; Rizzolatti, Fogassi, and Gallese, 2001), enactive perception and embodied communication (Kinsbourne and Jordan, 2009). Certain cells in an individual's brain, known as the mirror neurons, represent the movements that the brain sees in another individual and produce signals toward sensorimotor structures so that the corresponding movements may be "previewed" in simulation mode, or actually executed, at least in trace form, by the viewer. This partial common coding of perception and action, which is referred to as *enactive perception* and *simulation,* enables individuals to *entrain* or link continuously to one another's actions and meanings.

The profound implication of these discoveries for an understanding of emotion schemas and for their organization or dissociation needs to be more fully recognized. Through such entrainment and simulation, representation

of others in one's own emotion schemas can incorporate their movements and other experiences that are subsymbolic in form (Bucci, 2011b). This provides the basis for a population of emotion schemas linking one's own bodily experience to the bodily experience of others as they move and express themselves, not only to others represented as images in discrete symbolic form.

Varieties of dissociative processes

Based on the concept of emotion schemas, and their relation to the schemas of the self and others, we can identify two major types of dissociative processes; these are disconnections of subsymbolic and symbolic components *within* emotion schemas, and disconnections *between* the various schemas of self in relation to others that each person develops throughout life. Both the *within* and *between* forms of dissociation occur in adaptive form for all people to varying degrees, underlying the flexibility that is necessary for different ways of being in different functions of life. Where extreme stress or trauma has occurred, in chronic or acute form, the disconnections are more severe. As I will argue here, however, all disconnections between schemas, even those that emerge in severe form as dissociative identity disorder (DID), originate as a function of disconnections within the emotion schemas—between activation of subsymbolic bodily experience and representations of the people, places and things that constitute the source of the activation.

Dissociative processes involving disconnections within schemas

Emotion schemas, like all memory schemas, are constantly in a state of reconstruction. The major turning points in development—the shifts from infancy to toddlerhood and middle childhood, the major changes in adolescence, and the various changes as the individual ages—are all marked by changes in the nature of the bodily components of the affective core and changes in expectation and beliefs concerning oneself in relation to others. The child must give up early patterns of bonding to his caretaker; parents must give up earlier schemas of nurturance in relation to their children, in some cases transforming to schemas of being nurtured by them. Such disconnections and reconstructions of schemas occur for all people, with varying degrees of success.

Effects of trauma on organization of emotion schemas

The disconnections within schemas that result from trauma and stress include situations that I have identified as *primary dissociation,* in which

stress interferes on a physiological level with the initial formation of the schemas, and situations of *secondary dissociation,* where schemas that have previously been formed are disconnected (Bucci, 2011a).

Primary dissociation

In extreme trauma, the moment of connection of subsymbolic experience to its source may be disrupted. Bion wrote about the registration of such fragmentary experiences at the moment of birth. Throughout infancy and early childhood children sometimes show what appears to be a state of inconsolable distress—from a gas pain, an earache, or from a sound or sight that was frightening to them in some way. Under such conditions, fragmentary images of events may be encoded in the amygdalar memory system, while encoding of organized memories (as in emotion schemas), which would be dependent on hippocampal mediation, is disrupted (LeDoux, 2002). There is evidence that memories of such painful and threatening experiences laid down in early childhood before hippocampal functions are fully developed are likely to be registered in such fragmentary form.

The same failures of connection may occur in times of stress throughout life. The memories of soldiers returning from the trauma of war provide vivid instances of such disconnected bodily and sensory imagery. Elements of experience associated with fragmentary memories—sights, sounds, smells—will have the power to activate the visceral experiences associated with the traumatic event, without recognition of the source of the activation. As LeDoux said, with regard to amygdalar memories:

> The good news is that even when the ability to form explicit memory is impaired, we can store useful information about harmful situations. The bad news is that if we don't know what it is we are learning about, those stimuli might on later occasions trigger fear responses that will be difficult to understand and control.
>
> (LeDoux, 2002, p. 225)

Secondary dissociation: Disconnection within previously formed schemas

In addition to primary failures of connection, situations of acute or chronic trauma or abuse throughout life may cause disconnections within emotion schemas that have previously been formed. A young child for whom schemas of attachment to the caretaker have been developed, but who is beaten, or provoked and over-excited to an unbearable degree, or humiliated verbally by the caretaker, will be in a state of bodily activation that may be seen as equivalent to psychic shock. There is nothing she

can do. She is torn in conflicting directions—terrified by the caretaker, hating the caretaker, having extreme flashes of rage, with impulses to attack, while subsymbolic processes of bonding with the caretaker are activated as well.

The child *does not recognize her self in these feelings*. She cannot feel all these different and incompatible affects *in relation to the same person at the same time*; she cannot be the *me* who is frightened and needs protection; who is rageful and wants to kill; who is ashamed and wants to hide; who wants to love and be loved. The threat is particularly great because the child can feel, *within herself*, through the processes of embodied communication, entrainment and simulation, the way the caretaker feels. She not only knows and responds to the caretaker's rage or the caretaker's desires, she feels them in her own body.

The basic resolution of the dilemma must be internal—to turn attention away from some of the incompatible impulses, and to turn attention away from the caretaker as the source of the conflictual activation. These disconnections enable the person to maintain some homeostatic balance, some sense of self, and some connection to the caretaker, but somatic activation associated with the affective arousal is likely to continue, now without an apparent source.

Multiple affects in search of a source

In such situations, people seek to find a source, to know "why I feel this way." The nature of the reconstruction of schemas is determined by each individual's life, dependent on the nature of the stress, and the familial and social context in which it occurs. The child and later the adult may attribute certain types of painful activation to sources other than the caretaker, to another person, to one's own failings, or to somatic illness. These form the narratives of one's autobiographical memory and one's current life, covering over the narratives of the source. The painful activation that continues to occur may also be expressed or self-treated in ways that themselves carry serious dangers—through violence, by alcohol, drugs, through eating disorders or through various forms of self-injury. All of these are quasi-solutions that help the person to survive, but that become life problems in themselves.

People may also self-treat disconnections within the emotion schemas in adaptive ways. Nietzsche's comment: "We have art in order not to die of the truth," is compatible with a view of art as an adaptive means of managing overwhelming dissociated activation as outlined here. Other more or less adaptive means may involve intense dedication to work or religion or political causes.

In traditional psychoanalytic terms, the functions characterized as defenses of isolation, or isolation of affect, denial, and disavowal can be seen as

related to disconnections of various types within the emotion schema. For example, according to Moore and Fine, the defense of isolation:

> Separates a painful idea or event from feelings associated with it . . . ideas may appear simply without the conscious presence of associated feelings. Fleeting aggressive thoughts—plunging a knife into someone, throwing a child out of a window, shouting obscenities in a public place—often occur without the emotion (anger) appropriate to such thoughts.
>
> (1990, p. 49)

Dissociative processes involving disconnections between schemas

The fundamental dissociation within the schema may also lead to construction of a range of schemas involving incompatible states of the self. Such problems of dysfunctional dissociations between schemas should be distinguished from the adaptive processes through which people develop different ways of being, flexible affective responses to different people and in different contexts, that enable them to carry out the multiple roles of their lives. In a widely read twitter message, posted on the Clinton Foundation website, Hillary Rodham Clinton described herself as "Wife, mom, lawyer, women and kids advocate, FLOAR, FLOTUS, US Senator, SecState, author, dog owner, hair icon, pantsuit aficionado, glass ceiling cracker, TBD". (We can add candidate for POTUS and Grandmother as well.)

The difficulty arises not so much in managing different responses in different contexts (although Ms. Clinton acknowledges possible difficulties with those), but in managing clusters of actions and feelings that are experienced as overwhelming the maintenance of the self. The threats that are experienced are multiplied through the processes of embodied communication and entrainment, as outlined above. The child can feel within herself the subsymbolic components of the mother's hostility toward her, as well as her own feelings of terror and rage, leading to a variety of self schemas that are experienced as incompatible and are likely to be managed in early, currently not adaptive ways.

For example, a person may *experience oneself* as victim in relation to the other as aggressor, or oneself as reacting with rage to the other, or as protecting oneself from the other. The person may also *experience the caretaker within oneself* as the hostile, humiliating, abusing aggressor towards others, then may hate oneself, feel guilty and ashamed; **or** the person may play out the role of the caretaker within oneself as aggressor *towards oneself*. Based on these and many other scenarios, emotion schemas become multiply layered and embedded, as in a Shakespearian repertory

company in which all the actors are men, and each actor plays a variety of roles—in some cases men playing women who are impersonating men.

The degree of disconnection among the personas and their expression will vary. Shen Te and Shui Ta are played by the same actor in Brecht's play. Each is at times aware that the other exists. At a dark moment in Brecht's play, the audience sees Shen Te with the suit and mask of Shui Ta in her hands, singing "The song of the defenselessness of the gods and good men," first in one voice and then in another as she puts on his suit and mask.

At the end of the play, Shen Te accedes to the Gods' directives. She agrees to remain as Shen Te, the good person they have found on earth, who shares the little she has with all people who ask her for help—but says she still needs her cousin to put her affairs in order, at least once a week. The Gods say "Once a month. That's enough." The situation remains unresolved.

Conclusions

The patterns and structures that are formed through dissociative processes, and the varied forms of attempted repair and reconstruction, are far more complex than can be accounted for in terms of a psychological model based on unconscious conflict, repression and defense. There are several points that need to be emphasized: (1) The basic dysfunction is not that the subsymbolic components of the emotion schemas are kept out of awareness, but that they remain active in the individual's experience while disconnected from their emotional meanings, the actual source of activation; (2) The respiratory, circulatory, digestive and other bodily functions that operate in the affective core of the emotion schemas are associated with maintaining physiological survival; in this sense the dissociative function was developed as the individual's means of preserving life; (3) The emotion schemas are inherently interpersonal; the other with his or her modes of feeling and behavior is incorporated within the emotion schema forming part of one's representation of one's own self.

Repair of disconnections within emotion schemas will involve recognition of the caretaker as the source of danger, and risks the flood of affect associated with such recognition, including reactivation of the threat to bodily survival and to the sense of self. Patients feel the risk of such activation, when it occurs even in trace form in a session, and will work to avoid it, using the mechanisms of avoidance they have developed. Clinicians working with patients who present with dissociative disorders are familiar with this dilemma. Clinicians working with all types of patients whose problems appear resistant to treatment might find it useful to consider the issues touched on here.

All these points are highly complex and I've only touched briefly on the related issues in this chapter. Current work in cognitive science and affective

neuroscience is now providing support from many directions for a general psychological model involving a multiplicity of processes, including different levels and types of conscious experience that are interconnected to varying degrees, and different types of associative clusters, constantly reforming; thus opening a new view of the nature of dissociative processes. A modern approach to understanding these complex processes can potentially open new ways of characterizing a wide range of disorders and lead to more effective modes of treatment as well.

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Chapter 17

The personal diagnostic crisis

The acknowledgement of self-states in DID

Richard A. Chefetz

It is the unusual person who does not experience a crisis of some sort when they first "get it" that their mind is a much busier and more complex space than they ever really imagined. It can be a shock to discover that you are not alone in your mind (Way, 2006), and that there are other ways of being you. It's not that people are fully bereft of the hints of the existence of other ways of being Jane, or Mary, or James. It's just that there are many ways of not knowing what a person knows. For example, rationalization is a mechanism of self-protection which relies upon dissociative process to strip coherent meaning from an event or something "known" and assign a meaning that is just enough "off" as to make it palatable for consciousness. It is an extraordinarily creative way of deflecting knowing about dissociatively isolated self-states, multiple centers of agency and initiative which can leave a person aghast, baffled, or startled by actions that "I didn't want to do."

> I was driving home on the Beltway and going past the exit for Baskin Robbins that I had avoided for a number of weeks when I found myself moving out of the passing lane and getting ready to exit. I didn't want to do that, and I tried not to, but I found myself steering in that direction while I was screaming inside my head to stop it. I couldn't control my arms. Then I went and got ice cream and ate it with my hands like I had done before. I was desperate to get it in my mouth. I don't understand why I do these things, but I know I've done this for years.

Sometimes a person has clarity that they are not alone in their mind:

> I finally became aware that I was in this hotel room with this guy I had just met the night before and it was beginning to get light outside. I had no particularly clear memory of what had happened, though I knew I had sex with him several times during the night. At that moment, I couldn't have cared less. I just wanted to get out of there. It's not that this kind of thing hadn't happened before. It's just that I thought I was done with that. I mean, it's driving me crazy that I really do have all

these different ways of being me. It's not just an idea. I don't really know how I am going to survive this.

There are complexities that can occur with the acknowledgement of the multiple self-states typical of dissociative identity disorder (American Psychiatric Association, 2013) that can be emotionally threatening. Such was the case for Anya. Early in her treatment it became apparent that she had a negative therapeutic reaction (Chefetz, 2015; Horney, 1936; Olinick, 1964; Wurmser and Jarass, 2013) to my efforts to help her reflect upon the meaning of her experience of her mind. Initially she would be significantly relieved of the painful tensions in her mind, and several sessions might go by where we both agreed things were easing up. Then things would suddenly get worse. She would become mute. She would be furious with me for raising the issue of the different ways of being Anya. She would berate me for bringing up, again, what she emphasized I already knew was not something she really wanted to talk about, nor something she could tolerate talking about. Yet, it was also true that what she told me pointed so strongly in the direction of her consciousness for her multiple self-states with semi-autonomous centers of agency and initiative that my intuition that she was ready to hear my curiosity misled me, repeatedly. I slowly became aware that it was likely that part of her was desperate for me to broach the subject. I also could be simultaneously clear that another part of her was desperate for me to just go away and leave her ability to deflect what she knew intact. I was getting caught in the internal argument, the perfect example of an externalization of conflict in her mind. I wrote earlier, "We both know that you believe that acknowledging that there are different ways of being Anya is like acknowledging your abuse. What I have never thought about is that not only do you and I know about different ways of being Anya, but that your father knew it too, and that he took advantage of it" (Chefetz, 2006, pp. 70–71). However, I did not take things much further in my own fantasies of the events in Anya's life and why she was so distraught about acknowledging what we both knew. And while my leap of logic led to a welcome decrease in her acuity, it did not tell nearly the whole story of the incestuous relationship her father had cultivated, nor did it speak to the adaptive response Anya had unconsciously crafted to cope with the ongoing action of the sexual relationship she had with her father.

By her own description, Anya's father introduced her to sexual contact around age two or three, but perhaps earlier. The exact initiation time was not clear. This was the most significant part of her relationship with her father whom she described as otherwise not talking with her or attending to her being alive. This was in contrast to what Anya saw in regard to father's relationship with Anya's younger sister and brother. Those relationships were filled with a wide-ranging conversation about personal and worldly concerns, regularly. In a sad and important way the experience of raw

sexuality and the satisfaction of her father's appetites meant that those sexual times would be the ones when Anya would be acknowledged as present and alive. This turns the concept of validation and confirmation of being on its head (Bromberg, 2006; Main and Morgan, 1996; Schore and Schore, 2008). Painful validation of being is not the model proposed. It adds an acutely miserable dimension to a teenage part of Anya exclaiming to me that they were "fucked into existence" by their father. It is not just that the sexual act was sometimes exceedingly painful and brutal, but it was that feeling present, alive, embodied, seemed only possible when there was the full permission of her father to be present and servicing his sexual needs.

This constellation of experience speaks to the presence of multiple dimensions of narcissistic injury, to use another nomenclature, and this perspective predicted Anya's hunger for valuation, longing to be noticed and admired, and the paradox that wishes for visibility regularly clashed with a wish for invisibility and a concomitant sensitivity and responsiveness to the pain in others. Anya did not fit the picture of a person with a narcissistic personality disorder. Instead, she showed flashes of what could be called a preoccupation with her own needs, sometimes without awareness of the needs of others, and a nearly simultaneous struggle to hold herself back from helping others in distress, making contact with them and their pain, and often failing to restrain herself. Along a dialectic of "being known and valued" there was a feeling of being bereft and desperate to meet her own needs, alternating with a fear of being visible, alive, noticed—lest she be abused, degraded, and grossly humiliated. This parallels the Kohutian dynamic of the bipolar self and demonstrations of grandiosity in tension with fears of annihilation (Kohut, 1971).

In Anya's situation, the selfobject function typical of these kinds of constellations of adaptive responses to adversity often felt like a request that my mind hold what she wished not to hold in her own mind. Mentalization functions (Bateman and Fonagy, 2006; Fonagy *et al.*, 2003) were corrupted by this arrangement. But it wasn't that she had a mind that couldn't create a theory of mind. It was that if she allowed herself to tune in to the content of the mind of the other she would become paralyzed with fear. If she allowed herself to approach tuning in to the content of her own mind she withdrew, became self-destructive as distraction from her internal pain, or simply disconnected, going into her "zone," oblivious to the passing of time. She knew from the experience of me reminding her about her concerns that I thought about things which she preferred not to think about, especially her mental states or the mental states of others in her family. She could rest assured in knowing that what she deflected toward me would not be lost, and also that she would not have to worry so much about finding these things in her own mind. "I can't think about this, it's too painful," was the invitation for me to hold what she could not hold. For my part, I could be comfortable providing some of the selfobject function she desired as she

placed her mind in my mind for safekeeping. But, I regularly ended up disappointing her when I proceeded with the work of the psychotherapy as she "teased" me with talking about, but not really, what she'd asked me to hold for her. Having unplugged her memory of something, she would regularly stimulate my associative tree by talking about some of the branches she had not dissociatively pruned from her mind. She would mostly tolerate my infractions, but not always, and at those times my active and sincere apologetic retreat, and sometimes honest confusion about how I had been a transgressor of "the law," was acceptable to her. There was indeed a dance going on, but every once in a while I felt compelled to connect the dots, and to put what was in her mind, and mine, on the table top of consciousness that was right in front of us in a particular session. This pattern of safe, but not too safe was a hallmark of the work we did together (Bromberg, 2003).

Putting things together in this psychological climate, meant that I had to be on my toes about what Anya had told me, not overwhelm her with connections, and also say things to her that were clearly just on the edge of the unbearable in order for her to grow and heal. A regular battle raged inside her regarding accepting or deflecting what she knew she knew, but didn't quite acknowledge, somehow, and was able to maintain a distance that robbed her of being real and also blocked the deep sadness and grief that threatened to become conscious. It was why she once wrote: "It's a relief to finally understand the person I've been missing most has been myself." I didn't think I was working harder than she was working. I often had the thought that I was hurting her as I pulled together the not so disparate elements of what she had told me and speculated about a more coherent narrative. This should have been a clue to what was evolving, but I was honestly clueless.

Such was the case as I listened to her talk energetically and emphatically about her hatred of her father "who raped me until I was twenty-five years old." I was troubled by her energy. It's not that her father didn't rape her, according to her reports of his behavior. Nobody could mistake the description of a rape. It was also true that there was a great deal of fog in her mind about what specifically had happened. This was not unusual in my office, and the fog tended to be most prominent for my patients who had histories related to the dynamics of incest. This was consistent with speculations about betrayal in a family constellation (Freyd, 1996) and the problem of having a casual family breakfast the next morning with the man who had sexually assaulted you the night before. Dissociation could come to the rescue, but it had to wipe clear not only the moments of abuse, but also the everyday moments of family life. The dissonance created by these real family scenes sandwiched against incestuous scenes with her father was unbearable for her. She'd had to submit her will to another member of their family upon whom they otherwise depended for sustenance and survival. It is easier to understand the more global amnesias of some

people in this context. Memory for everyday living was assaulted by the incongruity of unacknowledged everyday acts of cruelty. For the person with a compartmentalized mind, the elements of experience are spread across a mental landscape occupied by multiple self-states who like spies all sent on a mission to a distant land don't know each other's names, and only know that there are others like them who are on a mission, somewhere. In that way no spy can betray the whole network if captured. No self-state can recall the whole story if they become fully conscious. Anya wrote about it this way:

> Tonight I feel like I had this sudden huge understanding that I have been in an epic battle with myself. I thought for so long it was about my parents and all they had done or not done—I understand the fight has been inside of me and about the wish to not know fully about them or me and different ways of being me.

In another email she wrote about this ongoing struggle in her mind:

> I need your help—but I am not sure in what way—I guess with helping me know more about the different ways of being me and helping to orient all of my mind to the fact that it is 2012 . . . so even though all of the abuse memories feel and seem awful—they are all MEMORIES. MEMORIES OF TERRIBLE THINGS FROM THE PAST.
>
> I feel really terrible. There is so much terribleness and then so much remembering and then the weaving together. And now that the weaving together has started—it feels like my life is not at all the life I ever thought I had . . . but then not that at all. Then it suddenly seems exactly like the life I've always known—just have never been able to talk about.
>
> It is difficult for me to talk about different ways of being me to you—I feel like I should be doing a better job about that—but often when you bring it up I feel like I don't know the names or the ages or anything very much about the different ways of being me at all.

I replied via email:

> Hi Anya,
> I think you have been desperately trying to put things together, in your own mind, and that as much as I know you value me and our work together, and that is a lot, still, I think you are frightened of letting me know the extent to which your mind has compartments. I think this is true not only because you'll know too, but especially because the last time a man knew about the compartments in your mind he hurt you, badly. Does this speculation resonate?
> Thanks, Dr. C

Anya's reply was brief, and halting as if she was barely able to type the words she wrote:

"Yes. That. The last time a man knew, he hurt me terribly. Yes."

She was stuck in a familiar place in her treatment. There was a pressure coming at her from a number of different compartments in her mind, a pressure that demanded the freedom to speak. When it did not happen, then she was pummeled from within her mind by everything available to "throw" at her, memories of abuse, specific sensations of being raped and sodomized, preoccupations with pain. There was an effort to force her to accept what was in her mind, but she could not. I thought it was because the scenes of abuse were too terrible. I wrote to her and reminded her of the crisis she had passed through several years before when she could not bear to acknowledge any of the obvious switches between self-states that were occurring in our sessions until one fateful session where in an angry and authoritative voice she spoke about her abuse. The immediate result was a clearing of her mind, a sense of being in her body, a gross reduction of tension, and a sense of well-being for the first time she could remember.

The stage felt set for combining her willingness to consider the extent to which the pain she was in took origin in her own reluctance to know her mind, as well as the intuition that had been growing in me about why that was specifically the case right now. I continued to be struck by the vehemence of her attacks on her father, and the characterization of their incestuous relationship as always consisting of rape. I had heard her talk differently about what had happened, and I had become convinced that she could hardly tolerate knowing what had leaked out in conversation a year or so before.

If there was ever a reason to not know about the full meaning of having a mind with isolated self-states consisting of exclusive knowledge as well as overwhelming emotional content, then the scene that had been forming in my mind fit the bill. Some years before, Anya had talked about finding a nightgown stuffed in the back of a drawer, a dresser drawer in the home in which she grew up. She was terribly upset about this recognition. It turned out that it was what she wore when being sexual with her father. It was the signifier that pointed to a sexual relationship that included more than rape. It was the symbol of an ongoing incestuous sexual experience with her father. Anya had constructed a fantasy of her father as boyfriend, a man who would eventually leave his ineffectual wife, and live with Anya, exclusively. Anya's upset about being left by her father in a pile of soiled sheets after being sodomized was complicated by the reality that he returned to his wife, Anya's mother. The betrayal of incest was complicated by the betrayal of her father-lover, the competitiveness with her colluding mother, and the need to hide this activity, this complicated reality and the emotional baggage

of it all from her own mind. There were numerous times when the part of Anya who was livid about being raped by her father was disbelieving at how short a distance it was from the bed in her parents' room to her own bed where she and her father sometimes had tender sex, and more often also had violent sex. Anya was outraged with the idea that her mother knew and did nothing.

At this point, more importantly for Anya, was the fact that some parts of her mind participated in this scene while other parts looked on, and still other parts were oblivious to the action altogether. In the discovery of her multiple self-state subjective experience, Anya uncovered a Pandora's box of self-loathing, self-hatred, disgust, and despair alongside feelings of longing for her father, feelings of being jilted, and the forgotten history that even after she left for college in a somewhat distant city, she took special pains to figure out when her roommate was going to be away, how she and her father could rendezvous in a hotel room, and when all else failed, she went home for the weekend to be "fucked into existence" by her father. It is such a sad and painful story to know. It was something else altogether to have lived. It was ample motivation for not wanting to know about different ways of being Anya.

And so it turned out that in a very painful session, she came to understand that not only was Anya's constellation of different ways of being herself holding knowledge she could not bear to know, but that her father also knew about the different ways of being Anya, by name. These were names he had coined, in some cases. My wish to help Anya "map" her internal system of parts clashed with the need to keep this knowledge secret. My occasional use of the name of one of her parts of self threatened to unravel years of denial, disavowal, and amnesia. My interest in her self-states smacked of father's interest. My understanding of her mind threatened to topple the careful balance she had constructed of knowing, and not knowing, and only sort of knowing about her life. It was not just the scene of incest that was at stake, it was the entirety of the story of her life, a story she had believed, cultivated, and repeated. The story was shredded. Consciousness was a cruel companion.

In the words that follow, Anya talked about her emerging consciousness as she continued to struggle after this session:

> I've never felt more sadder (sadder seems like not the right word, but then yes) or felt this wounded by a memory in a very long time. I've also not had this level of relief since my last session with you. At first I just hurt from what I said; it was awful and difficult to think at all. Then yesterday it started to get a little better and now today I am feeling even better.
>
> It is good—to feel relief and to feel better—but then I remember why and feel quite sad anew.

I also have this other thing happening that is kind of new . . . instead of just seeing or remembering something about me [when I was in grade school] . . . I can see myself at school. My teacher was Mrs. Smith for the second grade. I can remember the room, my desk, other things about the school. It is good—I guess—to remember more—but it is also a little weird and scary and as I already mentioned—it is kind of hard to remember why I have only just now remembered.

But I've never felt this much continuous relief from one session. (Or from 8 years of work??) Anyway—it is very different—the feeling I have now and the feeling I have inside of my head.

I was thinking today how it is not that my idea of my family is now in tatters—it is that my memory has always been in tatters and nothing more—but I viewed it as a whole. I could not see the holes in the tapestry of my own life because they were too painful to understand and also—the tattered image was the only image there was and it took years of work to even see the holes at all.

I feel like I am not really describing any of this very well or clearly, but it also feels like a very difficult thing to describe.

At art therapy I often feel panic and eat and eat cookies if there are any around. Today I went into the kitchen part and there were cookies, but I did not eat any and I thought to myself: I was trying to tell me about having been a child who was anally raped and I didn't want to hear. I wanted to shut that child up. I know I had to.

Anyway—it is weird but good to feel some of the pressure off. It is insane to understand that when I was just [a grade school child] my father anally raped me. It is difficult not to ask the question: WHAT IN THE HELL WAS HE THINKING? I asked it when talking to [my art therapist] in some format or another and [she] said something about how "he was not thinking of me." Yes. That part is certain. I think for a second about how much my dad was not thinking about me or how much he was hurting me—then I can't think about it for longer. My mind scampers away.

In the treatment of dissociative identity disorder the ability of a person to gain a model of their mind is often based upon their therapist's capacity to hold that emerging model and to lay it out on the table where the framework is visible to a person who can then color it in, label the compartments, identify areas of confusion, places of not knowing, spaces too painful to enter, and so on. For some people the acknowledgement of the "different ways of being me" is riddled with the problems inherent in not just the content, the emotionality, the behavior of those self-states. Sometimes the knowledge is associated with knowing who else knew about those compartments. There are many other variations on why it is frightening to know about different ways of being. For these people, diagnosis can be a

treatment-long crisis of not wanting to know now what was not known then. When that happens, progress in the treatment is halting, and real gains are often truncated by the intense fear of knowing more and slamming the door on that knowledge before anything can leak out.

It was in this context that Anya told me once she had a false memory. There was no real crisis about this, no real anxiety at the point where she realized it. All the worry and storminess in her mind had preceded this realization:

> I had a false memory, Dr. Chefetz. I used to think I had a childhood that was mostly like what other people had, though there were occasional hard times. That's a false memory. My childhood was pretty much terrible all the time, with occasional times where things went OK.

The diagnostic crisis, where a person discovers that their mind is not at all what they thought it was, seemed a match for Anya waking up to the reality that the story of her life was not what she thought it was. It was like all of the signifiers of her entire life had fallen out of her pockets while she walked a brisk walk, until she arrived at a stopping point and found that her pockets, her life, were somehow empty of what she was sure had been there. It is no wonder that a diagnostic crisis occurs when a person discovers that neither their mind, nor their life was really of much resemblance to what they now understood. How does anybody really tolerate that kind of loss?

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Chapter 18

Psychoactive therapy of DID

A multiphasic model

Ira Brenner

Introduction

The "confusion of tongues" (Ferenczi, 1933) in psychoanalytic jargon has never been more problematic than when it comes to "dissociation." Described by the eminent Edward Glover, as having a "chequered history" (Glover, 1943), Freud's determination to create a totally new psychology with repression as its cornerstone (Freud, 1914) may have obscured his earliest insights into this often misunderstood phenomenon. At the time, he needed to differentiate himself from Janet, who theorized that dissociation was a disintegration of the mind due to constitutional factors (Makari, 2008). Instead, he proposed that the mind could split, create symptoms or induce forgetting because of an active, unconscious force keeping the mind apart. This revolutionary principle led to a totally new treatment based on free association instead of hypnosis, and ultimately into the most coherent and comprehensive depth psychology available today. Unfortunately, the orthodoxy of Freud's most influential followers, in their well-intentioned efforts to preserve and further the field, may have taken us even further afield from his earliest ideas.

For example, in Freud's seminal collaboration with Breuer, they conclude, "the splitting of consciousness which is so striking in the well-known classical cases under the form of 'double conscience' is present to a rudimentary degree in every hysteria" (Breuer and Freud, 1893–1895, p. 12). Moreover, they describe three types of divisions: splitting of consciousness (pp. 12, 67, 69, 123), splitting of personality (p. 45) and splitting of the mind (pp. 225, 234). They merged these ideas into the splitting of the mind between a conscious and an unconscious part, the forerunner of the topographic theory and the unconscious force known as repression.

However, there was a problem because the original description of splitting of consciousness referred to fixed, alternating states of consciousness. What was known, expressed and owned in one state would be replaced by another such state, at which time the former would not be remembered. As Breuer described it, "two entirely distinct states of consciousness were

present, which alternated very frequently and without warning and which became more and more differentiated in the course of the illness" (Breuer and Freud, 1893–1895, p. 24). This type of amnesia and mental functioning was carefully described in Breuer's legendary case of Anna O, who coined the term "the talking cure," and whose treatment was seen as the birth of psychoanalysis. It is indeed one of the great ironies of the field that the first patient treated by the psychoanalytic method was one with multiple personalities (Jones, 1953), a condition that then became anathema to classical analysts.

Freud may have unconsciously betrayed his uneasiness over his limited understanding of this most vexing problem by his facile explanations and his seemingly offhanded dismissals. For example, in his landmark explication of the structural theory in "The Ego and the Id," he asserts that different identifications taking over consciousness might account for what is seen in multiple personalities (Freud, 1923). Then, in one of his last works, he concludes,

> Depersonalization leads us on to the extraordinary condition of "double conscience", which is more correctly described as "split personality". But all of this is so obscure and has been so little mastered scientifically that I must refrain from talking about it anymore to you.
>
> (Freud, 1936, p. 245)

As a result, Freud's followers were left with the impression that psychoanalysis had little to offer and little interest in multiple personalities; the technique of free association accompanied by well-timed interpretations of unconscious drives was the domain of the psychoanalytic universe. However, Freud's "return of the repressed" was enacted in the psychoanalytic movement itself as the problem would not go away, and it kept reappearing in the literature under various names. Even his far-reaching concept, splitting of the ego (Freud, 1940), which was subsumed by object relations theory and self psychology (Brenner, 2014), could not make the problem go away. As a result, there appeared papers on "hypnotic evasion" (Fliess, 1953), a revisiting of the "hypnoid state" (Dickes, 1965) and the revival of the connection between early trauma and the "autohypnotic defense" (Shengold, 1967, 1989). However, there continued to be a disconnection between dissociation and multiple personalities in the renewed efforts to revisit this condition (Kernberg, 1973; Lasky, 1978; Berman, 1981).

The application of classical theory, therefore, fell short in explaining what was seen and experienced in the consulting room, although a minority view insisted that nothing different needed to be done to successfully treat what we now refer to as DID (Gottlieb, 1997). While object relations theory and self psychology did offer some help, and the relational model has recognized the central importance of dissociation and brought it to center stage, these

schools of thought were not developed with the goal of understanding dissociative disorders so that the importance of autohypnotic, defensive states was not taken into careful consideration here either (Brenner, 2001, 2004, 2009, 2014). As a result, trying to fit into the Procrustean bed of existing theory would require ignoring much of what I had observed and experienced with this patient population. The correlation between severe, ongoing, early traumatization and frank DID cannot be stressed enough, because the extreme measures that are necessary to prevent psychotic fragmentation, in my view, give DID its particular uniqueness and offer its greatest clinical challenges.

A clinical approach to DID

In-depth treatment of DID is not feasible with all such patients. My particular approach depends upon my capacity to develop a therapeutic relationship with those whose minds are organized in this most remarkable way. I describe this therapy as "psychoactive" because it can be powerful and truly mind-altering in the most positive sense of the word. With classical psychoanalytic training as well as extensive inpatient, psychiatric experience, my integration of these two extreme forms of treatment is a metaphor of the challenges of integrating the dissociated mind itself, which is kept separate and loculated. It is precisely, however, this integration of my experience in both settings that has allowed me to develop a treatment model that considers the individual's potential for significant regression as well as her resilience. As has been noted by many, these patients often have an unusual set of ego strengths and are capable of quite high levels of functioning, sublimation and empathy, which may almost completely obscure their underlying mental structures and vulnerabilities. Moreover, it is a totally different clinical presentation and treatment experience to begin analytic therapy with someone whose dissociative proclivities only emerge in response to anxiety in the transference as opposed to the totally decompensated, already-diagnosed inpatient.

Harkening back to a time, last century, when it was possible to hospitalize someone for many months, the standard of care was daily visits, five times a week. So, I had the opportunity to work with very regressed, traumatized patients with both "analytic frequency" and a safe holding environment with 24-hour nursing supervision. An unprecedented confluence of factors enabled me to become an administrator on an internationally renowned dissociative disorders unit, headed by Richard Kluft, M.D. During this time, I had the opportunity to work with literally hundreds of such patients in my various roles as consultant, supervisor, group facilitator, individual therapist and Associate Director. As a result, I could meet regularly with rather decompensated people who were in the throes of: impulsive, suicidal despair; dangerous homicidal rage; drug addiction and withdrawal; alcoholism; posttraumatic delirium; anorectic starvation; and frequent, overt switching

to a number of personifications. In addition, those patients frequently suffered from psychophysiologic disturbances, conversion symptoms and autoimmune diseases. Needless to say, the classical, analytic model of quiet listening and well-timed interpretation of unconscious drives would have been grossly inappropriate and perhaps even contraindicated at times (Brenner, 2014). Nevertheless, I would endeavor to maintain an analytic state of mind of empathy, curiosity, flexibility, open-mindedness and the conviction that the symptomatology was largely dynamically driven, meaningful and therefore potentially understandable and, hence, "analyzable." Such inpatient experience is, indeed, a relic of the past but it greatly informed my evolving technique in the almost exclusively outpatient work I currently do and have done since the Institute of Pennsylvania Hospital closed in the mid-1990s.

Therapeutic alliance

With the advantage of collecting clinical data from a number of sources—from my "reverie" (Bion, 1962) in sessions to 24-hour nursing reports, artwork, group therapy and written journals—it became possible to recognize the fundamental importance of developing and maintaining a therapeutic alliance with the patient in as many altered states of consciousness as are feasible. While the notion of a therapeutic alliance (Zetzel, 1956) or a working alliance (Greenson, 1965) is hardly novel, the significance here is that certain segments of the mind do not appear to engage in the therapeutic process without active interest on the analyst's part. As though the phenomenon of resistance may literally be personified in this patient population, it becomes necessary at times to "include," "invite," or even seek out the most dissociated selves for treatment to progress.

For example, there was a severely sexually abused teenager, whose violent alter, based on an identification with the aggressor, was physically threatening to his grandmother, his primary caretaker. His abusers had threatened to kill him in his sleep if he told anyone about their sexual violations, which they insisted he had instigated. They had almost completely convinced him that his grandmother was the evil one who must be eliminated and, like a brainwashed, cult member, he menaced her in a terrifying, robot-like state. It was clinically necessary to actively seek out this dissociated self, empathize with his plight as a "protector" and guarantee him time in the sessions in order to secure a safety contract and continue outpatient work. Before he would leave the office, this self would be asked to "return" back inside the mind in order to regain the mental equilibrium needed to exit safely. In this way, a crucial aspect of the dissociated mind entered the treatment, which was necessary for a successful outcome.

Should these individuals require surgery, the vital importance of this type of alliance is convincingly demonstrated. The failure to get "informed

consent" from the most destructive and sabotaging selves may result in post-operative complications because bandage changes, suture removal, physical therapy and the need for pain medication in accurate doses require co-operation and understanding. Otherwise, there may be confusion between previous painful, traumatic experiences and the surgical procedure, which might result in unforeseen problems. One particularly unusual and dramatic example of the inability to get "all parts of the mind" involved occurred when a patient impulsively opted for laser eye surgery to correct nearsightedness. It was too early in therapy for an alliance to have been established with all of her selves, especially with one who had a different refraction and a different set of eyeglasses, and would have justifiably opposed the operation. Internal communication among these selves, facilitated through the alliance, could not occur and, predictably, the operation was a dismal failure. The patient had blurred vision for almost a year, which completely befuddled her ophthalmologist (Brenner, 2014). The procedure was based on a set of ocular calculations when the patient was in one state of mind, but when she "switched" to other selves with different refractions, she could not see clearly anymore because her old glasses were rendered useless. Had "everyone" been able to participate in the decision-making which would have made the conflict explicit, then the surgery would not have taken place and she would have been spared this suffering. Analogously, in the treatment itself, it is essential for the patient in her various, altered states of consciousness to develop a rapport with the analyst.

As the treatment progresses, it remains essential to stay mindful of this first phase, as problems in the alliance are endemic throughout. Ruptures occur regularly, quite frequently owing to underlying attachment problems especially of the disorganized, disoriented and avoidant types. A particularly vicious form of this disturbed attachment, which could not be exclusively contained as an outpatient, manifested in a profoundly traumatized and angry woman who was "fine" during my absences but so severely self-mutilated upon my return that she ultimately self-amputated three fingers (Brenner, 2004). Left with only her thumb and middle finger, it appeared that she was constantly giving everyone "the finger."

Delineation of the mosaic transference

It soon became clear that different selves relate differently to the analyst and, in fact, may develop seemingly separate transferences. The pattern of these disparate relationships comprises what I have termed the "mosaic transference" (Brenner, 2001), the delineation of which would comprise the second phase of treatment. Given the clinical observation of the problems with object constancy as well as the obvious lack of self-constancy, a rapprochement-style, mosaic transference is typically evident. Consistent with Mahler's description of the "darting and clinging" (Mahler, 1972) of the

18- to 24-month-old, rapprochement-stage child, there may be young child selves with enormous object hunger who desperately cry out for help, never want to leave the office and are terrified of any separations even from one day to the next. At this age, object constancy and self-constancy would likely not have been firmly established, a developmental fixation typically seen in DID. Indeed, since DID is the quintessential manifestation of a disturbance in self-constancy (Brenner, 2009), such early issues would be expected. In stark contrast to a clinging, child-like self, there may also be a negativistic, hostile self who expresses rejection, hatred and fear. Over time, this self may also present itself as being worried about losing control of the others and therefore feel threatened by the growing alliance.

An instructive and memorable example of this internalized, interpersonal conflict occurred early in my work with this population. A very regressed inpatient would switch to a childlike self, suck her thumb and want to sit at my feet while I read melancholy fairytale stories, which she brought to me. During a very turbulent time when she was quite agitated and suicidal, her only moments of calm were in this childlike state, which was a huge relief. After one such moment of expressing a tender desire for a loving parent who would nurture and not exploit her, an angry, violent, teen self appeared during the hour on the following day. She immediately ran toward a framed painting on the wall and started pounding on it in an effort to break the glass, take a shard of it and cut either herself or me or both of us. Emergency staff needed to be called in to prevent a clinical emergency.

It was understood that, over time, the young child self's deep wishes in the transference were deemed dangerous and bad and needed to be countered by a repulsive, violent act to drive me away and get herself punished. The seemingly disparate, dissociated self-states, therefore, did indeed have an obscured, but vital, relatedness, which could best be understood in the context of the transference. Once an alliance was established with this violent self-state, impulse control greatly improved in direct proportion with her capacity for symbolization and verbalization.

I endeavor, therefore, to facilitate a relationship with the patient in all states of consciousness, allowing my mind to become a psychic holding environment, or container, for this mosaic transference. This composite transference, as mentioned earlier, has a distinctive rapprochement quality to it. Moreover, the relationship between the alters and their dynamic, spontaneous emergence in sessions provides important information about the defensive aspect of these multiply-determined structures. It takes a certain amount of mental agility and flexibility to work this way because, not infrequently, it has felt as though I were conducting group therapy with an unknown number of members, most of whom have little or no knowledge of the others. Other times I have felt like a switchboard operator serving as a go-between, connecting two parties trying to communicate with each other, whereas other times I have felt as though I were playing a game of

three-dimensional chess with an unlimited number of permutations and possible moves. In addition to this challenge, working with this population can have a hypnotizing effect on the analyst, whereby sudden fluctuations in alertness, energy level and the like may occur. It has been described as feeling drugged or put to sleep (Brenner, 2004). The clinician also needs to be prepared to be surprised and taken off guard by the sudden emergence of different selves.

Confronting the "It's not me!" self

The next phase of treatment is confronting the "It's not me!" self (Brenner, 2001, 2004), which, if well timed, promotes the dissolution of the underlying dissociative psychic structure. This construct, or specialized ego function as I see it, essentially generates the different selves by deploying certain mental functions, described as "organizing influences." These selves appear to be a creative, last-ditch effort to stave off psychosis and encapsulate the overwhelming traumatic affects and memories. This encapsulation is analogous to the way the body tries to fight off an overwhelming assault of bacteria by encircling it with white blood cells, creating an abscess, and keeping it separate from the rest of the body. As a result, the "It's not me!" self creates the illusion that, indeed, whatever traumatic event may have been sustained either did not occur, or if it did occur, happened to somebody else. The organizing influences recruited in this life-saving effort include well-known aspects of mental life that are utilized in an unusual way, such as: (1) the divisive or splitting effect of aggression; (2) the character-forming quality of perverse sexuality; (3) the personification of altered states by the dream ego; (4) the collapse of time and identity with intergenerational transmission of trauma; and (5) the out-of-body perception in near-death experiences. As a result, the patient may be convinced that indeed "It's not me!" when challenged to consider that there are parts of the mind out of awareness that have a sense of autonomy, independence and even different wardrobes, sexual predilections, groups of friends, relationships, lives, careers, talents, etc.

One such patient, who was outstanding in her field, was to be honored with a top award. She was totally mystified as to why she was chosen, which I initially sensed was out of undue modesty and self-effacement. As I got to know her better, I realized that this feeling had more to do with the fact that she, in the state of mind to whom I was talking, spent little time at work and that another self was actually the industrious employee. Therefore, she truly felt undeserving. Through the gradual increase in clinical evidence of the existence of these seemingly separate selves, the patient was empathetically confronted, which presented an enormous challenge to maintain this illusion. It became progressively more difficult to do so after a series of dissociative fugues, interestingly occurred during the time of our sessions.

After she would "come to" and find herself in dangerous situations in different cities, she would call the office in a panic, not realizing I was waiting for her to arrive. The sessions were then conducted by phone, enabling her observing ego to process what was going on and helping her take ownership of her selves.

An effective way of helping such a patient own these seemingly separate selves is by bringing to her attention an unusual manifestation of the repetition compulsion (Brenner, 2014). Not infrequently, the patient may dream she is witnessing a young child being mistreated in a particular way. Around this time, before or after the dream, the patient "switches" during a session and a young self relives an almost identical, traumatic experience firsthand, in the here-and-now, totally absorbed and oblivious to her surroundings. In that state of mind, she has no recollection of the dream and has reciprocal amnesia when she returns to her former state of mind.

The analyst, as container, then shares his observations that the dream and the dissociated self-state portray almost identical traumatic scenarios that are amnestically kept separate, but have a common origin in the patient's mind. It is quite gratifying to see such patients with a significant "narcissistic investment in separateness" (Kluft, 1993) look shocked, puzzled, curious and ultimately convinced that, indeed, all of these mental phenomena must be connected and must ultimately be owned by the patient.

On the road to integration

As in all analyses, the integration of one's ego and one's self- and object representations is up to the patient. Therefore, I do not try to impose a structure or timetable with DID patients. As opposed to the stated goal of many DID therapists about the primacy of integration (Kluft, 1993, 2013), the psychoactive treatment model allows it to evolve organically. Integrative experiences occur spontaneously as part of the process rather than the endpoint of a hypnotic ritual of guided imagery exercise. This process begins with the patient's internalization of the analyst's capacity to accept, tolerate, contain and maintain a cohesive mental representation of her shattered psyche.

The "It's not me!" self then shifts from Type I to Type II, as the disowning of mental contents diminishes. Instead of the patient insisting, "It's not me!" regarding dissociated memory and behavior, she now concedes that "It's me and it's not me" but is puzzled by this paradox. Indeed, she likely experiences the dissociative triad of "It's me and it's not me," "knowing and not knowing," and being "here and not here" (Brenner, 2014).

When the treatment progresses satisfactorily and life circumstances, such as ongoing traumata or sadomasochistic relationships, do not conspire with internal reality to maintain life in a trance, then more integrative experiences may occur. When they happen within the treatment dyad, they are

especially meaningful and durable, being analogous to well-timed transference interpretations which, from a classical viewpoint, may be "mutative" (Strachey, 1934). Not infrequently, these integrative moments are accompanied by psychophysiological, sensory or perceptual changes affecting the tactile, auditory or visual spheres. For example, one patient had a series of spontaneous abreactions and profound insights associated with a whooshing sound, like a huge vacuum cleaner, as she ruefully concluded that what was disowned actually belonged to her after all. After years of living through many episodes of life-threatening self-mutilation requiring multiple hospitalizations, she had a series of epiphanies catalyzed by a deeply ambivalent paternal transference.

Another patient, a high-functioning outpatient, experienced a young girl's voice quietly saying, "I'm sorry! I'm sorry!" which heralded an integrative experience, which, for her, was associated with increased visual acuity and a brightening of her perception of color. This constellation occurred after weeks of feeling betrayal, anger and fear associated with a small increase in my fee in which an enactment relived in the transference revived affects associated with a heinous, sexual assault by a trusted male relative (Brenner, 2014). Her "protector," adolescent self had failed the patient by giving into a futile wish for healthy attention and love that culminated in an utterly humiliating rape. Vowing to never again become vulnerable to a man, her feelings in the transference became extremely dangerous and the patient felt cruelly betrayed by the circumstances around the fee increase.

After many hours on the couch dwelling on her extreme mental pain, she eventually became better able to appreciate my subjectivity of the events, which resulted in a better differentiation of the past from the present. She then was able to neutralize and sublimate some of her aggression and with a reduction of this divisive influence she then experienced a merger of these selves. In the vernacular of a child self who reported on the changes in her internal world, everything got "smooshed" together. As a result, there were many more disturbing affects and memories to contend with but with a greater sense of cohesion and continuity of the self.

Consolidation and working through

This phase of treatment, the penultimate step before termination can be realistically and mutually considered, enables the patient to become more comfortable with the structural changes occurring in her mind. The all-purpose defense of dissociation, which may literally provide autohypnotic amnesia effective enough to withstand major surgery, may all but disappear. It may be replaced by the more familiar manifestations of repression and its seamless and less dramatic forms of forgetting.

One such patient, a number of years after termination, re-consulted me following the bizarre and unexpected death of her major perpetrator.

She experienced a recrudescence of anxiety and vivid memories of sadistic, sexual practices that were visited upon her in childhood but did not lose time or become disoriented or "switch" to any of the dissociated selves who had formerly inhabited her psyche until the end of her treatment.

Experiencing enormous amounts of anguish and grief, she lamented not being able to retreat into her private world of dissociated selves who would protect her by holding the pain and enabling her to forget everything. From her integrated and consolidated vantage point, which she had sustained for a number of years, she was rather amazed at how different she now was, as she was not able to regress to her formerly divided self. She did, however, experience accident-proneness, misplacement of emotionally charged personal items and other signs of the psychopathology of everyday life (Freud, 1901).

Caveat and conclusion

This rather abbreviated report condenses about thirty years of trial and error in which this type of treatment has evolved. The multiphasic model is intended to provide a series of clinical landmarks for those working in-depth with a most challenging population that was thought to either not exist or be of little interest because it was outside the realm of analysis. Like any model that employs phases or stages, what is described in a book may not be quite as neatly delineated in actual clinical situations. However, I have found in my own practice and in the supervision of other clinicians, that this outline helps me pinpoint where the patient is in the treatment process and where the dyad needs to go in order to maximize the psychoactive nature of this work.

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Chapter 19

The seeming absence of children with DID

Valerie Sinason

> The history of childhood is a nightmare from which we have only recently begun to awaken. The further back in history one goes, the lower the level of child care, and the more likely children are to be killed, abandoned, beaten, terrorized, and sexually abused.
>
> (Lloyd de Mause, *The History of Western Childhood*, 1982)

With regard to the abuse of children, the early Greek myths told what happened to children who refused to comply with sexual demands of adults or who knew too much. Cassandra, because she rejected Apollo's sexual overtures, was punished by being condemned to know the future, but had to endure being disbelieved in her own time. Similarly, Echo was punished for witnessing Zeus's infidelity by having her words made into meaningless repetitions.

Even in today's more "enlightened" times it is often difficult to accurately assess child abuse and dissociation, especially with institutionalized children. Despite the complex history of dissociation in working with adults (Howell, 2005) it is more of a paradigm shift when confronted with a child who dissociates or who has DID.

The child psychotherapist or psychoanalyst is well acquainted with the volatility of children in whom mental states can change with great rapidity. Ironically, the very capacity to endure and work with shifting emotional states that are in the normal range can impede the recognition of dissociative disorders in children. And, societal and familial pressures that are internalized by practitioners can also contribute to the exacerbation of this lack of awareness. And yet, there is international acknowledgement that most cases of dissociative identity disorder (DID) have their roots in childhood trauma. This chapter addresses some reasons for the inadequate diagnosis and treatment of dissociative disorders in children.

The denial of child abuse

At the end of the nineteenth century and the beginning of the twentieth century several great pioneers in the field of mental disease wrote about the

lifelong impact of child sexual abuse, among them Freud (1896) and Ferenczi (1929). However Freud's abandonment of his seduction model and the concept of dissociation, in favour of his fantasy model and the concept of repression, led, to a great extent, to the recurrent disavowal of the reality of the sexual abuse of children and the devastating impact it had on the child's developing mind. In the latter half of the twentieth century, mental health workers of varied backgrounds began to refocus concerns over this issue, allowing the topic to be spoken of and acknowledged once again. Much of the effort to expose this unthinkable crime and have society acknowledge that it still persists today is disavowed: Indeed the crime and the perpetrators are hiding in plain sight.

If we apply the structural model of dissociation (Nijenhuis, van der Hart, and Steele, 2004) to societal responses to sexual abuse of children we can see that this work functions as a social "emotional part" of the personality, frozen in its Cassandra moment of speaking the truth and not being believed, whilst the "apparently normal part" of the personality continues everyday life, agreeing that this subject exists but that far too much attention is being given to it!

In 1962, over half a century ago, Dr. C. Henry Kempe and his colleagues wrote a seminal paper on the battered child syndrome that spread shockwaves of recognition across the Western world. The 1960s remained a period where children in most Western countries could still be legally assaulted in schools and at home under the name of "reasonable chastisement." It was only in 1987 that corporal punishment in schools was abolished in the UK (it is still permissible in the home).

In the 1970s Jeffrey Masson and Alice Miller, amongst others, struggled with their psychoanalytic allegiances. As Masson (1984, p. 285) put it, "Each [therapy] shows a lack of interest in physical and sexual abuse." Miller's books, *Prisoners of Childhood* (1981) and *For Your Own Good* (1983) also exposed the painfully high incidence of abuse and abusive attitudes toward children at a time when most Europeans working in this area were only just beginning to put their ideas on paper. Indeed, America led the field in such work, with Kempe (1962) and De Mause (1974) clarifying the meaning and incidence of child abuse.

In this same period, I was a trainee child psychotherapist at the Tavistock Clinic, a major British health service centre for psychoanalytic psychotherapy training and treatment. During my tenure there, sexual abuse was rarely mentioned. Nonetheless, there were certain leading psychiatrists/psychoanalysts, such as Drs. Judith Trowell, Brendan McCarthy, and Arnon Bentovim who were key pioneers in addressing the issue of childhood sexual abuse and its impact on the developing mind. Like the early Freud and then Ferenczi, they met with enormous public and professional inertia and disparagement. In particular, they had to find a pragmatic way to deal with this unpopular subject in psychoanalytic circles.

When in the 1980s I was a consultant child psychotherapist at the Tavistock, I was one of only a handful of staff members who had actually knowingly treated an abused child. It is hard to convey the impact of historical change when we consider that the leaders of the Adult Department of the Tavistock proudly stated there had been no abused adult treated there. Fear of professional peer disapproval backs the premise of Bowlby's (1979) seminal paper, "On knowing what you are supposed not to know and feeling what you are not supposed to feel."

Nowadays, it would be rare to find a child psychotherapy trainee who did not work with victims of abuse. It seems that, historically, the individual professional trajectory of each of us seems to mirror or only slightly lead the socio-historical capacity and understanding.

Disorganized attachment and dissociation

The human infant, more than any other mammal on Earth, remains dependent for survival on her parents for a very long time. To insure survival, the infant and young child must find a way to accommodate to the needs of its parent(s), regardless of how disturbed they may be. As seen in disorganized attachment, the consequences of this accommodation can be tragic. A rejecting parent heightens the child's need for attachment and simultaneously is also the source of nurturance and affection of whatever form. When the rejecting parent is also abusive, a delusional system can be the only means of survival. As Shengold (1979) presciently wrote: "if the very person who abuses and is experienced as bad must be turned to for relief of the distress that parent has caused, then the child must out of desperate need register the parent delusionally as good."

Disorganized attachment refers to grossly disorganized behavior on the part of the infant or child: apprehension in the presence of the mother or primary caretaker, which coincides with the parent being experienced as frightened or frightening, while at the same time the attachment system is activated.

Disorganized attachment is now understood to be a precursor and early form of dissociation (Liotti, 1992, 2004, 2006). Whereas Alice Miller and others have seen childhood trauma as a key determinant of adult mental health problems, dissociation and particularly dissociative identity disorder is now thought to occur when childhood abuse co-occurs with a disorganized attachment (Liotti, 1992). Fonagy and Target (1995) found that over 90 percent of dissociative disorders have etiology in disorganized attachment and childhood abuse. Following in the same vein as Brett Kahr's (2007) and Valerie Sinason's (1992, 1994) work on infanticidal attachment and internalizing external death-wishes, Adah Sachs (2012) has elucidated the dangers of a literal infanticidal action as opposed to merely symbolic wishes.

However, when working with a child, a small being, the reality of the discrepancy in physical power between adult and child becomes palpable, and undeniable. Acknowledging the reality of a child in your charge being abused is difficult to bear. In addition, it is worth considering how language can be used as a way of medicalizing, minimizing, sterilizing, and devaluing children, and as a way of dissociating the impact of what has happened to a child. We often use the term "child abuse" when the expression "child rape" more accurately describes what is happening. In a similar way, adults with an intellectual disability, when raped, are also spoken of as "abuse victims" rather than victims of a criminal offence that is more accurately called rape.

The lower status of children

In my work with infants and very young children before I trained as a child psychotherapist, and in voluntary work in old age homes, it became clear that work with the youngest and the oldest groups of patients was equally undermined and denigrated. Working with those who are vulnerable and dependent, whether young or old, can stir up pre-verbal states of the patients, and the helpless experiences of rage and fear in earliest childhood may be re-enacted. In the fields of teaching, medicine, and psychoanalysis, those who work with non-elderly adults have a higher status than those working with children or the elderly.

Perhaps it is therefore not surprising that "Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents" were only put together in the 2003 ISSD Task Force on Children and Adolescents, chaired by Joyanna Silberg. Although even very young children who appear to meet the criteria for DID have been described (Putnam, 1997; Riley and Mead, 1988), the actual prevalence of DID in early childhood is currently unknown. Within the UK, Midgley (2002) and Bentovim (2002) have commented on the small number of children with DID evaluated and treated, compared to a similar population of adults.

Whilst I have been at the forefront with colleagues who have spoken about abuse of learning-disabled children (Sinason, 1992, 1994), each new awareness only comes after a period of disavowal. When I look back, I see trauma I have missed at each stage of my professional journey. In trying to understand why dissociative disorders in general and DID in particular are under-diagnosed in children, I am also looking at the component parts of my own disavowal, and I offer the case of Anne as an example.

Anne

Anne was 11 years old when I first met her in the 1980s. I was informed that her violent and psychotic parents had lost contact with each other and her, and that following a series of broken placements she was now in a residential

home awaiting adoption. I was asked to work with her following a painful trauma. A family intending to adopt her chose another child instead. This understandably caused an escalation of disturbance. Her concerned and caring residential workers approached the school asking for treatment for her.

Anne was a wiry, hypervigilant, angry girl who could not relax. She took care to keep her mop of greasy blonde hair straggly and unkempt, whilst occasionally speaking longingly about Barbie dolls and their beautiful blonde tresses. Her clothes, regardless of how staff dressed her, became disheveled and dirty. She struggled with bedwetting and washing, and at school lunchtime licked her food in a sadistically erotic way.

In therapy she spoke with three distinct voices. One voice was frighteningly harsh and mocking, one was a prissy voice that mimicked her current housemother, and one was a shy, childish voice that expressed her rejection fears (the emotional personality). At the time, in the 1980s, even though I used the term "fragmented," I—along with the vast majority of my colleagues—knew very little of dissociation.

Pearl King, my supervisor for twenty years, commented to me that where something was not part of a professional's training it would be harder to see it. "Don't get angry with colleagues," she counseled, "write about it so they can understand" (personal communication, 2000).

There was nothing in my training that informed me about dissociation. I was already dealing with the skepticism that comes from reporting abuse in a culture that wasn't ready to know what was knowable. Therefore I was not ready to adequately see what I see now. Looking back at the clinical notes I now see how her angry, mocking ripostes were accurate responses to my ignorance. For example, I once said to the state who sounded like her housemother "When you were speaking in that angry voice you said X." She burst out loud with mocking laughter. "When you speak in that voice, Valerie Sinason, you are a stupid therapist and not a sensible person." She was trying to tell me she was not just a state. She was a different personality. Partly because she had an excellent teacher as well as other sources of emotional kindness, in addition to her therapy, she was able to become more integrated over time. I wrote, "Once she was more stable she did not need her different voices." I was correct in one way but so wrong in others.

Each week in therapy she would tear up pieces of white paper, pour them over a girl doll's mouth and go "eech." It might be obvious now but at the time it was not. Each week I would try and provide an interpretation that might help but of course they were all the words of a "stupid" therapist, who was failing to see the cause of the trauma. One day I finally understood. Slowly and tentatively I said "You know the way you tear up white paper and pour it on a doll's mouth and go "eech"—I spoke very slowly while she nodded with great boredom on her face. After all, I had been useless at understanding this for nearly a year. With great internal fear, fear of a

supervisor's response, fear of the reality, fear for the child, I finally slowly said, "It makes me think of the white stuff that comes out of a man's penis."

There was a charged silence. I waited in fear. Then slowly Anne gave me a big smile and began a slow handclap. "Well done!" she said.

Only after I carefully and slowly reported this to the administration of the school did the different layers of dissociation melt away. I was later allowed to see a part of the file that was initially hidden from me. It stated that she was born to a psychotic, frequently hospitalized, traumatized mother and a violent, alcoholic father. After one particularly long hospitalization, Anne was left with her maternal grandmother and then an aunt and uncle. Her father reappeared when Anne was two and complained that his brother-in-law had abused Anne, making her suck his penis. This was acknowledged, and as a result, Anne was put in a foster-home. Tragically, the same situation happened in what appeared to be a disturbingly accurate re-enactment with a foster-father with no previous history of abusing children. She was then placed in a children's home from the ages of 5 to 11 with behavior that escalated in violence.

In conclusion, for the trainee or junior professional to be able to recognize, acknowledge, and engage with childhood dissociation, there has to be a context of support, good supervision and a theoretical understanding of attachment and abuse. We are embedded in our own time and place in our particular part of a history. Whilst our civilization might be advanced in some ways, we are still influenced, however unfortunately, by events occurring close to us in time. We, as professionals, are not above or immune to the influence and pressure from our esteemed professors, supervisors, and colleagues. We must be on the alert, to know what we know and to follow our own instincts and judgment. We must not be afraid to speak up for what we believe in and what we believe to be the truth. This is particularly true when working with abused and battered children. The children in our charge need us to speak about the unspeakable, especially when we are confronted by others who do not want to believe.

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Part 4

Current research trends in complex trauma dissociation and dissociative disorders

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Chapter 20

A tale of two offenders

Why dissociation is under-diagnosed in forensic populations

Abby Stein

A tribute to Abby Stein, Ph.D.
We had the pleasure of enjoying lunch together with Abby at one of Manhattan's Upper West Side bistros where we discussed our book and invited her to write a chapter. We were very happy when Abby agreed to write for our book. At the time she was finishing up and readying her new book *Cupid's Knife: Women's Anger and Agency in Violent Relationships* for publication. She talked with us about her recent medical workup for the disease that would eventually end her life and explained that as long as she had her health she would do her best to complete the chapter. We were very fortunate that Abby was able to complete this draft of her chapter. Unfortunately her disease progressed before we were able to work on it further with her. We are pleased to present here Abby's original contribution.
Elizabeth F. Howell and Sheldon Itzkowitz

At the time I was first writing about forensic populations, I was focused on the connections between childhood histories of abuse and adult violent crime. Interning at a large urban hospital, our offices situated between the child/adolescent psychiatric unit and a male prison ward, it was easy to see how seeds stepped on early and often enough would develop full blown splits as they grew: known versus unknown, good against evil, doer and done to. They sometimes carried diagnoses of impulsivity, bipolarity, or schizophrenia, and always had a list of status offenses, like truancy and promiscuity, for which adolescents of another socio-economic class would never be hospitalized. However, what was most obvious (but not always most accessible) in working with these kids was the suitcase of neglect and abuse they toted behind them to every interview. It is in this way that the children and young teens with whom I worked most resembled the guys two floors down, handcuffed to their beds. Indeed, it was hard to imagine how

we could save the little boys on 21 North from growing up to be the men on 19 South.

Muscular defenses against trauma helped to submerge the consciousness of their victimhood as they aged and, by the time they were recreating those early violent dramas in the streets, the path from one to the other was occluded by so many other life experiences—substance use, unemployment, educational neglect—it was nearly impossible to delineate the causal arc that attached a battered boy to his manhood crime. The picture became both more alarming and more complicated when I went with my mentor, the pioneering forensic psychiatrist Dorothy Otnow Lewis, to interview serial offenders pro bono.

It has always been difficult to argue persuasively, in court anyway, that criminal behaviors are the unconscious performance of a highly traumatized part of the self (Saks, 2000). Still, who could not be swayed by the most sordid reenactments of repeat rapists and killers; their insistence that an "entity," not of their making, had come unbidden to the local bar, the onion field, or the desolate highway where victims met their fates? Even today, two decades away from my first foray into the forensic arena, I read the newspapers and am struck by the dissociative notes in criminal narratives.

A man armed with five butcher knives kills his wife, but pauses at the beds of his children. He does not want to kill them, does not mean to take their lives. He loves them very much. However, checking his escape route supplies, the man realizes that he has not brought their car seats. Oh, well. It would be too dangerous to drive the toddler without one, much less the infant. He stabs the babies to death instead, after kissing and hugging them goodbye and asking their forgiveness (Cusmo, 2014; Schwartz, 2014). If only the "good" papa, the one who purchased the car seats, had shown up the day of the murder instead of the predator self or the someone, equally unrecognizable, who took his place.

This "not me" state, so called because the actor does not recognize himself in his actions, was first articulated by Harry Stack Sullivan (1953). "Not me" comprises the third rail of a tripartite personality configuration that interfaces with the world at varying levels of consciousness and volition. While "good me" and "bad me" are personifications that can eventually be mainstreamed into working identity, "not me" is based on caregiver interactions so toxic that the uncanny emotions they inspire have forever to be walled off, dissociated, and repudiated. Sullivan's brainchild, the "not me" self-state, closely resembles many theoretical constructs posited by criminologists and forensic psychologists over the years to explain criminal trespass and lack of empathy, such as "zero" (Yochelson and Samenow, 1976) and "reptilian" states (Meloy, 1988). Even Freud, in his limited foray into the criminal mind, espoused that undeserved childhood suffering gave rise to unconscious guilt, which, in turn, triggered acts that might incur punishment (1916). Homicidal acts, especially, accentuated the blindness

of the perpetrator's fury, and signified his identification with the dead (Freud, 1928). The killer sought, in Bollas's (1991) stirring latter-day phrase, "the companionship of corpses," signaling that he, too, was empty, zero, a reptile, dead to the world. Searles (1960) even went so far as to characterize this "not me" self-state as being of a piece with the non-human environment, engaging others as if, they too, did not fit the criteria for being human. This is certainly true for the most violent amongst us.

"Not me" also explains the avalanche of research exploring claims of amnesia by violent criminals in a more psychologically sophisticated way than simply ascribing an ulterior motivation to them when, at least in my experience, offenders rarely claim not to have committed crimes, only to not remembering committing them (Koppelman, 1987; Schacter, 1986). Finally, "not me" comports seamlessly with the narratives of the men and women I personally interviewed, or whose case files I analyzed, who were fond of describing themselves as peaceful, sometimes nearly Gandhi-like (as an evil self needs a pure one to maintain homeostasis), even when confronted with the artifacts of their handiwork: a severed foot, a slit throat, a blood-spattered ceiling. I still aver that this is the basic operation through which child maltreatment is translated into violent assault.

However, I now believe that I severely underestimated the degree to which such dissociative processes are integral to a range of non-violent, anti-social behaviors as well as the violent ones I encountered earlier in my career.

More and more, even our turnstile jumpers, trespassers, and pot sellers are showing up in lockdown with a diagnosis of serious mental illness. The Los Angeles County jail alone currently spends $10 million per year on psychiatric medications, and other correctional facilities are not far behind (Treatment Advocacy Center, 2007). While their illnesses are usually described as having a biological basis (for reasons I will get to later) what is consistently overlooked is the exacerbating, or even causative, nature of the multiple traumas most have endured and the role they play in the development of symptoms that fit posttraumatic or dissociative diagnoses.

One only needs to examine the history of complex trauma and its sequelae in the general population of inmates to infer that, a good deal of the time, what is diagnosed as anti-social personality disorder, borderline personality disorder, bi-polar disorder, and paranoid schizophrenia contains a full complement of dissociative signs and symptoms (Timmerman and Emmelkamp, 2001; Hempel *et al.*, 2002; Spitzer *et al.*, 2003). An absorption with fantasy, the sense that one is acting out of sync with the body or is watching interactions unfold at a distance, and, finally, the dual-self motif that describes any offender who can conduct a life of wholesomeness and clarity while simultaneously living in the hellish chaos of bad intentions: these mark dissociations of a great magnitude, whether the enactment that follows them is assault with a deadly weapon or merely passing a bad check.

A brief history of crime and mental illness

Prior to the mid-1850s, unless an "insane" person had the financial resources to be cared for at home, they were likely to be confined in local jails or prisons, where treatment was non-existent and abuse in the pursuit of discipline was commonplace. Massachusetts—the very place where Dorothea Dix made her statement to the legislature—was at that point the only state in the union to have made it illegal to incarcerate the mentally ill. By the 1880s, other states followed suit and most mentally disordered inmates were moved to the public psychiatric hospitals where, despite the good intentions of reformers like Dix, they continued to be held like prisoners, a condition that continued through the mid-twentieth century.

According to a review by Torrey and his colleagues (2008), things began to change dramatically at that mid-century juncture. Circa 1955, the discovery of a heavily sedating class of neuroleptic drugs engendered a more docile patient profile, raising the possibility that the mentally ill might remain at home or at least in treatment facilities closer to home. Newly enacted Medicare and Medicaid policies in the 1960s further supported the move away from hospitalization as a default placement for psychiatric patients. By the 1970s, deinstitutionalization became a moral crusade, as investigative journalists revealed the horrors of Willowbrook and other long-term facilities for the mentally retarded, developmentally disabled, and psychiatrically impaired. A new set of reformers successfully lobbied the Carter administration to transfer patients out of hospitals and, ultimately, to shut the facilities down. Total deinstitutionalization began in earnest.

According to the Mental Illness Policy Organization, by 1994, the number of patients in public psychiatric facilities had dwindled to about 70,000, from a high of half a million in the mid-1950s, based on a national population of 164 million. Psychiatrists—many psychoanalytically trained in the 1960s—sang a reinvigorated song, hawking community solutions to neighborhood problems, envisioning safe harbor for the seriously impaired close to home, where they could be given access to an array of services including both psychotropic drugs and group therapy. Freedom, autonomy, self-determination, self-respect: this was the movement's mantra.

As we progress through the twenty-first century, there is a new population of homeless mentally ill, many of whom abuse alcohol and other substances in an attempt to self-medicate, and whose behavior is likely to be at odds with law enforcement's emphasis on monitoring low-level indices of urban disorder such as vandalism, trespass, or public drunkenness. Consequently, as many as four in ten mentally ill individuals have interfaced with the criminal justice system at one time or another. In actuality, deinstitutionalization policies have led to reinstitutionalization of a different but eerily familiar ilk.

Our prisons have been repopulated with legions of mentally ill. Total institutionalization has turned into total confinement. If you tally up the

numbers, you will find that the three largest psychiatric facilities in the United States are Riker's Island Jail in New York City, the Cook County Jail in Chicago, and the Los Angeles County jail. Remember the LA County jail? It spends $10 million per year on psychopharmaceuticals. And not a penny on trauma detection or treatment.

Fifty-six percent of those housed in US federal prisons are mentally ill, as are 64 percent of those in our local jails. The numbers are even higher for female inmates; almost three-quarters have been diagnosed with a psychiatric illness (James and Glaze, 2006). Currently, there are more than a million and a quarter prison and jail inmates in the United States who have a psychiatric diagnosis. More troubling, between 13 and 24 percent of inmates are severely ill, skating in and out of psychosis and suicidality. Most have been picked up for minor crimes or for drug possession. They are dragged from the street to the only 24-hour psychiatric clinic in town: the one at the local jail.

Because of the severity of their impairment, mentally ill prisoners present management problems. They often end up in segregation, which only exacerbates their angry outbursts, anxiety, delusions, and hallucinations. One study found that the mentally ill incarcerated had a suicide prevalence five times higher than the general inmate population (Goss *et al.*, 2002). Moreover, the mentally ill tend to be "frequent flyers": over a third have been incarcerated at least ten times (Torrey *et al.*, 2010). Almost all receive a designation of "antisocial or borderline personality disorder," along with an Axis I diagnosis of depression or some kind of psychosis, most commonly paranoid schizophrenia.

What are generally overlooked are a raft of dissociative signs and symptoms stemming from early childhood trauma. In my own experience with forensic populations, even the most common presentations involve a stunning degree of dissociation. Given the traumatic histories of many inmates, this is no surprise. Yet, there is tremendous prejudice against recognizing dissociation in inmates and, dare I say it, even a good bit of dissociation on the part of the forensic practitioners charged with making those psychiatric assessments. In the twenty years that I have been interfacing with the criminal justice system, attitudes about dissociation have barely changed among forensic practitioners. If anything, the reluctance to chart dissociative phenomena has hardened, companion to the belief that most inmates are lying about either their abuse history, their symptoms, or the memory of their crimes in order to twist things to their legal advantage.

In jails especially, any drive to implement suitable interventions for posttraumatic or dissociative disorders seems downright fanciful. After all, twenty percent of jails have no mental health services whatsoever. Only in the largest urban jails do corrections officers receive any training in how to deal with mentally ill prisoners and, even then, training consists of a two- or three-hour tutorial. The number of licensed qualified clinical staff varies

widely among jurisdictions, but even in large urban settings the ratio of staff to inmates is woefully inadequate. For example, the guidelines in New York State recommend that there be 2.1 full-time staff available for initial assessment and crisis intervention per 10,000 annual jail admissions and 7.6 staff per 1000 average daily jail census for ongoing treatment and support services (Metzner, 1997). The detailed inquiry necessary to tap both a history of trauma, and dissociative adaptations to it, is unlikely to happen under such circumstances.

Trauma, dissociation, and incarceration

Historically, the misdiagnosis of dissociative disorders has had everything to do with the criminalization of mental illness. No wonder, as trauma creates the backdrop for dissociation, and most of those we imprison—have *always* imprisoned—come from backgrounds rife with poverty, mental illness, physical and sexual abuse, and the chaos that attends such states. The examination of presenting symptoms in an offender population helps us trace the arc from trauma endured to trauma meted out in the blindest—and often cruelest—of ways.

Kinsler and Saxeman (2007) wryly joked that, because of their multi-generational history of trauma, the most fitting diagnosis for the mentally ill offenders group was "horrible life disorder." Many offenders have grown up in conditions of abject poverty. They may have been raised by a revolving cast of relatives, with one or both parents in prison or disabled by their own substance abuse. In chaotic, unsupervised homes, many become victims of physical and sexual abuse. As juveniles, they are chronically truant from school, and are often without any adult supervision, and these children witness their share of violence in improvised families joined on the streets. Each of these conditions individually qualifies as traumatic and yet, amazingly, most studies looking at the prevalence of mental illness among incarcerated offenders have not included PTSD symptoms or diagnoses. The association between trauma and criminal behavior seems more than correlative, as can be gleaned from the following studies.

The National Institute of Justice has reported that a history of child abuse and neglect (and remember that this is only one of the types of trauma commonly experienced) multiplies the probability of juvenile arrest by a factor of five, doubles the rate of arrest for adults, and triples the likelihood that the victim will go on to commit a violent crime, as compared with matched controls (English, Widom, and Bradford, 2001). My own work (Stein, 2007) details how violent victimization during childhood is negotiated through dissociative processes that protect the victim in the moment but almost guarantee a legacy of violent enactment later on.

Given this profile of both more and less violent arrestees, it seems downright criminal that traumatic symptoms, including derealization,

depersonalization, flashbacks, automatisms, and amnesia, are consistently ignored, mislabeled, or dismissed as malingering. Of the sixty-four violent felons I interviewed for my book (Stein, 2007), not one carried a diagnosis of dissociative disorder not otherwise specified (DDNOS), dissociative identity disorder (DID) or posttraumatic stress disorder (PTSD), despite the fact that the majority easily fit the criteria for one or more of these diagnoses and eleven inmates met the criteria for full-blown dissociative identity disorder. As already noted, where non-violent crimes are concerned, post-traumatic and dissociative diagnoses are rarely even on the menu from which forensic clinicians choose diagnoses.

What does dissociation behind bars look like?

Imprisoned, the mentally ill are constantly exposed to conditions of threat that exacerbate their paranoia and depression. Worse yet, the scant treatment that exists includes unproven "therapies" that greatly increase the likelihood of re-traumatization. Re-traumatized inmates come to rely ever more strenuously on dissociative defenses, yet, when they have flashbacks or outbursts, claim not to remember incidents, regress to childlike states, or dwell on their own histories of victimization, they are seen as uncooperative, self-pitying, or unmanageable, and are subjected to inhumane punishments such as solitary confinement (Human Rights Watch, 2009). Under these conditions, they again must dissociate to survive

Like the variety of experiences that landed them in jail, inmates resort to primitive defenses, which is both self-destructive and paradoxically necessary for inmates, given the constant exposure to re-traumatizing stimuli in prison life. This is demonstrated in the harrowing stories of inmates for whom dissociation becomes a default position. When the strip search performed by guards throws one into a flashback of childhood sexual abuse, when the friendship of fellow inmates can only be bought in the guise of a whorish female, when the fear of beatings brings forth the same protector self who once shielded the child from his or her erratic caregivers, when the terror of isolation causes someone to regress and become an iconic feces-throwing baby: these are the moments when the mind has been overwhelmed and incapacitated and retaliatory violence is laid bare. See Howell (2014) for an exposition of identification with the aggressor and the relationship and interaction of victim and abuser self-states. Moreover, for the inmate, dissociation is not only an adaptation to difficult circumstances but also an invitation to further abuse by the in-house psychiatric system. Her dissociative break will buy her not treatment but a windowless cage for one. The restraints, sometimes cloth and sometimes metal, will wrap themselves around her limbs like primordial tentacles. See you next week, inmate. Next month. Next year. Her only recourse is to stop inhabiting her body, to lapse again into dissociative reverie.

The "treatment" buttresses the defenses instead of dismantling them; the patient is worse off than when she started.

Whither empathic engagement?

Forensic intake and treatment units are short-staffed and, unfortunately, the management of them is often short-sighted. With overwhelming numbers of inmates to process, making sophisticated diagnoses is seldom a priority to correctional officials, who create a culture of indifference, at best, and outright hostility toward inmates, at its most myopic. Psychopharmacology being central to psychiatric/psychological training, there is a tendency to find illnesses that can be easily treated with psychotropic remedies. The dispensing of drugs is thought to be the least labor-intensive and most cost-effective method of treatment, not to mention that it is the path of least resistance for forensic patients who have gotten used to self-medicating, rather than talking, their troubles away. When psychologists are called on to run mandated treatment groups, either in or out of prison, they implement an array of state-approved protocols, usually modeled on widely used cognitive behavioral interventions that demand a conscious attention to, and interference with, symptoms. That may be an impossible demand for dissociated individuals, as so many of their "symptoms" (i.e. traumatic enactments) are cut off from conscious awareness.

Heckman, Cropsey, and Olds-Davis (2007) described a variety of trauma treatment modalities that have been piloted on a very small scale with prisoners: eye movement desensitization and reprocessing (where trauma exposure is conjoined with bilateral stimulation of the eyes); traumatic incident reduction (a guided visualization technique); expressive therapies utilizing art, writing, or drama; cognitive processing therapy; psychoeducation and problem-solving; seeking safety (a self-control strategy); and hypnosis. All treatment modalities, except the first, have been conducted with groups, rather than individuals, to save money. They are all relatively brief interventions, involving 1–24 sessions. Due to small sample sizes, methodological flaws, and high attrition rates, it is impossible to draw firm conclusions about the efficacy of the interventions.

Unfortunately, there is a total absence of anything resembling the kind of psychodynamic therapy that might present an opportunity for the in-depth inquiry that helps a clinician understand idiosyncratic experiences and offer the unconditional support needed to begin reparative work with trauma victims. Still, something is better than nothing which, in correctional settings, is the only thing prescribed in abundance. Any intervention at least provides human contact with a concerned other; perhaps the method is not as important as the imprimatur to think, feel, speak, and to have one's trauma witnessed.

Unfortunately, attempts to deliver services like these are met with great resistance, not only from correctional departments but also from the clinical

staff that comprise the frontline at jails and prisons (Browne, Miller, and Margulin, 1999; Kinsler and Saxman, 2007). All we can do in the meantime, I guess, is to keep our trauma interventions for prisoners under the radar screen, delivered, as Kinsler recommends, "subtly" (Kinsler and Saxman, 2007, p. 94), cut off from the watchful eye of officers and clinic directors; dissociated, unfortunately, from the normal course of treatment for inmates in the United States.

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Chapter 21

An update on research about the validity, assessment, and treatment of DID

Bethany L. Brand and Daniel J. Brown

Prevalence of dissociation and dissociative identity disorder

Dissociative phenomena, including DID, are found throughout the world (Lewis-Fernández *et al.*, 2007; Spiegel *et al.*, 2013). In a community study of 25,018 respondents from sixteen countries, Stein *et al.* (2013) found high levels of dissociative symptoms among 14.4 percent of the sample that had posttraumatic stress disorder (PSTD). International studies have found that DID is linked to repeated childhood abuse and poor attachment experiences (e.g., Martínez-Taboas, 1991; Middleton and Butler, 1998; Ross *et al.*, 1990b; Sar, 2011). DID patients report more severe and earlier age of first abuse compared with other psychiatric patients (Boon and Draijer, 1993a). Objective documentation (e.g., police records) and/or witnesses have corroborated histories of severe abuse in DID (Coons, 1994; Lewis *et al.*, 1997; Martínez-Taboas, 1991).

The trauma model vs. fantasy model of dissociation

Two theories have arisen to explain the relationship between trauma and dissociation. The trauma model (TM) holds that the relationship is direct: trauma causes dissociation. The fantasy model (FM) claims that dissociation causes fantasy-proneness and/or suggestibility, which in turn lead to confabulated traumatic memories (Giesbrecht *et al.*, 2008; McNally, 2003; Merckelbach, Horselenberg, and Schmidt, 2002; Merckelbach and Muris, 2001).

The FM has been associated with the notions that DID is iatrogenic and that recovered memories may be "implanted" by suggestive therapists. FM theorists argue that the relationship between trauma and dissociation is weak and inconsistent, and if it exists, it may be limited to severe dissociative disorders (DD) (Giesbrecht *et al.*, 2008, 2010). Some FM proponents have ventured that dissociation is related to self-reported but not objective trauma.

Dalenberg *et al.* (2012) offered eight predictions regarding trauma and dissociation that can be used to test whether there is more support for the TM or the FM. The authors conducted several comprehensive meta-analyses. Overall, the research consistently and robustly fit the predictions of the TM, rather than those of the FM. Dalenberg *et al.* reviewed all studies published that met their strict inclusion criteria. A meta-analysis of thirty-eight studies resulted in moderate effect sizes for the relationship between childhood abuse and dissociation. Four studies using non-trauma controls and DD patients found that trauma-exposed individuals were four times more likely than non-traumatized individuals to have a DD (effect size of $r = .5$). The relationship between trauma and dissociation was found to be consistent across cultures, research designs, and samples, as suggested by the TM.

The FM prediction that objectively-confirmed trauma should show weaker correlations with dissociation than self-reported trauma was tested by comparing effect sizes of studies with objective measures of trauma exposure to studies that used self-report measures. The results speak to the heart of the difference between the two models. The objective vs. self-report studies on sexual abuse had very similar correlations (i.e., r of .30 and .32, respectively) as did the studies on physical abuse (i.e., r of .30 and .26, respectively). These findings refute the most important tenet of the FM. If the trauma–dissociation relationship was caused by fantasy-proneness and exaggeration, the relationship should have been weaker when trauma was measured with greater objectivity.

Dalenberg *et al.* (2012) also found that, consistent with the TM, dissociation was highest just after trauma and decreased over time. The FM predicts that trauma therapy would not result in improvement in dissociation; Dalenberg *et al.*'s (2012) meta-analysis of eight PTSD studies found that dissociation decreased with trauma therapy yet did *not* decrease for untreated controls.

Similarly, a meta-analysis of eight DD treatment studies showed that dissociation decreased significantly with treatment specifically tailored toward trauma-related dissociation.

Furthermore, when fantasy-proneness was controlled, trauma history still predicted dissociation. Research showed that DID patients tend to show similar levels of fantasy-proneness to healthy controls, and that the relationship between suggestibility and dissociation was non-significant ($r = .11$). In a meta-analysis of thirty-four studies examining suggestibility, Dalenberg *et al.* (2012) found that dissociation only accounted for 1–3 percent of suggestibility. Another important finding was that recovered memory was not more accurate than continuously recalled memory. Due to the longstanding debate about whether recovered memory is accurate, this is a critical finding with significant implications.

Indeed, the evidence was so consistently in support of the TM that FM theorists have recently conceded that some recovered memories are likely accurate and that trauma treatment does not generally worsen dissociation (Lynn *et al.*, 2014). This represents notable changes in the arguments put forward by the FM, and speaks to the compelling research that has amassed in support of the TM.

Is DID a valid diagnosis?

Data support that DID demonstrates *content validity* (a consistent and specific symptomatology), *criterion validity* (psychobiological data that match the clinical presentation) and *construct validity* (it is distinguishable from other diagnoses). These types of validity are central to establishing a disorder as a valid diagnostic entity (Robins and Guze, 1970).

Content validity

Identity confusion, *identity alteration* and *amnesia* form the core symptoms differentiating DID from other disorders. They have been found in studies worldwide (e.g., Boon and Draijer, 1993b; Gingrich, 2009; Martínez-Taboas, 1991; Middleton and Butler, 1998). The consistent presentation and etiology of DID around the world using different samples and methodologies support the validity of DID.

Criterion validity

Structured clinical interviews for DID have consistently demonstrated high inter-rater reliability for both presence and severity of DID—sometimes higher than for other psychiatric disorders. For example, the SCID-D yields severity scores and diagnoses that have very good inter-rater reliability (weighted kappas ranging from .85–.98; Friedl and Draijer, 2000). Additionally, neurobiological research has demonstrated that dissociative patients show limbic suppression and resulting hypo-emotionality consistent with the emotional numbness observed in dissociative individuals (e.g., Brand *et al.*, 2012). These neurobiological findings characterize dissociative individuals, as well as dissociative-subtype PTSD, from the overaroused/re-experiencing subtype which tends to involve *higher* levels of limbic activation and emotional reactivity.

Construct validity

DID can be distinguished from other disorders using structured interviews and self-report measures. Identity alteration and amnesia distinguish DID from other disorders (Putnam *et al.*, 1996; Rodewald *et al.*, 2011; Steinberg,

1994) as does the co-occurrence of identity confusion, depersonalization/derealization, and somatoform dissociation (e.g., Dell, 2006; Nijenhuis *et al.*, 1999). Psychotic and dissociative disorders may resemble each other due to overlapping symptoms (including Schneiderian symptoms; Kluft, 1987; Ross *et al.*, 1990a; Welburn *et al.*, 2003). However, recent research provides data that can assist with making the needed differential diagnosis. Individuals with DID more commonly hear multiple voices before the age of 18 than do individuals with psychotic disorders (Dorahy *et al.*, 2009). DID patients do not demonstrate genuine delusions (e.g., they usually do not endorse delusional perception; Kluft, 1987), and they show better insight than patients with schizophrenia (Brand *et al.*, 2012). Patients with DID can be distinguished from psychotic and borderline personality disorder (BPD) patients by their heightened self-reflective capacities (Brand *et al.*, 2009a; Şar, Öztürk, and Islam, 2012). They may appear psychotic due to temporary poor reality-testing, but the source of the process is posttraumatic for DID individuals (Brand *et al.*, 2009a). For example, DID patients may experience hallucinations with traumatic content (Şar and Öztürk, 2009).

DID patients are consistently found to have multiple comorbid psychopathologies (e.g., Boon and Draijer, 1993a; Mueller-Pfeiffer *et al.*, 2012; Rodewald *et al.*, 2011) including depression and suicidality (e.g., Ellason, Ross, and Fuchs, 1996; Middleton and Butler, 1998), PTSD (e.g., Boon and Draijer, 1993a; Brand *et al.*, 2009b; Middleton and Butler, 1998), and non-PTSD anxiety disorders (e.g., Rodewald *et al.*, 2011). BPD is the most common personality disorder found among DID individuals, and can be diagnosed in half to two-thirds of cases (Ellason *et al.*, 1996; Horevitz and Braun, 1984; Lipsanen *et al.*, 2004; Middleton and Butler, 1998; Şar *et al.*, 2003), although BPD can be distinguished from DID on the Rorschach test (Brand *et al.*, 2009a) and DID patients' BPD symptoms tend to resolve as their acute dissociation stabilizes (Ellason and Ross, 1997). Psychiatric patients sometimes purposefully or subconsciously imitate DID (Draijer and Boon, 1999). Some authors opine that DID stems from fantasy, suggestibility and iatrogenesis (e.g., Lynn *et al.*, 2012; McHugh, 2013; Paris, 2012; Piper and Merskey, 2004; Spanos, 1994). Thus a crucial aspect of the construct validity of DID is determining whether imitators who have been exposed to media portrayals of DID can simulate DID on psychobiological tests. The research on DID imitation is consistent: psychological and neurobiological results indicate that genuine DID can be distinguished from feigned DID. Structured dissociative interviews show great promise in this differential diagnosis, and new research indicates that personality tests may also help. The SCID-D can assist clinicians in distinguishing genuine from malingered DID (Draijer and Boon, 1999; Friedl and Draijer, 2000). Using the SCID-D-R with a small pilot sample, Welburn and colleagues (2003) found a 0 percent false positive rate in distinguishing feigned DID from DID.

"Fake bad" validity scales have been developed, consisting of answers typical of individuals who malinger mental illness. Unfortunately, many validity scales include items that are related to trauma, so they are endorsed by traumatized individuals who are reporting on their experiences, including those with DID. Trauma patients who endorse these items can be mislabeled as feigning or exaggerating because the more items that one endorses on this type of validity scale, the higher the probability of being classified as malingering. One study compared the MMPI-2 profiles (Butcher *et al.*, 2001) of DID patients with coached and uncoached DID simulators (Brand and Chasson, 2014). The DID group scored higher than genuine psychiatric groups on some of the so-called "fake bad" scales, but not the PTSD or child abuse groups. The DID patients were not elevated on a validity scale (i.e., the MMPI-2 Infrequency Psychopathology Scale (Fp); Butcher *et al.*, 2001) that was designed to not over-classify patients as exaggerating. Furthermore, the majority of correlations (i.e. 83.3 percent) between dissociation and MMPI-2 scales were in the *opposite direction* for genuine DID patients compared to feigners. The majority of simulators and DID cases (83 and 86 percent, respectively) were correctly classified. The feigners could not accurately imitate DID, even with financial incentives and intensive media exposure about DID.

Similarly, studies using the Structured Interview of Reported Symptoms (SIRS or SIRS-2; Rogers, Sewell, and Gillard, 2010) show that simulators and real DID patients can be differentiated with overall diagnostic power (ODP) as high as 83.3 if a trauma index is used (Brand *et al.*, 2006; Brand *et al.*, 2014). Many tests, such as the NIM scale of the Personality Assessment Inventory (a "fake-bad" scale; Morey, 1991), include dissociative items on their scales. This may explain why DID individuals score high on subscales that assess exaggeration. A key point supporting DID's validity, however, is that DID patients score in the range found with non-DID trauma samples, and they score in acceptable ranges on validity scales that do not use dissociative content (Brand and Chasson, 2014; Brand *et al.*, 2014). These studies demonstrate the potential hazard of classifying DID patients as malingerers based on scales that were not constructed in a dissociation-informed fashion.

Neurobiological tests also demonstrate that genuine and feigned DID can be reliably distinguished (Reinders *et al.*, 2012). DID patients showed different patterns of psychophysiological activation according to what type of self-state listened to the autobiographical trauma script. When tested in a self-state that experienced traumatic scripts as autobiographical memory, patients showed different patterns of brain activation and arousal than when tested in self-states that did not so identify; importantly, these differential response patterns could not be replicated by simulators.

In summary, DID is a disorder that: (1) has a complex clinical presentation; (2) can be reliably discriminated from other disorders on the basis of the

frequency and severity of multiple symptoms; and (3) meets accepted standards for content, criterion, and construct validity. A large and expanding body of research using a wide range of methodologies finds consistently that DID is a valid diagnosis that cannot be fully imitated, nor explained by personality factors or media influence.

Treatment outcome with DID

Many of the same authors who support the FM have repeatedly opined that therapy for DID may be harmful for patients (e.g., Gee, Allen, and Powell, 2003; Lambert and Lilienfeld, 2007; Lilienfeld, 2007; Lynn *et al.*, 2012; Powell and Gee, 1999). Contrary to their concerns, recent research continues to confirm earlier research: when treatment is provided that is consistent with expert guidelines for DID treatment (International Society for the Study of Trauma and Dissociation, 2011), DID patients show improvements in symptoms and functioning. Several early case series demonstrated that treatment for DID is helpful rather than harmful: Kluft's (1994) case study review suggested that DID patients tend to improve with treatment; notably, he found that patients in treatment for longer periods showed significantly higher rates of symptom reductions than those who were in brief treatment. Ellason and Ross (1997, 2004; Ellason, Ross, and Fuchs, 1996) and Coons and Bowman (2001) found in their case series that DID patients who remained in treatment showed significant improvements in depression, dissociation, PTSD and somatoform symptoms. Both series also found that patients who integrated their self-states showed more improvement than those who had not.

Brand *et al.* (2009c) conducted a meta-analysis of eight DD treatment studies. They found that DD treatment was associated with decreased dissociation, depression, PTSD, suicidality and general distress. The effect sizes were moderate-to-strong across the studies. Included were the studies of Ellason and Ross (1997, 2004; Ellason, Ross, and Fuchs, 1996) who followed 135 DID inpatients for two years. While their study suffered from a high dropout rate and lack of a control group, the researchers utilized structured diagnostic interviews (Dissociative Disorders Interview Schedule, DDIS) and assessed outcome across a wide range of symptoms. They found that patients at two-year follow-up showed significant decreases in number of disorders diagnosed, dissociation, depression, general psychiatric symptoms, all subscales of the DDIS, and medication use.

Brand *et al.* (2013) conducted a longitudinal, naturalistic study of 280 DID or DDNOS patients and 292 community clinicians treating these patients over a period of 30 months. It is the largest and most geographically diverse sample of DD patients ever studied, and the results were clear: over 30 months of treatment, DD patients showed significant decreases in dissociation, PTSD, overall distress, drug use, physical pain, and depression,

and showed significant increases in adaptive behaviors such as socializing or attending school. The participants' Global Assessment of Functioning (GAF) scores, as rated by their therapists, increased over 30 months.

Jepsen *et al.* (2013a) followed forty-eight inpatient survivors of childhood sexual abuse prior to admission to a trauma unit, at admission, at discharge, and at a one-year follow-up. The interaction between pre-admission dissociation and declines in interpersonal functioning predicted poor outcome at follow-up; dissociation alone was the *only* significant predictor of poor outcome at discharge from the program. Jepsen *et al.* (2013b) found that although the DD and non-DD trauma patients demonstrated parallel improvement during treatment and through follow-up, DD patients remained significantly more symptomatic, were much more dysfunctional initially, and took longer to show symptom improvement. The authors concluded that DD patients require therapy which specifically addresses DID symptoms in order for amnesia and identity alteration to improve. While they acknowledge the same drawbacks as any naturalistic study, these studies featured improved methodological rigor, including large sample sizes and prospective longitudinal data.

The authors who claim DID treatment is harmful have not published nor found a single empirical study that shows that treatment for DID results in worse outcomes (Brand, Loewenstein, and Spiegel, 2014). They have overlooked the published research on DID treatment and instead relied on citing opinion pieces, non-peer-reviewed literature, and first-person accounts.

The research on DID shows that long-term therapy that focuses on dissociation is associated with significant improvements in nearly every type of symptom and functioning that is assessed, while therapy that does not specifically address dissociation is significantly less effective in reducing dissociation. Claims that DID therapy actually worsens dissociation are not supported by any data.

Conclusions

Assessment, neurobiological, and treatment outcome studies indicate that DID is a valid diagnostic entity which stems from severe childhood trauma that can be differentiated from feigned presentations when psychometrically sound measures are utilized. DID improves with treatment consistent with expert guidelines.

The recent concessions from fantasy model theorists regarding the existence of DID and its relationship with early childhood trauma are indicative of how far research in the field of dissociation has come. It is critical that quality research continues in this area to increase both the chance of synthesis between divergent theories, and the possibility of greater cooperation in the future study and treatment of dissociation.

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Chapter 22

Speaking one's dissociated mind

So should my thoughts be severed from my griefs and woes

Brian Koehler

GLOUCESTER: The king is mad: how stiff is my vile sense,
That I stand up, and have ingenious feeling
Of my huge sorrows! Better I were distract:
So should my thoughts be sever'd from my griefs,
And woes by wrong imaginations lose
The knowledge of themselves.
(Shakespeare, *King Lear*)

Harry Stack Sullivan (Pao, 1979) understood dissociation to be an active security operation to defend against the emergence of the "not-me" experience and its concomitant uncanny dread-panic-terror states. Sullivan saw "schizophrenia" as a reorganizing attempt at reintegrating terrifying "not-me" experiences due to a failure of maintaining dissociation of the latter, e.g., as experienced in night-terrors and acute psychotic states. Vermetten, Lanius, and Bremner (2008) noted that there were overlapping phenomenologies as well as pathophysiologies between dissociation and psychosis. However, these researchers stated their belief that despite their similarities, dissociative disorders and psychotic disorders can be differentiated by etiology and neurobiology. This may be a premature conclusion, in that the etiology and pathophysiology of the "schizophrenias" are still unknown. There are no neuroimaging signatures that can be used for diagnostic or predictive purposes. Sullivan and colleagues (2006, p. 40) emphasized that the "pathogenesis of schizophrenia is unknown, and no compelling biological markers of sufficient sensitivity and specificity exist." The present chapter underscores the dialectic between dissociation and psychotic disorders.

Dissociation and unbearable affects

Bromberg (2006) has made many significant contributions to psychoanalysis, which I have found to be very relevant in psychotherapeutic work with

persons struggling with a psychotic disorder. He notes that psychological self-continuity plays a central role in human life. When this is threatened, the mind can turn the future into a version of past danger. Bromberg suggests, "future self-continuity is proactively guaranteed by the creation of a dissociative mental structure, an early warning system" (p. 5). The dissociative structure takes as its highest priority the preservation of self-continuity "through turning the act of living into an ongoing reminder that trauma is always waiting around the next corner and that it will be more than the mind can handle" (p. 5). According to Bromberg,

> past trauma is not allowed to enter narrative memory as an authentic part of the past; it is transmuted into affective and body memories in the form of experiences that are beyond relational self-regulation and that shape the present and the future in a way that plunders life of both genuine safety and of spontaneity.
>
> (2006, p. 5)

Dissociation protects the stability and continuity of the self through controlling unsymbolized traumatic affect that it is not able to regulate. The capacity to tolerate internal conflict and to engage in interpersonal relationships is diminished in those areas of the personality characterized by dissociation. For the analyst or psychotherapist to take an interpretive stance during times of enactment runs the risk of escalating the enactment and the use of dissociation. It may even feel like an attack to the patient. Bromberg suggests:

> Basically, dissociation mediates the dynamic of enactment through a subsymbolic form of interpersonal engagement that results in one's not-me self-states being experienced as existing in the other, as existing only in the other, and sometimes as defining the total truth about the other. For such a patient the other becomes an object to be managed and lacks a separate center of subjectivity.
>
> (2006, p. 8)

Over the years, psychiatrists and psychologists have offered an evolutionary viewpoint in the search for meaning in psychosis (Burns, 2007; Brüne, 2003, 2008). Such evolutionary principles as "rank-hierarchy" and "dominance-submission" have been proposed as conceptual tools to understand depression, e.g., the concept of the "social rank hypothesis of depression." Since depression is very frequently observed in schizophrenia and other psychotic disorders (Birchwood *et al.*, 2009), these concepts should be relevant to psychotic disorders. In fact, Birchwood and colleagues (2009) have made a strong case that such affective symptoms as depression and anxiety in schizophrenia are misleadingly referred to as "co-morbidities," which tends

to render them to a subordinate status in the symptom hierarchy in psychotic disorders. Unbearable and intolerable affects, e.g., "organismic panic" (Pao, 1979) or "primitive agonies" (Winnicott, 1974), have been proposed to be both the result of a failure of dissociation as well as the manifestations of a threat to the cohesion and continuity of the self. Hundert (1992) noted: "If the brain evolved to maximize our chances for survival through its many subtle adaptive mechanisms, we may well ask whether one such mechanism is the brain's capacity to form delusions [i.e., dissociate?]" (p. 347).

The overlap between the neuroscience of traumatic stress, psychotic disorders, and dissociation

In 1997, at an international ISPS conference on schizophrenia in London, I proposed that the neuroscience of the severe mental disorders significantly overlaps with the neuroscience of chronic and traumatic stress, trauma, social isolation, extreme loneliness and social defeat (Koehler, 1997). Since that time numerous studies on the symptomatology arising from childhood relational trauma, have demonstrated the following: affect and impulse dysregulation; disturbances of attention, cognition and consciousness, e.g., dissociative symptoms; distortions in self-perception and systems of meaning, e.g., post-abuse shame and guilt; interpersonal difficulties including mistrust, poor boundaries and social skills, etc.; somatization and psychobiological dysregulation, e.g., chronic pain, migraines, cardiopulmonary symptoms, digestive distress, sensory integration difficulties, poor balance and proprioception, etc.; and co-occurring symptoms, e.g., substance misuse, depression, panic, etc.

DeBellis (2010, p. 124) defined developmental traumatology as: "the systemic investigation of the neurobiological and psychological impact of early life adversity on the developing child. It is a relatively new field of study that synthesizes knowledge from developmental psychopathology, developmental neuroscience and stress and trauma research."

Van der Kolk and d'Andrea (2010) observed that hundreds of research studies over the past three decades have documented the effects of "childhood interpersonal trauma on the development of affect regulation, attention, cognition, perception and interpersonal relationships" (p. 57). Research by such developmental traumatologists as Martin Teicher, Michael DeBellis, Ruth Lanius, and others, demonstrated a constellation of neural abnormalities associated with childhood maltreatment, including neglect, bullying, etc. Based on the consistent results across studies, van der Kolk and d'Andrea concluded: "being in a persistent low-level fear state affects development of the primary information-processing areas of the brain" (2010, p. 58). Teicher and colleagues (2006) have conducted research on the

effects of childhood maltreatment on the developing brain, with implications for the emergence of psychiatric disorder. They noted:

> We have proposed that early maltreatment produces a cascade of physiological and neurohumoral responses built on the following . . . fundamental premises: First, that exposure to stress early in life activates stress response systems, and fundamentally alters their molecular organization to modify their sensitivity and response bias. Second, that exposure of the developing brain to stress hormones [e.g., cortisol] exerts consequences by affecting gene expression, myelination, neural morphology, neurogenesis [the birth of new neurons] and synaptogenesis [the creation of new synaptic connections].
>
> (Teicher *et al.*, 2006, p. 180)

DeBellis (2010) has documented the neurobiological effects of child neglect and psychological unavailability. He noted: "Neglect, without social intervention, is a chronic stressor that may negatively influence the development of biological stress system responses and may lead to adverse brain, cognitive and psychological development" (p. 124). DeBellis pointed out that primates subjected to maternal and social deprivation demonstrate altered catecholamine, cortisol, and immune function.

Early life trauma such as physical/emotional/sexual abuse as well as neglect, bullying and social isolation, are correlated with pervasive neural alterations in both gray and white matter, e.g., atrophy and dysmyelination, respectively (Lanius, Vermetten, and Pain, 2010). Van der Kolk and d'Andrea (2010) noted that studies have documented associations between interpersonal trauma and structural/functional abnormalities in the following neural regions: prefrontal cortex, corpus callosum, amygdala, hippocampus, temporal lobe, and the cerebellum. These researchers concluded: "Taken together, these areas of the brain represent key pathways for the regulation of consciousness, affect, impulse, sense of self and physical awareness" (2010, p. 63).

Teicher and colleagues (2010), in reviewing the more recent research on the neurobiology of childhood trauma, noted:

> Exposure to early life trauma is associated with a host of structural abnormalities. There is consistent evidence for a reduction in the midsagittal area of the corpus callosum. Similarly, there is compelling evidence for reduction in hippocampal volume in adults but not children. There is also evidence from multiple laboratories for alterations in symmetry, gray matter volume (GMV), neuronal integrity, and EEG coherence in portions of the neocortex . . . It is particularly striking that exposure to repeated episodes of sexual abuse (SA) most significantly attenuated GMV in the occipital cortex and reduced GMV in the left fusiform and right lingual gyri. These regions appear to play an

> important role in recognition of familiar faces and dreaming. Witnessing domestic abuse was associated with reduced fractional anisotropy (FA) [a measure of directionality of axons forming fiber bundles, used as an index of fiber integrity, and to a lesser extent, myelination] in the inferior longitudinal fasciculus, which relays visual information to the limbic system. Exposure to peer verbal bullying (VB) was associated with reduced FA in the insula, where multisensory information is integrated, and with a reduction in the left lingual gyrus, which is involved in processing emotional response to visual or verbal stimuli. There was a substantial reduction in FA in subjects exposed to parental verbal abuse (PVA) along a portion of the arcuate fasciculus [an area identified in research to be associated with severity of auditory verbal hallucinations], which connects regions involved in the perception and expression of language . . . exposure to harsh corporal punishment was associated with alteration in FA and mean diffusivity throughout components of the cortical pain pathway. Hence, these findings suggest that exposure to various forms of maltreatment affect sensory systems or pathways through which the aversive stimulus is processed or interpreted. These findings are consistent with the idea that sensory systems are malleable and strongly influenced by early experience.
>
> (Teicher *et al.*, 2010, pp. 119–120)

These findings by Teicher and colleagues raise the intriguing possibility that the neural alterations observed post-childhood maltreatment or social adversities, may be adaptive in that they are designed to reduce transmission and reception of specific pain and danger signals, perhaps involving the looming threat of unrelatedness and social isolation. These phenomena may be, along with excessive corticolimbic inhibition (Schmahl *et al.*, 2010), a neurobiological form of dissociation.

Dissociation often "involves a disruption in the usually integrated function of consciousness, memory, identity, body awareness and/or perception of the environment" (Schmahl *et al.*, 2010, p. 178). Schmahl and colleagues (2010) noted that in two prospective longitudinal studies (Bureau *et al.*, 2010), parental emotional neglect and disorganized attachment in infancy were the two strongest predictors of dissociation in young adulthood. Dissociation, as proposed by Moskowitz and colleagues (2008), may play a significant role in mediating psychotic symptoms. Lines from Shakespeare's *King Lear* appear to illustrate this link between dissociation and psychosis. As Gloucester said of Lear's madness,

> Better I were distract:
> So should my thoughts be sever'd from my griefs,
> And woes by wrong imaginations lose
> The knowledge of themselves.
>
> (Shakespeare, *King Lear*)

The neurobiology of "schizophrenia"

In reviewing recent research on structural brain imaging in schizophrenia, Lawrie and Pantellis (2011, p. 341) noted: "It is beyond doubt that there are gross neuroanatomical changes in patients with schizophrenia, but these are probably non-specific, weakly related to the cardinal manifestations of the disorder, and of largely unknown cause."

Neurodevelopmental (Weinberger and Levitt, 2011), dysconnectivity, and dimensional models of schizophrenia are quite prominent. In regard to the last, a dimensional model is represented in the viewpoint of Weinberger and Levitt (2011) who went so far as suggesting:

> Schizophrenia, of course, is not something someone has; it is a diagnosis someone is given. It is worth considering that the syndrome of schizophrenia is not a disease at all, but a state of brain function based on an altered developmental trajectory from early programming with changing repercussions throughout life . . . That there appear to be numerous genetic and environmental factors that can contribute in various combinations to this recognizable state of altered brain function further suggests that what we call schizophrenia may represent "not the result of a discrete event or illness process at all, but rather one end of the developmental spectrum that for genetic and other reasons approximately 0.5% of the population will fall into."
>
> (Weinberger and Levitt, 2011, p. 408)

MRI studies have reported volumetric and/or morphometric white matter abnormalities in schizophrenia as well as in first episode patients. White matter is basically the information highway of the brain, and approximately 40 percent of our brain consists of white matter. Whitford, Kubicki, and Shenton (2011) have reported that there have been over fifty studies investigating white matter abnormalities in persons with schizophrenia. By far the most consistent finding is of FA reductions relative to healthy controls. Another consistent finding is the positive correlation between FA and severity of psychotic symptoms. Schneiderman and colleagues (2011), using the largest known sample to date to examine anisotropy in schizophrenia, confirmed a white matter deficit in these individuals. There exists a significant overlap in the neuroscience of traumatic stress and the neuroscience of psychotic disorders as observed in the above research studies.

Shah, Mizrahi, and McKenzie (2011), in their review of a multidimensional model for the social etiology of psychosis, proposed that social factors play an etiological role in psychosis. From a sociocultural framework, the following factors have been demonstrated in epidemiological research to be associated with the initiation, course and outcome of severe mental disorders: urban birth/urban living, socio-economic status, migration, reduced

social support and networks, social isolation, social defeat and marginalization, childhood adversity, expressed emotion (particularly hostile criticism) in caregivers, stigma and discrimination, ethnic density, marital status, relative inequality, etc. (Freeman and Stansfeld, 2008; Morgan, McKenzie, and Fearon, 2008; Shah, Mizrahi, and McKenzie, 2011). Martti Siirala (1983) proposed a different perspective on the social factors involved in the initiation and course of the schizophrenias. Siirala focused on social pathologies and a common sickness that we all share: "manifest schizophrenia is part of a common darkness" (1983, p. 19). Schizophrenia, according to Siirala, emerges "out of a common soil of sickness" (p. 19). Could this "common soil" of Siirala's theory be our capacity for dissociation, in line with Harry Stack Sullivan's one-genus postulate (1953, p. 32) that "everyone is much more simply human than otherwise"? Davoine and Gaudilliere (2004) emphasized the need to restore the disrupted link in psychosis between the family and the social fabric, a link disrupted transgenerationally by dissociated experiences arising in the individual's "big history" such as social-familial catastrophes. Davoine and Gaudilliere, in discussing their psychotherapeutic approach, noted:

> we aspire to continue along the lines opened by our predecessors, who considered transference in the psychodynamic treatment of psychosis as a process of co-research with the patient, exploring the "death areas" that represent ruptures [dissociation?] in the social fabric, in order to regenerate lost capacities for speech and history.
>
> (Davoine and Gaudilliere, 2009, p. 143)

Shah, Mizrahi, and McKenzie (2011) noted that an increased risk for psychosis is associated with cumulative exposure to traumatic life events as well as daily hassles: "Genetic, biochemical and neurological evidence supports the link between stress and psychosis" (p. 11). Gene–environment interactions are being studied to identify the relevant polymorphisms, which may partially account for these correlations.

The dialectic of dissociation as a defensive process and the failure of dissociation in psychosis is represented in the contemporary theories of symptom formation and psychotherapeutic reparative processes in the work of Gaetano Benedetti (1987; Koehler, 2003). Benedetti and Peciccia (Koehler, 2003) believe that schizophrenia is characterized by a de-integration (dissociation) of the separate and symbiotic selves. For these psychoanalysts, the danger the psychotic individual faces is one of self loss, whether at the pole of separateness (separate self) or at the pole of relatedness (symbiotic self). If this is indeed the phenomenology and psychodynamics of many psychotic disorders, the patient would be confronted with a terrifying and painful loneliness (Fromm-Reichmann, 1990; Klein, 1993). In addition, Benedetti (1987) understood that the ego of the

person diagnosed with a severe mental disorder is often dissolved by its own perceptions and conflicts. For example, if the person feels people are laughing at him, this not only reflects on projected self-contempt, but also on the fact that the latter as well as other chronic burdening emotions have weakened the person's ego structure to a point that such perceptions can no longer be organized within it. Thus, the person's ego/self becomes transformed by that which it cannot include safely within itself.

Relational psychosis psychotherapy

In my concept of "relational psychosis psychotherapy" (Koehler, 2009), I proposed that the psychobiological threats of unrelatedness, and their dissociation, which account for a large share of the neuroscience findings and suffering in the person with a severe mental disorder, can be ameliorated with psychotherapeutic approaches that place the capacity for relatedness and containment of the dual terrors of unrelatedness and emotional closeness, i.e., loss of a sense of self, at the center of their models of care. In this model, excessive hostility, envy, contemptuousness, and other "negative" emotions, are seen to arise from the more basic psychobiological threat of unrelatedness and loss of self. The relational psychotherapist attempts to not lose sight of the forest for the trees by keeping in close contact with the anxieties and terror of unrelatedness, and their dissociation, embedded in psychotic symptomatology.

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