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TITRATION OF TECHNIQUE: *Clinical Exploration of the Integration of Trauma Model and Relational Psychoanalytic Approaches to the Treatment of Dissociative Identity Disorder*

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Psychotherapeutic work with patients presenting with severe dissociation and dissociative disorders such as dissociative identity disorder (DID) is challenging for both patient and therapist. It was the goal of this article to explore, through the chronological unfolding of the case of Emily, a woman who had previously been diagnosed with DID, the development of this writer's process of theoretical reconciliation between a trauma model approach to treatment and relational psychoanalytic ideas about working with dissociative patients. This article reflects this writer's process of finding balance between the containing yet sometimes confining trauma model in which I learned to be a therapist and the expansive yet sometimes nebulous psychoanalytic theories of trauma and dissociation.

Keywords: dissociative identity disorder (DID), childhood sexual abuse, relational psychoanalysis, trauma treatment

Psychotherapeutic work with patients presenting with severe dissociation and dissociative disorders such as dissociative identity disorder (DID) is challenging for both patient and therapist. Engaging with the violent battles that wage within the minds of patients whose early lives were obliterated by abuse and neglect and who resorted to dissociation for their psychic survival can challenge the integrative capacity and emotional wellbeing of psychoanalysts who work with these traumatized patients. Engaging with a psychoanalyst, a new hope for a new experience, can be terrifying, paralyzing, and arouse the deepest

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conflicts within the minds of the dissociative patients. Regardless of the significant desire for a new and healing relationship by both members in the analytic dyad, this work may be mired in disruption and distress. There can be an ongoing struggle to find balance between safety, containment, and active processing of traumatic material, on the one hand, and in-depth exploration of the internal life of the patient and growth of embodied awareness of the interpersonal devastation of childhood traumas at the hands of attachment figures, on the other.

Where do psychoanalysts obtain the skills, knowledge and support to work with these challenging and highly distressed patients? Models of intervention arising from the traumatology literature emphasize safety, containment, and cohesion. These models provide clinicians with techniques and strategies to assist patients struggling with the emergence of terrifying traumatic memories, overwhelming affect states and the influence of alter personalities that may sabotage the therapeutic relationship, or even the safety of the patient through self-injury or other dangerous behaviors. However, these models may privilege safety and containment over exploration and development. The term "containment" has multiple meanings. In the trauma literature this term refers to a clinical stance and techniques that emphasize the containment of traumatic affect and memories. However, psychoanalysis has utilized this term to refer to "a suitable container for projections," the use of the analyst as a "container" for the patient (Moore & Fine, 1990, p. 32). For the purposes of this discussion, the term containment will refer to the trauma model usage.

Psychoanalytic approaches to the treatment of traumatogenic dissociation, primarily introduced into the relational psychoanalytic literature, offer the clinician expansive ideas that inform the analyst in engaging with the patient in their world to allow for exploration and understanding of the impact of trauma. This exploration allows for deeper understanding of the impact of the trauma on the internal life of the patient, traumatic internal object relations between dissociated parts of the self, and the interpersonal consequences of the traumas. These may be at the heart of why the patient came to see you. This exploration may also provide a mechanism for understanding the challenging therapeutic relationship where one patient may feel like many, and one transference dance may feel like a tango with an octopus. However, these expansive explorations may feel unfettered and unsafe for both patient and analyst, especially as affect swirls out of control and intrusive memories and alter self-states invade the therapeutic milieu.

It is the goal of this article to explore, through the chronological unfolding of a clinical case, the development of this writer's process of theoretical reconciliation that allowed for a growing capacity to titrate between trauma model techniques and a psychoanalytic stance. The case we will explore in this discussion is the case of Emily, my patient, a woman who had previously been diagnosed with DID and the woman with whom I journeyed toward this integration. For Emily this journey would be a struggle to reclaim her divided mind from the ravages of the brutality of her childhood and find some integration within herself. For me, this journey was a struggle to find balance between the containing yet sometimes confining trauma model in which I learned to be a therapist and the expansive yet sometimes nebulous psychoanalytic theories of trauma and dissociation to which I turned for new insights into this challenging work. This was a necessary integration, a titration of technique, which allowed my tortured patient to slowly find her way into relationship with her slowly integrating therapist from inside the rigid minds of her many selves.

History of the Study of Dissociation in Psychoanalysis

Psychoanalytic theories have only begun to reintroduce the topic of dissociation in the past 20 years. Psychoanalytic clinicians are often not trained in their institutes to work with dissociative patients, especially those presenting with severe dissociative processes such as DID. Current studies of dissociation and trauma emerged from the womb of Charcot and Janet's work at La Salpietre, where dissociation induced by trauma was first considered as etiological in the development of Hysteria. Freud was exposed to this work and continued explorations of dissociative phenomenon in collaboration with his mentor, Breuer. The two wrote Studies in Hysteria, an account of dissociative phenomenon. However, Freud's break with Breuer, repudiation of the seduction theory and emphasis of pathology as arising from internal conflict rather than external trauma, decisively set in motion a path for psychoanalysis that no longer considered trauma and dissociation to be central to the development of psychological distress (Davies & Frawley, 1992a; Everest, 1999; Kluft, 1992). A number of authors would argue that this change in direction led to a "legacy of mistrust and misunderstanding" (Davies & Frawley, 1992a) between psychoanalysis and traumatology (Chefetz & Bromberg, 2004; Kluft, 1992). They see this as pivotal in initiating the divide that we now see in the study of trauma and dissociation.

Psychoanalysis had a bumpy start on the road to developing a theory of dissociation. In fact, with only a few exceptions (Ferenczi, Sullivan, Kohut, and others) (Bromberg, 2009; Loewenstein & Ross, 1992), psychoanalysis neglected the study of trauma and dissociation in any coherent manner until Sullivan's work. Sullivan articulated a theory of interpersonal psychoanalysis that understood the central role of dissociation, not repression, as a primary defense in response to trauma (Hirsch, 1997; Stern, 2004). He further articulated that these traumas remain unsymbolized, not hidden or repressed. These ideas lay the foundation for the current emphasis of dissociation and trauma in the relational psychoanalytic literature (Hirsch, 1997; Stern, 2004). From this foundation has grown a relational model of the mind that emphasizes development in the context of early relationships with caregivers, and articulates the deleterious impact of a traumatized child's need to maintain attachments at all costs (Schwartz, 1994).

The field of trauma studies and the world of psychoanalysis have remained essentially separate until the last 20 to 30 years (Howell, 2005, 2011). Davies and Frawley (1992a) described the controversy and conflict that emerged within the field of psychoanalysis when discussions of trauma, sexual abuse, and dissociation were reintroduced into the literature. When Mitchell (1993) began writing about multiple selves in 1993 something had begun to shift in the foundations of psychoanalysis such that the idea of fluid, complex and nonlinear multiple selves could begin to be discussed and explored (Davies, 1999a).

A Comparison of Models

In a dialogue between a primarily trauma model and psychoanalytic writer, Chefetz and Bromberg (2004), they reported that when they began to converse, their conversations felt as though they were "raised in different families" with a "unique commonality" regarding how they thought about their work with dissociative patients. These two writers, each prominent in a different stream of traumatology, suggested that while the language is different, much of the sensibilities of their work with dissociative patients were similar (Chefetz & Bromberg, 2004). In exploring foundational ideas of these two models in the literature, I found that Chefetz and Bromberg (2004) had an important insight. These theories use language that is very different but, underlying many differences, there is

much that is compatible and consonant. However, there are significant and important conceptual differences between the models that bear exploring.

Trauma Models of Treatment

The current field of traumatology evolved continuously from Janet's work through the exploration of combat veterans with posttraumatic stress and into the work of feminist trauma therapists with sexual abuse survivors. This group of clinicians and researchers developed strong and cohesive models of etiology and treatment of dissociative disorders with virtually no participation from psychoanalysis. While there have been several important analytic contributions to the study of dissociation in the last 20 years, the concept of dissociation continued to exist primarily outside of the analytic mainstream, and very little communication occurred across the trauma model-psychoanalysis divide (Kluft, 2000).

The trauma model views the "normal" personality in relation to the *Diagnostic and Statistical Manual of Mental Disorder–Fourth Edition–Text Revision* (*DSM–IV–TR*) (American Psychiatric Association Task Force, 2000) definition. The *DSM–IV–TR* defines integrated unitary consciousness as normative and the development of DID and other dissociative disorders as related to a failure of normative integration (International Society for the Study of Trauma and Dissociation, 2011). Trauma models emphasize the failure of normal integrative function as a result of the neurobiological, developmental, and cognitive impacts of chronic, early, and severe abuse as etiological in the development of pathological dissociation.

The International Society for the Study of Trauma and Dissociation has published treatment guidelines for practitioners that reflect a fairly strong consensus in the field of traumatology (International Society for the Study of Trauma and Dissociation, 2011). The goal of treatment is "integration" and includes a focus on reducing dissociative divides between parts of the self. This allows the patient to experience themselves as one whole, integrated, unified self (Kluft, 1999). Unification or fusion is seen as the overall a priori goal of therapy, although it is acknowledged that this is not always a possibility for all patients (International Society for the Study of Trauma and Dissociation, 2011). In fact, in a recent review of the treatment practices of 36 international dissociative disorder experts, only a minority reported that integration of self-states occurred (Chenail et al., 2012).

The process of treatment within the trauma model is clearly delineated in stages. These stages move from safety and stabilization to processing of memories and trauma-laden material to a stage of reconciliation and reintegration with oneself and with the outside world (Courtois, 2009; International Society for the Study of Trauma and Dissociation, 2011; Pearlman, 2001). Trauma model therapists are provided with techniques such as hypnosis, Eye Movement Desensitization Reprogramming (EMDR) and other creative approaches to processing trauma memories, working with affect dysregulation, building bridges, and dissolving divides between self-states to facilitate integration (Briere, 1997; International Society for the Study of Trauma and Dissociation, 2011; Kluft, 1999, 2000; Loewenstein & Ross, 1992). Trauma model approaches allow the clinician to keep both feet on dry land while holding out a helping hand to their sometimes-drowning patients. There is need for relational engagement but no need to enter into the dissociative dance; containment requires clarity and a certain clean distance. For a full review of these

approaches to treatment see: Dell (2009); International Society for the Study of Trauma and Dissociation (2011); Nijenhuis, van der Hart, and Steele (2010).

Relational Psychoanalytic Model

Relational psychoanalysis has moved toward an understanding of the normal personality as nonlinear and dynamic, a model of normative multiplicity (Mitchell, 1993). Mitchell (1991, 1993) expanded upon the idea of the multiple self—that the self is not a single unitary state of mind but rather a cohesive collection of self-states that are simultaneously knowable. This has become a well-accepted contemporary relational model of the self that has been adopted by relational writers on the topic of trauma and dissociation with contributions by writers interested in exploring dissociation as a clinical phenomenon (Bromberg, 1998, 2006, 2011; Davies, 1996, 1998; Davies & Frawley, 1992a, 1992b; Howell, 2005, 2011; Pizer, 2001; Slavin, 1996; Stern, 1997, 2010). These authors suggest that the difference between normal and pathological multiplicity and dissociation is simply the degree to which parts of the self are fluidly overlapping versus sequestered, separated by permeable versus rigid boundaries, experienced simultaneously versus amnestic and unknown to each other (Bromberg, 1994, 2006, 2009; Howell, 2005, 2011; Stern, 2003, 2010, 2012a). Bromberg (1993) asserts that the essence of health is the capacity to "stand in the spaces between realities without losing any of them-the capacity to feel like one self while being many" (p. 166).

Schore (2003) described dissociation as a defense of last resort, which "may represent the greatest counterforce to effective psychotherapeutic treatment" (p. 132). Stern (1997, 2003, 2010) indicates that while dissociation is a protective phenomenon, sequestering certain self-states from contact with others and the painful affects and memories they may hold, this restriction restricts the experience of the traumatized person by reducing their imagination, emotional depth, capacity for intimacy, and fullness of experience. Similarly, Bromberg argues that while dissociation is protective, it robs the traumatized patient of the capacity for self-reflection, intersubjectivity, intrapsychic conflict, and self-regulation (Bromberg, 2011).

In recent years, relational psychoanalytic authors have led the movement toward a reintegration of the concept of dissociation into psychoanalytic models of treating traumatized patients. Relational psychoanalysis has posited multiple definitions of dissociation, but there is some consensus that dissociation can refer to both processes and structures. As a process, dissociation includes alterations in consciousness including spacing out, numbing, derealisation, depersonalization; defensive responses against painful emotions and memories. As structures, dissociation protects against overwhelming experience by separating parts of the self that are holding traumatic feelings and memories (Bromberg, 2011; Howell, 2011; Stern, 2012b). However, while these definitions all include an understanding of dissociation as a mechanism to protect the mind from overwhelming affect, Howell (2011) indicates that "the word can be used so loosely that it begins to lose its meaning," (p. 36) and that while the relational analytic literature has begun to explore the concept of dissociation more deeply, this evolving literature has included little explicit writing about DID.

During this initial period of resurgence of interest in trauma and dissociation, Davies and Frawley (1992a, 1994) explored the severe consequences of childhood sexual abuse and exhorted analysts to consider the particular needs of trauma survivors within an analytic treatment. Davies (1996, 1999b, 2005, 2006), providing poignant clinical exam-

ples, wrote about the treatment process with severely traumatized and dissociative patients, including in-depth explorations of the challenges to the analyst and his or her countertransference, the depths of processing and integrating traumatic experiences and dissociative self-states through analytic treatment and the termination process. In a different line of inquiry, yet similarly attempting to explore the impact of trauma and dissociation within a psychoanalytic framework, Howell (1997a, 1997b, 2002, 2003) reconceptualized classical analytic concepts such as masochism, narcissism, borderline states, and the harsh superego in terms of trauma and dissociation. These discussions illustrated to relational psychoanalysts the pervasive and destructive impact of trauma on the lives of survivors.

As the concept of dissociation became more accepted and integrated into the field, a number of key authors continued to move the discourse forward through presentations of theoretical explorations of the therapeutic process in the application of relational psychoanalytic treatment with dissociative patients and illustrative case presentations and discussions. These key authors include: Phillip Bromberg (1998, 2006, 2009, 2010, 2011, 2012), collaborations between Jody Messler Davies and Mary Gail Frawley (1992a, 1994), independent work by Jody Messler Davies (1998, 1999b, 2001, 2005, 2006); Elizabeth Howell (1996, 1997a, 1997b, 2002, 2003, 2005, 2011); and Donnel Stern (1983, 1997, 2004, 2010). These authors have been heavily influenced by researchers in related fields studying affect regulation, attachment, the impact of trauma on human psychology, and physiology and developmental researchers Bucci (2011); Schore (2009); van der Kolk (1994, 2007); van Dijke (2008).

Bromberg and Stern have focused on the continuum of dissociative processes and emphasized the importance of understanding the role of dissociation in all treatments (Bromberg, 2009, 2011; Stern, 1997, 2004). While they address the impact of severe dissociation on the treatment process, they explore the process of therapeutic action in the context of all treatments, where dissociative processes and "not me" states become alive and expressed in dissociative enactments between patient and analyst. Howell and Davies (Davies, 2006; Howell, 2005, 2011) on the other hand, place more emphasis, in their writing, on the severe impact of traumatic developmental experiences on the expression of more severe dissociative processes and the development of dissociative disorders such as DID.

Therapeutic Process

The relational psychoanalytic literature does not emphasize stages or steps, structured techniques, or any kind of linear process. However, safety and clarity of the treatment frame are highlighted (Bromberg, 2006a, p. 131; Davies, 1999). The therapeutic relationship is highlighted as one of the most important aspects in the treatment process and the impact of early trauma on attachment is emphasized (Saakvitne, 2000). The importance of engaging with and accepting all parts of the patient's self is articulated, with the goal of ensuring that the patient knows that, in this relationship, all are welcome to come and tell their truth (Bromberg, 2003, 2006; Davies & Frawley, 1992a).

Evidence is growing that psychoanalytic treatment in the context of dissociation can assist patients in developing the capacity for affect regulation and intersubjectivity and can restore connections between dissociated self-states so that the patient becomes able to hold their own mind in mind (Bromberg, 2011). The relational model, favors accessing alter self-states through the unconscious communication of dreams and enactments in the

therapeutic relationship (Bromberg, 2003, 2006; Bucci, 2011; Stern, 2004). As Davies (1999b) states:

> the goal of such an analytic agenda is to invite into interpersonal enactment those dissociated aspects of self/other experience that have been rendered unconscious . . . By making them conscious within the analytic relationship, patient and analyst potentiate a more inclusive redefinition of particular aspects of self/other interaction. (p. 186)

For Bromberg and other psychoanalytic writers, it is through enactments and dreams that dissociated parts of the self are entered into the analysis and rigid barriers between these selves are dissolved (Bromberg, 2003; Davies, 2006; Schwartz, 1994; Stern, 2004). Stern (2003) refers to "unformulated experiences," experiences that are dissociated and cannot be reflected upon, while Bromberg discusses the "dyadic dissociative process" (Bromberg, 2006, p. 136) of enactment as behavioral expressions of aspects of self and experience that enter into the analytic space that are, as yet, unavailable for verbal exploration (Bromberg, 2006, pp.49, 136; 2009; Stern, 2004). The normative dissociative processes of the mind are emphasized and do not specifically focus on only patients who evidence severe dissociation and DID but rather, all patients on a continuum of dissociative responses (Howell, 2013). Howell (2011) articulates the process of "dissociative attunement" (p. 233), which is very similar to the concept of dissociative enactments.

In the field, there is a growing consensus and articulation of a "treatment model" based, primarily, upon the dyadic dissociative process of enactment. Key proponents of this model would argue that dissociative enactments in treatment are necessary, inevitable, and universal (Bromberg, 2006, 2011; Davies, 1999a; Stern, 1997, 2003, 2010). In severely dissociative patients, what must be known, felt, and processed, cannot be tolerated. Attempts to explicitly explore self-experience through language may trigger overwhelming traumatic reexperiencing, and explicit attempts to express dissociative self-experience may result in internal conflict that cannot be tolerated, shame and overwhelming dissociation. Bromberg (2011) exhorts the analyst, "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" (p. 44). Therefore, it is only through mutual enactments that we gain access to the sequestered parts of our patient's minds. Therein lies their pain, their intolerable memories and interpersonal expectations that become available to the dyad to begin to make meaning, reflect, take responsibility, and fully mourn (Stern, 2010, p. 179).

In an enactment, past experiences are relived along with the associated affects and responses. As this struggle plays out between patient and analyst, the patient's internal world is thrust into the analytic relationship. In this space, intersubjectivity is lost and each member of the analytic dyad is reliving their own dissociated experience with the other (Bromberg, 2006). The patient becomes stuck in a terrifying world of repetition where the relationship is assumed to be irreparably damaged. At the same time, the analyst is caught in a dissociated moment of their own and places the blame for the mess on the patient. It is only by wriggling out from under this oppressive fog of dissociation that something new, different, and surprising bursts open; a new coconstructed experience (Bromberg, 2001, 2003; Davies, 2006; Stern, 2004).

It is within an analytic relationship that allows for the titration of risk and safety where these enactments may emerge. Over time and struggle, this implicit expression grows into explicit knowing and accepting through repetitive attempts at negotiation and understanding. The process involves the not me of the patient entering the analytic relationship implicitly. Intrapsychic conflict that cannot be represented or tolerated must be implicitly

lived out in the interpersonal space between analyst and patient. Analysts become hooked in to the mutually dissociating phenomenon through their own vulnerability and dissociation; a necessary component of the process of change (Bromberg, 2006, 2010, 2011; Davies, 2006; Stern, 2004, 2010). It is equally necessary that the analyst resolve their dissociation for successful resolution of the enactment.

"All instances of successful understanding begin with the absence of understanding" (Stern, 2003, p. 852). Enactments resolve only when explicit awareness of what is attempting to be communicated implicitly by one or the other member of the analytic couple is achieved. As implicit communications continue in the enactment, negotiation takes place as a channel of implicit communications or a "conversation between limbic systems" (Bromberg, 2011, p. 18) and a new intersubjective experience that belongs to both members of the dyad is created. Analysts are encouraged to tune in to shifting self-states in their patients and reciprocal shifts in themselves to sense burgeoning enactments (Bromberg, 2011; Stern, 2003). Ironically, one of the defining characteristics of enactment is the inability to identify and articulate the very process in which one is embroiled. This creates challenges for the exploration and working through of whatever implicit, unformulated experience is attempting to emerge into knowing. Stern (2003) describes, through a clinical case, the experience of deadlock experienced as he struggled in the mire of an enactment. He suggests that it is only in "the analyst's awareness of the inadequacy of his response" (p. 864) that keeps the clinical situation from deteriorating, and allows the analyst to continue struggling for the light of meaning. The dissociation may feel uncontrollable or unknowable, and the analyst must be able to tolerate and acknowledge his or her own vulnerability and dissociation to begin to shift out of the stuck place in which the dyad has found itself. As the analytic dyad attempts to negotiate and find mutuality, it is suggested that at some point one member of the dyad emerges into some new consciousness which allows for the creation of a new experience of the other and a growing awareness and tolerance of the self (Bromberg, 2011; Howell, 2011; Stern, 2003, 2010). Stern (2003) writes, "suddenly I had hypotheses about that. Suddenly I could use my mind again" (p. 862). Change, in this process, is not limited to the patient; growth occurs in both patient and analyst. As the enactment is resolved, the patient has the opportunity to experience something new and surprising within the analytic relationship. However, the culmination of successful resolution of enactment and, eventually, dissociation, is with the achievement of the capacity to experience internal conflict (Bromberg, 2006, 2011; Davies, 2001; Stern, 2003, 2004, 2010).

This model of treatment explores the universality of dissociation and enactment in analytic treatments. While dissociation is discussed as a continuum, DID is rarely explicitly discussed. Howell (2005, 2011), places emphasis on assessment and utilizing a phase oriented treatment of DID. She explicitly discusses working with parts, titrating exposure to different self-states and exploring the "we of me" (p. 16). She does not, however, indicate whether she explicitly evokes the emergence of alter self-states and whether her work is primarily technique driven trauma-focused work or whether it is more implicitly relational. Howell describes herself as a psychoanalytically trained psychologist who specializes in the treatment of trauma and dissociation. She does not appear to discuss her own process of developing a comfortable integration of models, although her suggested approach to treatment reflects considerable integration of multiple trauma and psychoanalytic models.

To a new psychoanalytic candidate, the therapeutic use of dissociative enactment as a primary mechanism of therapeutic action in the context of severe dissociation may feel terrifyingly lacking in clarity and leave her searching for an explicit "how to" manual.

Given that one of the key aspects of enactment is the lack of awareness of ones participation, this may leave an analytically oriented practitioner feeling like all feet have left the dry land of the safe, explicit and linear trauma models. Whither are containment, tools, and technique; all that keep the analyst safe and grounded in the therapeutic endeavor of exploring the horrors of human trauma? The essence of enactment is not knowing; slipping sand through grasping hands.

"With the advent of relational theory, psychoanalysis has undergone a sea change" (Howell, 2011, p. 27). However, Howell and other analytic writers struggling to articulate a coherent model of treatment for dissociative patients, agree that it is essential to amalgamate this model with other viewpoints to fully address the needs of severely dissociative patients and to address concerns about psychoanalytic approaches to dissociation (Howell, 2011; Lyon, 1992; Rothschild, 2009).

Background

As a therapist, I was trained in a trauma model approach to therapy; a model of fragmented minds structuralized in theories built on a foundation of cognitive neuroscience, trauma research and psychotherapy process studies. This trauma model provided me with clear, concrete, linear, and active techniques to guide my work with dissociative patients struggling to find peace within a tortured, divided, inner world. However, working within trauma focused treatment centers, I also found myself feeling constrained by the concretized approaches of structural models. I was fearful of how I might be engaged in further rigidifying and concretizing the fragmented self-systems of my patients. I sought out psychoanalytic training to find balance and found instead, greater conflict within myself regarding the answer to how best approach this challenging work.

Emily

Along came Emily. Emily had "learned" how to be a patient within the structural trauma model world, the same world in which I learned to be a therapist. She came to therapy already delineated in rigidly separated multiple selves that had unique names, ages, physical locations in the body, and very little openness to cooperation and coconsciousness. The struggle for integration had begun, in the mind of my patient and my own integration of seemingly dueling theoretical frameworks for working with dissociation.

Emily came to me on the precipice of horror. Images of closed doors, winding staircases, and dark hallways haunted her every waking and sleeping moment. Emily recognized these as harbingers of a coming terror. As the first signs of labor impel a birthing woman to call the midwife, Emily knew she needed help. Her first long-term therapist had retired and the second had died. Emily felt safe with therapists but did not know where to turn. She found me, as the labor was progressing, contractions coming closer and closer. As we said hello, she birthed a memory through the closed door of a darkened mind, the memory of being tied down to a hospital bed and forced to push out the baby her father had impregnated in her. There was no time to catch our breath. We were off into the mire and abyss of her tortured soul and fractured mind.

Emily was a 48-year-old woman who, at the time of self-referral, had begun to experience a resurgence of traumatic symptoms. These included hyperarousal, hypervigilance, intrusive memories of previously unprocessed traumatic experiences, somatic symptoms such as migraines and physical pain. Additionally, she experienced a resur-

gence of internalized fragmentation of self-states that she described as having been integrated during a previous therapy. She left her stressful position in her workplace as memories were intruding upon her daily functioning. She was having migraines every day and vomiting at work.

Emily's family was mired in poverty. Emily is the only girl in a sibline of six. Regardless of Emily's middle position in the sibline, she was required to perform the majority of household chores including cooking, cleaning, laundry, and childcare for her younger siblings. Emily described her experience growing up as a form of servitude, sexual and domestic. From the earliest years of her life, Emily had the experience of being groomed and sexually primed by her father. He told her "this is a special thing that Daddies and little girls do together." She described how his sexual abuse was perpetrated with physical gentleness and attempts to arouse and stimulate her prepubescent young body. Over the course of many years of sexual violation, Emily was forced to engage in highly ritualized sexual activity disguised as games and "playtime with Daddy." Conversely, her older brother approached his sexual predation of Emily from a sadistic place. He would smother her with pillows while raping her, choke her, beating her over the head repeatedly until she passed out, drug her, and allow his friends to rape her in a group over and over again. These diametrically opposed approaches to overwhelmingly frequent, severe and violent sexual abuse, from a very young age, and not ending until Emily was old enough to leave home, could simply not coexist in the same mind. Emily described her ability to dissociate as having saved her life. She reported that she purposely built compartments and self-states in which to survive the abuse and store horrible memories and contradictory experiences of family, life, and safety.

In initial sessions, Emily was open and engaged. She spoke the "language" of therapy with ease and comfort, maintained steady eye contact and we quickly developed what appeared to be a collaborative working alliance. Emily was warm yet cautious and described her distress using third person language. She appeared to distance herself from her experience with intellectualized self-help book-type language. Emily's previous intensive therapy processes focused extensively on helping her process a large volume of dissociated trauma memories. This therapist, who was known to me, used a trauma model approach to treating dissociative disorders. This approach was focused on extensive direct work with her fragmented self-states and processing of traumatic memories. It was in this climate of therapy that Emily learned to be a patient.

Emily used the term "integrated" to describe her inner world. However, what she meant by this was that she had achieved a stable sense of coconsciousness and collaboration between her multiple self-states. Eventually I learned that after this first therapy she continued to have an internalized child state (Lynn) that curled up inside her stomach and needed a great deal of quiet and nurturance. She also described an adolescent "rebel" self-state that used food, fast driving, and "affairs" to cope with overwhelming affect and other "compartments" where memories and emotions were stored. She spoke of a "spiritual" part (Maeve), who helped ground her through prayer and spiritual music and other "angry" parts that she did not like to talk about and described as being very far away from her. It was this "integration" that was crumbling when she approached me to begin therapy.

Titration of Technique

With these concerns in mind and with Emily in front of me, I approached my analytic training. Titration of my own therapeutic technique between the more containing trauma

model techniques and the more expansive exploration of a psychoanalytic approach was necessary for Emily to move along and through the horrors she had experienced. With the content—violent traumatic memories, affect dysregulation and out of control selves, Emily needed the containment of active, structured trauma model techniques. With the process and outcome—mistrust, fear of her own mind, fear of relating, Emily needed the space and relational focus allowed by psychoanalytic exploration. These needed to be balanced and titrated through close attunement to all of the parts of Emily that were available in our relationship.

In the Beginning

The beginning of therapeutic work with Emily was focused on remembering and processing traumatic memories. She was in a traumatic crisis and there was little room for anything but building safety and containment. There were times in Emily's treatment that the containing structure of trauma model techniques such as grounding exercises, structured approaches to working with traumatic memories and negotiated communication between self-states were necessary aspects to maintaining both her and my safety in our treatment process. It was not easy to be with Emily as she relived the disturbing memories of birthing her father's child, rapes and beatings, and her mother performing an at home abortion. Not only was this last to emerge memory devastating to Emily but also it was the memory that confirmed for her that her mother did know about the abuse and violence to which Emily was subjected.

Early in the therapeutic process when Emily began to demonstrate high levels of dissociation in sessions and traumatic memories began to emerge and be relived by self-states, there was an easy fit between us of the how of therapeutic process. Emily quickly became aware of new fragmented self-states within herself of which she had not previously been conscious. These parts of herself were holding these newly emergent trauma memories, memories that were more unknowable than those that had emerged during past therapy processes. These self-states indicated that they did not think that they could hold these memories and feelings anymore and were playing a role in potentiating daily migraines, an internal signal of distress. What appeared to be necessary containment and parts work also seemed to obfuscate exploration of her complex emotional experiences within the transference as we stayed close to the surface. At the same time, there was little room for exploration of our emerging relationship. This was not possible, as the inner world of Emily's own multiple self-relationships were violent, dangerous, and overwhelming. In many ways, I felt that I did not exist for Emily other than as a container or safe place for her to excise these violent memories. It was not yet time for explicitly exploring transference together. It was as if there was no transference, simply a mutual dissociation.

As memories of rape, assault, childbirth, and forced abortion that were held by Lynn and other unnamed self-states tumbled out, I believed that Emily would begin to be able to know, feel, and think about these experiences more widely within herself. To my distress, this did not occur. Each time Emily relived a state dependent memory in a session, despite utilizing techniques oriented toward developing shared consciousness, it was like she was reliving the memory for the first time. I held the story of Emily's abuse but no other parts of Emily's mind were sharing these stories and emotional experiences. Emily's consciousness was not expanding, her mind was getting more rigid, divided, and concretely fragmented.

I explored my countertransference anxieties about her well-being, my capacity to help her and my ongoing conflict about how to blend theories. I knew that this intellectual

battle was, in part, holding me back from engaging emotionally with Emily and preventing Emily from having the kind of relationship with me that she needed. I became overwhelmed by anxiety that I would hurt her, based in part by therapy experiences from my own life. My awareness that she needed more than containment, which I was well trained to provide, fuelled my anxiety about finding a path to another way of working with her. This anxiety obfuscated my capacity to simply be with her. As we engaged in the therapeutic relationship in the moment, there was very little affect in the room. Emily's present tense adult self could not find the feelings that were embedded in her inner world and I maintained my intellectualized trauma model stance as we stayed in containment mode together. When Emily entered her inner world of selves steeped in traumatic memories and dissociation, she closed her eyes and became overwhelmed by affect that she could not later remember or feel, and I became further away from her affectively as I attempted to help her contain these overwhelming states of terror that frightened both of us. It seemed as though we could not find each other, emotionally, no matter which theoretical world we were in, and my conflict over theories was, perhaps, keeping me further away from her.

My concerns about the potential reification and concretization of Emily's mind grew, and I began to question, not the overarching goals of treatment, but the process through which treatment could achieve them. Emily could do the tasks of trauma model treatment. In doing the tasks, we both stayed safe. In doing the tasks, Emily stayed away from both her and my "primary vulnerability" (Davies, 1999b). We shared a nonverbal agreement to stay in the safe zone. Davies (1999b) describes the power of unconscious processes through which the analyst makes clinical choices to stay safe. I felt confident, competent, and containing. Emily felt comfortable in the way we were working at a distance from her horror and, so did I. That safe space where, as Emily stated, "you always know what to say," but at what price? In staying safe we were not engaging with all of Emily, all of the parts of her that were anything but safe. We were not engaging with the parts of her inner world that tormented and taunted her, that she kept from me and that she was afraid would tear her apart.

As our work continued, I began to become more and more uncomfortable with the evolution of unbridgeable distinct relationships between Emily's self-states and myself. When Emily's multiple selves would come into a session, the shift was preceded by Emily closing her eyes, starting to shake and rock, going far inside of herself, and switching to another part. I believed that the closing of her eyes was a shutting out of the outside world, along with me, and a tuning in to the inside world. However, Emily could not remember these events. For example, at the beginning of a session during this period of the treatment, Emily began discussing the physical pain that accompanied the recovery of these painful memories. She appeared to be engaged with me, and yet described the pain of her brother beating her over the head over and over again without any apparent emotion. My own response seemed to empathically resonate more with the dissociation than the dissociated affect, as I too could not feel for the beaten child she described with such experience distant words. Within five minutes of the session beginning Emily closed her eyes, started to shake and moan in visible pain and discussed her physical wounds with emotional vigor. The dissociated affect was suddenly upon us and my own anxious response to the rapid switch shifted me into another state of not-feeling, a containing but fearful stance filled with feelings of hopelessness that I would ever help Emily find some middle ground in her world of on or off.

(E = Emily, T = Therapist)

E: (in a tiny voice, curled up on the couch clutching her body and shaking, “Lynn” is in the room) So much pain, I’m so tired, I’ve lost all of my hiding places, and there is nowhere to put anything anymore.

T: It sounds as though you are feeling everything now, no place to hide, your body is feeling all of that anger, sadness, and shame all the time.

E: I should have been annihilated, I should have died. I don’t know why I survived,

T: There is a lot of anxiety there about not being able to hide anything anymore?

E: (sounding more like “rebel”) I should just quit being a wimp and shut up.

T: whose voice is that?

E: My mother’s, just suck it up.

T: How awful to be hurt so badly by your brother and father and for that to be the message from your mom.

E: (shaking more, rocking, and moaning) This is scary (back to “Lynn’s” little voice), I don’t like telling you so much. There is so much pressure inside of me.

T: Tell me about scary.

E: I’m the one who carries all the tears, that’s not fair.

T: No, it’s not fair.

E: It’s very scary. (shudders and shifts back to “rebel”) I don’t want her coming (to therapy), she’ll tell her everything.

T: Her being me?

E: There’s a code in our family, keep things to your self.

T: Why?

E: People need to keep things in the family.

T: Why?

E: Secrets.

T: What kind of secrets?

E: All kinds . . . If I tell you, you’ll want me to say it was wrong . . .

T: I don’t need you to feel or think things you don’t for me to talk to you and listen.

E: She was a pain, always going to tell on us, always getting in the way. She saw too much and I needed to make her feel guilty.

T: How did you do that?

E: I have my ways.

T: hmmm.

E: She listened when I threatened her.

T: Is it still your job to keep her from talking?

E: Yeah.

T: What's going to happen if she tells?

E: I did bad things to her . . . (shudders again and back to little Lynn's voice) why would anyone care for me, I'm just little, I remember trying to find someone to take care of me.

T: No one was there for you.

E: Daddy was there, he paid attention to me.

T: Sometimes that attention didn't feel good.

E: That's what daddies do.

T: It's so sad that the only person who paid attention to you, hurt you.

E: That's why I'm invisible; maybe they won't notice me anymore. If I hide in the closet, I hope they won't find me.

T: It sounds very scary.

And around and around we went, containing, holding, trying to rebuild inner communication, and shared narrative while holding steady against the frightening tide of traumatic affect that threated to overwhelm us both. The trauma model techniques were required to help Emily and I hold on to some safety and containment of overwhelmed and overwhelming self-states. On the one hand, these were times when valuable information was provided regarding her feelings, needs, memories and beliefs and the relationship between all of Emily's many selves and myself was growing into safety. On the other hand, Emily was highly dissociated in these moments, did not remember what was said and did not appear to be processing any of the trauma material outside of the part that was reliving the nightmares. I was learning new things about Emily, but Emily was not or, at least, she did not appear to be. I bore in mind the very clear recommendation that no trauma processing be undertaken while patients are in a dissociative state and yet, without this, Emily came and went as chipper as she began and told me stories about her dogs, partner, and daily struggles with family. There was a gulf developing between the work of the daily world and the work of the underworld.

I began to feel a deep conflict between my training as a structurally oriented trauma therapist and my growing interest in integrating a psychoanalytic stance with Emily. I was trying to engage affectively with all of her multiple selves through our relationship and the treatment process rather than in dissociated bursts. In my trauma model training I was encouraged to contain, hold and structure interactions with all parts of my patient's self to begin the process of integration and remembrance; to stand on the shore with both feet on dry land. In my psychoanalytic training I was encouraged to immerse myself in the emotional reality of my patient's world, to engage with her emotional experience and all of her selves; to dive with both feet into the water of her world. In the one model, I feared I was abandoning her to supposed safety and in the other model I feared we would both be drowned. I was desperate to find a way to keep one foot on dry land as the other foot waded in the water of her world, with her, engaged, but able to pull us out should she begin to drown. It was at this juncture that it felt, more than ever, necessary to begin integrating more psychoanalytic exploration of Emily's emotional life, her internal worlds of self-experience and her relationship with me.

Enters Psychoanalysis

While Emily achieved greater stability and resolution from traumatic memories, she also appeared to be becoming more rigid, fragmented, and compartmentalized. She did,

however, begin to be more able to tell me about how her internal selves felt about our relationship and about me. I began to exist and the transference began to be explored. She started to tolerate and regulate more emotion in the session without dissociating. It seemed time to begin a different kind of journey as we moved forward.

Approximately one year into the therapy Emily and I moved from once a week sessions to a psychoanalytic treatment frame of multiple sessions per week. The vomiting of memories was beginning to subside and Emily was starting to look outside her own chaotic inner world, look around her and wonder about her life and relationships. The relationship with me was an important place to start. We began to shift gears and Emily tolerated some integration of an analytic mode of inquiry, which included less active use of specific techniques, and more focus on her internal experience, interpersonal life, and the relationship between the two of us. We were even able to start to bring some limited aspects of her internal self and experience into our relationship, and Emily was able to tolerate some minimal empathic reflection. This timid beginning allowed for some explorations of enactments that were occurring between us.

Working With Enactments

For Emily and I, the opportunity to explore enactment, seen and unseen, came quickly on the heels of the shift into a psychoanalytic treatment frame. Emily was on disability insurance from her work because of her extreme distress and so was not in a position to pay for these extra sessions. However, we negotiated a fee that allowed her to come two to three times per week at close to the fee she had been paying when she had insurance to cover her sessions. For the first week of this arrangement Emily missed the first of these multiple appointments. Emily never missed appointments. When I called Emily she seemed surprised, as she had thought that I did not actually mean to offer her the sessions. It did not occur to her to ask me whether this assumption was true and so, she did not come and had completely "forgotten." As we tried to explore the meaning of this forgetting experience, it became clearer that Emily expected me to fail her. She expected me to lie to her, hurt her, stay at a distance from her, and offer her help that was painful or damaging. This was an opening for us to begin talking about her relationships with family, her partner, and me. As soon as we shifted into an analytic treatment frame the relationship between us assumed a focus of our work and processing traumatic memories became less pivotal to our sessions. The memories bursting into life in the early stages of therapy did not leave any room for talking about how they had affected her ability to trust, share, be intimate, and set boundaries for her own safety. Something exciting and new was beginning. Emily gradually allowed for the growing emergence of the unthought known (Bollas, 1987) within our work together as we began to explore, not the traumatic memories but, the traumatically embodied expectations of others as represented in our relationship.

The Unresolved Enactment

As the process continued the tension between our trauma model and analytic mode of relating continued to be enacted between us and within me. While Emily was becoming more real in the sessions and sharing more of herself, she was also dissociating a great deal in the sessions. More frequent sessions seemed to open up the divisions within herself, and she seemed at times to be experiencing more confusion within her own mind, more alienation from herself and greater feelings of fragmentation.

As therapy continued and my concerns increased, I began to ask Emily to keep her eyes open during sessions so that we could stay connected with each other. With her eyes closed in her inside world, Emily was sucked into the horrors, alone. In this inside world, our relationship did not exist and Emily disappeared from me. I felt that we needed to find a way to stay connected during sessions and to decrease Emily's need to dissociate to experience any affect. While I did not want to exclude all of Emily's experience from the therapy process, I had become extremely concerned about her level of dissociation in sessions, the growing concreteness of her internal self-states and how little of our sessions Emily could remember. This began a serious rupture in our relationship and probably the most significant repetitively unresolved enactment.

Emily, being so accommodating, complied with my request to keep her eyes open in sessions and "stay with me." However, she stopped bringing any material to sessions, stopped journaling outside of sessions and stopped sharing any of her internal world with me. When asked about her feelings Emily reported, "I am not allowed to close my eyes and go inside anymore so there is no way that I can know the answer to that question." Emily was angry with me for asking her to try to learn how to be a patient differently. We were lost. I was lost. I had rejected the only way she knew how to share these parts of herself with me at the same time as I was trying to not reject my early training as a trauma therapist as I embraced my new identity in psychoanalysis. We were both struggling at accepting all that needed to be integrated within us and I was, in this dance, unknowingly rejecting parts of Emily that she needed for survival and could only access through a limited window of experience.

Our impasse continued. Emily came to her sessions with a warm smile. However, my relationship with Emily became as thin as the small part of her that lived on the surface of her. I worried that perhaps she had learned too well how to be a patient within the structural model. I worried that perhaps the only way to find our way back to engagement was to, paradoxically, return to Emily's dissociative ways of being with me. However, we had been doing that for 3 years and Emily still could not remember what had happened in our sessions and did not appear to be integrating any of the "new" information garnered in these explorations of her inner world, into the rest of her life or self.

As time moved along, Emily tried to engage with her inner world in sessions without becoming lost in a dissociated haze, but her sense that she was "not allowed" to do it her way lead to ongoing disruption. Eventually she reported feeling as though she was going to explode and began switching all over the place in a session. I tried to find some kind of compromise, focusing on inquiring about the overwhelming nature of her affective experience while engaging in parts dialogue as Emily went inside of herself. Unknown, unfound, unarticulated enactments continued to swirl between us. I could, tentatively, name those enactments that were known and yet, I felt lost with both feet in the water knowing that so much more was living in the dissociated space between us.

Perhaps Emily was too far along on the trauma model train and was too firmly entrenched in this way of being, the only way of being she had ever known, and to let go of her dissociative divides. Perhaps Emily was incapable of engaging with me in imagining something else was possible for her and was unwilling to let go of the only way of functioning she had ever experienced. Perhaps she was too narcissistically invested in her identity as a person with DID, rendering her one of the subtypes of patients not amenable to treatment (Kluft, 1999). Perhaps, integration as I defined it was my goal for Emily and one that was not shared by the many parts of herself that continued to sit on the fence of the therapeutic relationship. I could imagine Emily's mind as a more fluid,

cooperative, and safe space for her but she could not. Perhaps in buying into a goal, integration, that is defined by a model and not negotiated between a patient and an analyst, I was failing Emily in understanding her desires and longings for wholeness. Also possible is that in asking Emily to relate to therapy in a new way and to move toward becoming a more fluidly organized self, I was asking her to turn her back on the therapist with whom she had done 10 years of therapeutic work to create the functional, structurally divided internal world she seemed to want to hold onto. It was a world in which this therapist existed within her as the only safe mother she had ever known. Emily made it clear to me that I would never inhabit the place within her that this therapist had inhabited. (E= Emily, T= Therapist)

> E: It was a special relationship. She was so warm and mothering. She was older and it just felt safe with her. You are so different from her. I can really laugh with you.
>
> T: Can you tell me other ways that our relationship is different?
>
> E: Well, I can bring things to you that I would never bring to P. I can curse and swear with you. You are incredibly competent; I always leave here thinking, "Oh My God, she is so good; she knows what to say to everything." I just know that you will always know how to respond.
>
> T: What about that nurturing, warm, mother need? That was so important with P, and you have told me that that is not something that you feel is in our relationship; that only you should be looking after Lynn. Is there something about me or how I am with you that makes it particularly difficult for us to have that element to our relationship?
>
> E: (emphatically, almost yelling but certainly laughing) I would never put you in a mother role!!!
>
> T: Why?
>
> E: (she looks at me like the answer is obvious and I am now assuming alien like features) Well, you are younger than I am and I just don't see you that way.

Emily went on to describe me as a "head" person who would always have the answers and her previous therapist as a heart person who could nurture and care for her. In a way she was right, I was spending most of our time together "in my head" trying to reconcile the clinical issues contained in this discussion and, in so doing, was frequently far away from Emily.

Over time, with much self-reflection and supervision, Emily and I found a workable balance between emergent psychoanalytic exploration and trauma model techniques in working with her traumatic memories and self-states. I gradually learned how to titrate my application of more trauma model techniques with a psychoanalytic stance of exploration, attunement, and focus on the transference/countertransference phenomenon between us. Eventually, I was able to balance these modes of being in response to her needs in each session and in the process, overall. Over time I was more able to be engaged with Emily rather than absorbed by my anxieties about my ability to help her. These anxieties simply became enacted in my own distracting intellectual battle between theories that felt incompatible and irreconcilable and was certainly not helpful to Emily. Eventually I was able to shift my focus from dueling theories to my patient and her needs. She did not need me to be one kind of therapist or another; she needed me to be her therapist, a therapist who could flexibly hold multiple realities in mind as I engaged with her and her unique needs in each moment of each session over the course of many years. My integration was necessary to hers. However, I believe that Emily continued

to hold back from full engagement in the therapeutic process and in the relationship with me.

After years of therapy Emily has never once brought in a dream for discussion. When I asked her about this she told me that she had no memory of having ever had a dream. Emily continues to live in a world without dreams where the internal parts of herself do not imagine that they can ever feel safe or trust another. However, she lives in a world where it is possible to share her stories with another person, where she can be angry and sad and acknowledge hurt by another person, where she can laugh and be strong and weak with another person. She lives in a world where there is still hope for her healing.

Conclusion

Will Emily ever live in a mind that fluidly shifts from state to state without losing a sense of continuity and identity? I do not think so. I do not know that Emily would want that either. Was it wrong of me, as her therapist, to shift away from the model in which she learned to be a patient, where she felt loved and nurtured by a previous therapist and from which she derived a sense of safety and containment? I do not think so. In fact, I believe it was necessary. I believe it was necessary for Emily to know that there is so much more to her than her violent memories and traumatic history. I believe Emily needed to know that she was made up of thoughts and feelings, beliefs, and hopes of her own; she was not defined by her traumas but rather shaped and hurt by them.

I believe that for Emily and for all patients with severe dissociative disorders, the trauma model provides a strong containing framework for the early stages of therapy and a gentle resting place to return to when the therapeutic seas are rough. For therapists, it guides them in working with severe dissociation and abreaction in sessions, traumatic memory processing, affect dysregulation, self-harm, and suicidality in ways that the current psychoanalytic literature does not. However, as the patient moves beyond this first stage, relational psychoanalytic models of treatment for dissociation and trauma have much to offer. For instance, so often treatments with dissociative patients become hung up on unresolved enactments unnamed and unidentified by trauma therapists. Rather than leading to the destruction of the therapy and pain for all concerned, a relational approach to working with these stuck spots allows for something new, an experience of hope and resolution that bashes away at rigidly held beliefs that no relationship can ever be safe or work. Even when those enactments do not come to full explicit articulation, hanging on to a sense of knowing that there is something there, may allow a tired and overwhelmed analyst to keep holding on to the side of the boat and trying to get back in. There is a limit to the amount of explicit memory processing that is helpful, at some point, the analytic dyad must address what is beyond what is explicitly known and is, rather, simply relived over and over again. However, I do believe that, perhaps, the dissociated enactments that arise between the DID patient and analyst hold many, many layers of complexity and may be far more challenging to traverse than those with the “normally” dissociated patient that is predominantly exemplified in the relational literature. In my work with Emily, it certainly felt like at the bottom of each pit was another deeper pit of something new and horrifying; for each uncovered enactment was a new mutually dissociated challenge. This primary aspect of the relational treatment model for dissociation is most helpful to hold in mind and also incredibly complex and cannot be the only tool in the analyst’s therapeutic toolkit.

My work with Emily has been a mirror of my struggles to integrate my trauma model training with my psychoanalytic training. We stumbled and fell many times. At times I left Emily alone in silences I imagined she could tolerate and fill with her own reflections. At times I pile drove through her need for gentleness with my memory processing agendas. At times I was too much, too little, and everything in between. I suppose this is what every analysis is, in the end. However, this analysis helped to define for me the importance and value of integrating both of these parts of me; my history as a trauma therapist and my future as a psychoanalyst. Emily's story and mine hold up the value of integration. My work with Emily helped me find a way to titrate technique.

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